



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Date: Wednesday 26 November 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

26/11/2025 12:00 - 14:30

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**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 24 SEPTEMBER 2025**

Present:	Prof. C Balch	Chairman
	Mr J Teape	Chief Executive
	Dr M Beaman	Non-Executive Director
	Mr J Corrigan	Interim Chief Finance Officer
	Mrs L Edwards-Smith	Non-Executive Director
	Mr A Ghadiali	Non-Executive Director
	Dr C Lissett	Chief Medical Officer
	Mrs E Long	Director of Corporate Governance and Trust Secretary
	Ms A Jones	Deputy Chief Executive/Chief Operating Officer
	Mr P Richards	Non-Executive Director
	Mr S Tapley	Chief Strategy and Planning Officer
	Mr R Williams	Non-Executive Director
In Attendance:	Ms Jo Bassett	Director of Midwifery and Gynaecology
	Mrs V Browning	Lead Governor
	Mrs L Densham	Governor
	Mrs S Fox	Corporate Governance Manager
	Mrs A Hall	Member of the Public
	Mrs J Hughes	Mother of Patient Story Subject (for item 115/09/25)
	Mr M Joyce	Governor (part)
	Mr A Postlethwaite	Governor
	Mrs A Ramon	Governor
	Ms B Smith	Allerton Ward Manager (for item 115/09/25)
	Mrs J Spinks	Governor
	Mr D Thomas	Governor (part)
	Mr S Wadham-Sharpe	Deputy Chief Operating Officer
	Mr G Yardy	Governor

	WELCOME AND INTRODUCTIONS
97/09/25	The Chairman welcomed all those in attendance.
	PRELIMINARY MATTERS
98/09/25	Apologies for Absence and Quoracy

	Apologies for absence were received from Mark Greaves, Non- Executive Director, Nicola McMinn, Chief Nursing Officer, Jess Piper, Interim Chief People Officer and Chris Saxby, Non-Executive Director. The Chair confirmed the meeting as quorate.
99/09/25	Declaration of Interests No declarations of interests were received.
100/09/25	Corporate Objectives The Trust's Corporate Objectives were noted.
101/09/25	Board workplan The Board workplan was noted.
102/09/25	Unconfirmed Minutes of the Meetings held on 30 July 2025 The Board received the minutes of the meeting held on 30 July 2025, circulated with the agenda pack. The action log was reviewed, and updates were received on outstanding actions. The Board was informed by the Chief Executive of an error in the minutes of the meeting held on 28 May 2025. The patient story had been stood down and the minutes recorded it was due to sickness. It was in fact due to the sad passing of the brother of the gentleman due to present the story. The minutes would be amended to ensure they accurately reflected the reason why the story had to be stood down. The Board wished to record its apologies to the gentleman concerned and especially if this had caused any further distress. The Board APPROVED the Unconfirmed Minutes from the Public Board meeting held on 30 July 2025 as a true and correct record
103/09/25	Chair's Welcome The Chair briefed the Board as follows: • A number of consultant appointments had been made since the last meeting, with a good level of interest in the positions. Successful applicants were both internal and external to the Trust. The majority of these posts were to replace colleagues who had retired, rather than new posts. • The Chair had recently visited Ashburton, Brixham and Dartmouth community sites and reminded the Board of the excellent facilities and services provided at those locations. • John Govett (previously Chair of Cornwall and Isles of Scilly Integrated Care Board (ICB) had been appointed as Chair of the Devon and Cornwall Cluster. He had stated he was keen for his team to be forward looking, in particular around the implementation of the 10 Year Plan. He was also keen to see how the neighbourhood model that had been adopted in Cornwall could be applied to Devon. • The Chair and Chief Strategy and Planning Officer had supported Torbay Council with a visit from the Casey Commission, who were undertaking a review of adult social care. They were interested in the Torbay integrated model of care and how it worked, both the benefits and challenges attached to the model.

	Ashish Ghadiali was welcomed as a substantive Non-Executive Director following the departure of Siân Walker-McAllister. The Board approved the following non-executive changes in Board Sub-Committee membership: - o People Committee – Liz Edwards-Smith to become Chair, Chris Saxby and Ashish Ghadiali formal members. - o Finance and Performance Committee – Mark Greaves to become a formal member. Liz Edwards-Smith to stand down. - o Audit and Risk and Non-Executive Directors' Nominations and Remuneration Committees – Liz Edwards-Smith to join as Chair of People Committee. - o Charity Committee – at present, with the departure of Siân Walker McAllister, there was a vacancy on the Committee. In addition, Liz Edwards-Smith would need to stand down as Chair but remain on the Committee. This was in the process of being resolved. • The Trust's overall committee structure was also in the process of being reviewed, following feedback from the Well-Led review. The Board received and noted the report of the Chairman.
104/09/25	Chief Executive's Report The Board received the report of the Chief Executive, circulated with the agenda pack. The following was discussed: • It was noted that Simon Tapley had been appointed to the substantive Chief Strategy and Planning Officer position, and Sam Wadham-Sharpe as Deputy Chief Operating Officer. • The Board was briefed on the context to the Board self-assessment process that was taking place. There would be a need to hold an extra-ordinary Board meeting to review the assessment before it was submitted as the submission date was before the next Board meeting. ASW Assurance would also be asked to review the assessment to provide additional assurance. • It was suggested the Board needed to be better briefed on Pathology given the current challenges to the Trust's diagnostic services. It was noted that the Board had been due to receive a report on this issue at this meeting, but it had been delayed because further work was required at peninsula level. It would be presented to both the October Finance and Performance Committee and Board of Directors. It was requested that the report discussed not just system, but also regional and national arrangements for the service. Action: ST • Following the new national segmentation guidance, a league table had been established in place of the national oversight framework, with Trusts assessed from 1 to 4 and a segment 5 for those providers facing the most significant performance or governance challenges. The Trust had been assessed as being in segment 3, however as it was still part of the recovery support programme and had been part of the national oversight framework, it had been put into segment 5. It was important to note that this was due to the Trust's financial position and not because of the quality of care provided. The Board RECEIVED and NOTED the report of the Chief Executive.

	FOR APPROVAL
105/09/25	Responding to the invited Developmental Well Led Review The Board received the Responding to the invited Developmental Well Led Review report, circulated with the agenda pack. The following was discussed: • The Report detailed the findings of the Well-Led Review, noting that many of the actions were already being taken forward and were part of the Integrated Improvement Plan (IIP) • It was proposed that, rather than having a separate action plan, any actions not already included in the IIP were added to that framework. • The Board would further discuss organisational structure and committee framework at its development session in October. • It was suggested a review of delivery of actions be undertaken in February 2026. • The Board welcomed the report and that it had been presented in the public domain, demonstrating the Board's willingness to be open and transparent in terms of the findings of reviews such as the Well-Led Review. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also: • formally received the output of the well-led review; • accepted the recommendations made to strengthen Board and organisational governance arrangements; • discussed and approved the proposed alignment with the integrated improvement plan 'Our Plan for Better Care'; • agreed that progress against the 'Well led-review' key recommendations would be reported through the revised 'Our Plan for Better Care' governance arrangements; • approved the outline October Board Development Programme priorities; and • agreed that a further report would be brought to the Board in six months (March 2026) to consider what further action might be required in respect of the wider findings of the review.
106/09/25	Reports and Recommendations from Board Committees The Board received the Committee Chairs' report, circulated with the agenda pack. The following was discussed: Finance and Performance Committee • The review of the Board reporting framework was welcomed as the current meeting timings meant that, often, papers for the Committee were not able to be prepared in time for paper distribution due to constraints on when information was available to inform the reports. • The increased level of grip and control on the Trust's financial position was welcomed and the link between the Care Group triumvirates and clinical teams. It was felt that a lot of what was being delivered continued to be due to

	executive oversight and focus and this needed to be moved to the next tier down in management. Quality Assurance Committee • The Trust had been a pilot for Martha's Rule and since it had been in place 23 referrals had been made to the Outreach Team, however it had been found that nothing had been missed by the clinician/team treating each patient concerned. A discussion was held around whether the process should be extended to the Emergency Department for a cohort of patients that were located in the Trust's Resuscitation Unit, sometimes for extended periods of time. These patients were not well enough to be discharged or ill enough to be admitted so stayed on the unit until they either got better or were admitted. • It was noted that work was taking place to ascertain how this cohort of patients could be better managed, however due to their location in the Resuscitation Unit they actually received a higher level of care and oversight than other patients in the Emergency Department. • An action was agreed to consider both an extension to Martha's Rule for this cohort of patients and solutions to the need for a high dependency unit for the Emergency Department. Action: AJ/KL • The Committee received the first annual Mortuary Report, which was welcomed. It would also be reviewed by the Board later in this meeting. • Concerns around the reduction of non-clinical staff and unintended consequences in terms of additional pressure this might create on clinical staff had been discussed. Both the Chief Nursing Officer and Chief Medical Officer provided assurance that this was not the case. • The Committee welcomed the fact that all serious incident reports were now completed – there had been a significant backlog and a lot of work had been undertaken to remove the backlog and ensure the Trust learned from incidents in a timely manner. People Committee • A discussion had been held around the limited assurance presented by both the Workforce Race Equality Standard and Workforce Disability Equality Standard action plans and that there were not yet sufficient mechanisms in place to track progress. This was in the process of being addressed. Building a Brighter Future Committee • The Committee had received the Green Plan refresh and also an update on the Trust's digital innovation programme. • Concern remained around the significant fragility of the Trust's estate and the scale of the maintenance programme. • The urgent need for clarity around the risks attached to the Tower Block, what mitigations were being put in place, and also the view of the Fire Service, was discussed at the meeting. It was acknowledged that this was the Trust's most significant risk and one that had been raised at national level as one of the drivers for the new hospital programme. • The Committee received an update on the Electronic Patient Record (EPR) implementation. Concern was raised around the Trust's organisational

	readiness for implementation and assurance was provided plans were in place to ensure the Trust was prepared for implementation, and to ensure benefits realisation. It was noted that now the Chief Operating Officer was back at work, and with the support of the Deputy Chief Operating Officer, there would be a focus on the Trust's readiness for implementation. In respect of benefits realisation, this would be captured as part of the Trust's operational plan. - Assurance was sought around the impact of the decision to stand down some statutory and mandatory training during the Electronic Patient Record (EPR) training phase. It was agreed a report would be presented to People Committee on this issue, alongside an equality impact assessment. Action: AJ - The need to ensure all colleagues were fully trained before the EPR go live date was discussed, given the timing of the training which would be over the winter, with colleagues having to manage increased demand over that period. It was noted that work was being undertaken to ensure training was provided in a variety of different ways so colleagues were able to access it. - Concern was raised around the lack of progress to appoint a Devon Chief Information Officer. The Board was informed that a process had been agreed to progress this issue. Charity Committee - A new Finance Manager had been appointed and the Committee had received a number of positive impact stories around the benefits of the receipt of charitable funds.
107/09/25	2025/26 Winter Plan The Board received the 2025/26 Winter Plan, circulated with the agenda pack. The following was discussed: - Since the draft Winter Plan had been presented to the private Board meeting in August and also Finance and Performance Committee, regional planning events had been held and a system testing session would take place in early October. Learning from those events had and would be applied to the Plan. - A section on finance had been added to the Plan noting there was funding to support opening the discharge lounge overnight for four days a week. There was no funding for any other additional activity. - The Plan also now referenced Epic and the training requirements over the winter period and had also been updated to take account of draft ICB plans. - Risks attached to the Plan were articulated, including the need for a mobilisation plan and there was still limited assurance in respect of the Trust's ability to manage a surge in demand and meet its operational, performance and financial plans. - The Plan forecast an 83-day bed gap based on 92% bed occupancy, with an expected peak of 96-98% bed occupancy in January. There would be a national mandate of 80% bed occupancy leading up to Christmas which the Trust would need to consider how to achieve.

	• Learning from winter in Australia also needed to be considered. They had experienced a higher rate of flu and mortality and had a lower vaccine update than in previous years. • The Trust's approach to the flu vaccine was queried. It was noted that communication internally had already commenced, and the Trust was targeting a 5% improvement on last year. • A further risk related to the replacement of the Pharmacy Robot. The old one would be removed in early October, and the new one would become operational just before Christmas. In the intervening period Pharmacy colleagues would need to use manual processes which would impact on flow. • It was agreed the assurance document which the Board would be asked to approve needed to be amended to properly reflect the risks attached to the Plan, before it was submitted. Action: AJ/SWS The Board AGREED the recommended assurance rating and took LIMITED/SATISFACTORY assurance as to those matters reviewed. The Board also took SATISFACTORY assurance that significant progress had been made in the creation of a Trust wide Winter Plan and noted that further work had been undertaken ahead of September sign off. The Board also APPROVED the Board Assurance Statement, noting the changes to be made to it agreed in the meeting, before submission.
108/09/25	Green Plan Refresh The Board received the Green Plan Refresh, which had previously been reviewed by the Building a Brighter Future Committee and Private Board. It was noted that feedback had been received around ensuring the Green Plan was at the heart of the Trust's transformation strategy. The Board AGREED the recommended assurance rating and took LIMITED/SATISFACTORY assurance as to those matters reviewed. The Board also APPROVED the Green Plan Refresh.
109/09/25	Our Plan for Better Care People Programme 5.3 Culture Plan The Board received the Our Plan for Better Care People Programme 5.3 Culture Plan report, circulated with the agenda pack. The following was discussed: • The report articulated how the Trust would ensure it understood the culture of the Trust, what had or had not worked in the past to improve culture, and to set out expected standards of leadership and behaviours. • It was suggested the plan was ambitious and the Trust should seek to agree what actions it could deliver, rather than have lots of actions in place and not be able to deliver them all. • It was acknowledged the role of the Board was key in modelling expected standards of leadership across the Trust. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also AGREED the culture plan approach and priority actions as outlined, whilst noting that further refinement, engagement and socialisation was required. Progress with delivery of the actions against the key performance indicators would be reported via the 'our plan for better care' governance via the People Programmes Leads and Senior Responsible Officer.

110/09/25	Annual Mortuary Report 2025 The Board received the Annual Mortuary Report 2025, circulated with the agenda pack. The following was discussed: • The report highlighted the work of the Mortuary team over the last year and the work that had taken place to ensure the team could implement the requirements of the Fuller Inquiry Phase 2. • The report detailed the dignity and compassion in the care of the deceased and support provide to family and friends. • It was suggested the use of the word 'Fuller' should be amended given the nature of the crimes committed. Action: KL to provide feedback to the national team. The Board AGREED the recommended assurance rating and overall SATISFACTORY assurance as to those matters reviewed. • Air Handling Unit (AHU): Support was requested for replacing the AHU in the Post Mortem room, which was graded as 'Poor' and posed 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 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". • Human Tissue Authority 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.
	FOR REVIEW
	Finance
111/09/25	Month 5 Finance Report The Board received the Month 5 Finance Report, circulated with the agenda pack. The following was discussed: • The Trust had met its Month 5 target of a £9.8m deficit and was on plan to deliver its end of year forecast.

	• CIP was ahead of plan; however recurrent savings were below plan. It was agreed that future reports would provide tracking of the Trust's underlying position. Action: JC • Following a review of the month 4 forecast the gross risk had been assessed as £19.8m to delivering the £8m planned deficit. Actions were in place to reduce run rates and in total these actions gave the ability for the Trust to deliver the forecast plan for 2025/26. As yet, there was 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 was therefore £8.6m. • It was noted that limited assurance had been given to delivery of CIP, financial risks and workforce and what would need to take place to improve these to satisfactory was discussed. It was noted that the Trust was keeping a tight grip on delivery of these action plans, but it was too early in the year to report if they would be fully delivered by year end, so limited assurance was being reported. The Board AGREED 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. The Board also NOTED the Trust's financial performance to 31st August 2025
	Performance
112/09/25	Integrated Performance and Quality Report The Board received the Integrated Performance and Quality Report, circulated with the agenda pack. The following was discussed: Emergency Care • The Trust had experienced its best 4-hour performance since 2022. • Ambulance handover times had deteriorated but were still under 40 minutes. • 12 hour waits in the Emergency Department had remained under 10% for six months. • The national paediatric 4 hour wait target of 95% was not being met, but there was a trajectory to meet 90% by the end of the financial year. • The Trust had experienced the three busiest months in its history during the summer and had still managed to deliver improvements in performance. • There had been some challenges experienced in September, but performance had not deteriorated to previous levels during this time. • A Right Care Week had taken place in July and a further one would take place in November. • Work was taking place to reinvigorate the ward improvement plan. • The Trust would be holding a joint Emergency Department mental health summit with Devon Partnership Trust. Elective • 18 and 52 week performance was ahead of trajectory.

	- There remained a small number of 78 week breaches and the 65 week position had deteriorated due to industrial action. Cancer - The cancer faster diagnosis standard was behind plan. A new recovery plan had been put in place and had started to realise improvements in performance. Diagnostics - Work continued to take place to improve performance including a renegotiation of the contract for the Community Diagnostic Centre to provide more capacity. - The drivers to the increased demand during the summer months was queried. It was noted that the Trust's population increased during the summer months, but also there was a deficit in the system for musculoskeletal issues, mental health and dental for example. The Trust was now a member of the system Demand Management Oversight Group which looked at how to better manage demand across the system. - There was a risk the ICB could cap growth for 2026/27 at zero and the Trust would continue to experience growth in demand. - Patients who had no criteria to reside were discussed. It was suggested it would be helpful to understand how many of them were Torbay or South Devon patients, which would provide information on the success of the integrated social care model. Action: ST Quality - There had been eight 'death' or 'serious' incidents in August. Three related to obstetrics and full reviews had been undertaken with no concerns found (further detail was contained in the maternity report later in the agenda). The Chief Medical Officer provided assurance that the data did not present any trends or areas of concern. - It was suggested it would be helpful for the Board to have a presentation from an epidemiologist at a Board Development Session, which would help inform the Trust's strategy. It was suggested Torbay's Public Health Director be invited to a future meeting. The Board AGREED the recommended assurance rating and took LIMITED/ SATISFACTORY assurance as to those matters reviewed. The Board also 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 Urgent and Emergency Care (UEC) - approved the recommendation that the Trust had not met UEC performance trajectories and there was limited assurance. Strengthened plans and assurance were 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 Referral to Treatment, Cancer 62 days and Faster Diagnosis

	standard. Requirement for more detailed recovery actions and trajectory to improve assurance of delivery in 2025/26. • Finance – approved the recommendation that there was satisfactory assurance on financial delivery for month 5. Financial recovery plans needed to be developed to address areas of overspend. • Workforce – approved the recommendation that there was satisfactory assurance on workforce performance metrics and assurance ratings by care group.
113/09/25	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 Board noted the September delivery position of the separate elements of the Plan. - o There had been a slight pause in some areas of the Peninsula Acute Sustainability Programme. The ICB was in the process of producing a strategy and setting commissioning intentions which had slowed down the process. The Trust continued, however, to progress work on Dermatology and Oral and Maxillo Facial. - o Cancer performance was behind plan and had been discussed earlier in the meeting. - o The elective centre of excellence was red, pending agreement for funding for Ophthalmology diagnostic lanes. - o Estates issues had been previously discussed in the meeting. - o The Financial Improvement Programme had moved from amber to red. Assurance was provided that all the right processes were in place, but delivery was current rated red. - o The work to progress Manged Services, and Procurement and Finance Shared services were impacted by capacity issues and changes to regulations. • A query was raised around the processes in place and if they provided clarity of focus to achieve the required outcomes. It was felt that they provided focus, but there were issues around capacity in some areas and not all were in the Trust's gift to resolve. It was recognised the Trust needed to strengthen its Programme Management Office and ensure it had the right organisational capacity in place to deliver the programmes of work. It might also be necessary to make some hard decisions around which areas of work to progress and those to stop. It was agreed the Board would be informed of the plans to build organisational capacity. Action: ST The Board AGREED the recommended assurance rating and took LIMITED assurance as to those matters reviewed. The Board also: • Noted the first Integrated Improvement Plan delivery report and progress made during the reporting period. • Acknowledged the risks and ongoing work required to improve delivery in the core domains.

	• Took assurance that the improvement programme was being actively driven by the Executive Team and is beginning to impact on delivery of the organisation's key priorities.
114/09/25	Electronic Patient Record Progress Report The Board received the Electronic Patient Record (EPR) Progress Report, circulated with the agenda pack. The following was discussed: • Three programme risks had been escalated for executive oversight: Beacon protocol build and validation; estates electrical infrastructure; and materials management system integration. • The need to plan for the impact on staff morale during the implementation period was acknowledged. The impact would be significant and although colleagues were keen for the EPR implementation and the benefits it would bring to their working lives, they would need support during this time given the significant change it would introduce to working practices. • It was suggested People Committee might need to have oversight of the impact on colleagues during the implementation phase. • The likely downturn in activity during implementation was queried. It was noted that a significant downturn was not anticipated, and the Trust was taking learning from the experiences of the Royal Devon and Exeter University and implementation at other trusts. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board took SIGNIFICANT assurance that progress was good and that strong foundations had been created. Two independent assessments had described the program as "exemplar" This level of assurance was also based on the risks identified and the work being undertaken to mitigate these.
115/09/25	Patient Story The patient story concerned Ben Hughes, a young gentleman with learning disabilities and Down Syndrome. Prior to his hospital admission he lived in supported living with 2:1 care and had a very active life and many interests. Ben was admitted to the Trust after he had swallowed a large piece of plastic and was placed on Allerton ward to recover from his surgery. He subsequently required a second surgery due to a leak in his tummy. During his stay with the Trust Ben was highly distressed and frightened. The Ward team worked with him and his parents to ensure that his best interests were always paramount during his care. His parents were able to advocate for Ben and worked together with the ward during this time. Ben was an inpatient for around three months and found it difficult being constrained to a room, so the team found ways to ensure he was kept occupied and was able to be supported to get outside during his stay. Due to the incident a safeguarding concern was raised. This was upheld and an alternative placement was found for Ben, in Teignmouth, meaning his family were still able to visit him on a regular basis. Becky was asked how she and the team prepared for patients such as Ben. Becky explained that all ward colleagues were up to date with their training and had managed many patients with learning disabilities on the ward in the past.

	Mrs Hughes was asked if she if she felt there was anything more the Trust could have done during Ben's stay. She said there was not, and that she felt so fortunate to have been supported by Becky and the team and to have been listened to and not be made to feel an inconvenience when she was advocating for Ben. The importance of sharing learning such as this across the Trust was acknowledged. The Board received and noted the Patient Story.
	Quality and Safety
116/09/25	Perinatal Governance and Safety Report The Board received the Perinatal Governance and Safety Report, circulated with the agenda pack. The following was discussed: • The report presented satisfactory assurance in respect of the Maternity Incentive Scheme (current position) and Maternity and Neonatal Voices Partnership Capacity. • The Board Safety Champions were meeting with the Perinatal quadrumvirate leadership team at least on a bi-monthly basis. Any support required of the Trust Board had been identified and was being implemented. • Progress with the maternity and neonatal culture improvement plan was being monitored and any identified support being considered and implemented. • A multi-disciplinary perinatal review meeting had taken place in June to review some of the moderate incidents. This had been supported by the national team and a number of actions had been agreed to be taken forward by the team. • There continued to be a focus on culture, supported by the department's leadership team and Board Maternity Champion. • Listening events also continued to be held so concerns and issues could be discussed. • The department was currently on track to meet all of the ten Clinical Negligence Scheme for Trusts criteria this year. It was noted that some Trusts had been asked to pay back funding they had received for declaring meeting all of the ten criteria when it was subsequently found they had not. Ms Basset was thanked for her openness and honesty when preparing the previous year's assessment. • It was noted that work had progressed to resolve the maternity estates issues, however a start date for the works had not yet been agreed. • Mr Beaman stated that when he had visited the team he received positive feedback from colleagues. He highlighted the difficulties of newly qualified midwives securing preceptorships once qualified. It was noted that the Government had invested heavily in midwifery training, so there were a lot of newly qualified midwives looking for jobs, but unfortunately there were not enough vacant post for all newly qualified colleagues. The Department of Health and NHS England were currently looking at ways to resolve this issue. • A query was raised around the issue highlighted by the Care Quality Commission in terms of the availability of a second theatre team. It was noted that this was on track to be resolved.

	The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also NOTED: • the progress and compliance position regarding the priority areas; • the key quality and safety issues identified in the report and the measures in place to address any areas of concern; • 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 noting that the Devon resource would still not enable full compliance with all the recommendations for hearing the service user voice. It would remain as a risk on the service risk register and will require an action plan; • the current position of compliance against the Maternity Incentive Scheme with full compliance anticipated in March 2026; and • the collaboration with Somerset Foundation NHS Trust to second two Labour Ward Coordinators increasing resilience within our workforce.
117/09/25	Maternity and Neonatal Staffing Report The Board received the Maternity and Neonatal Staffing Report, circulated with the agenda pack. The following was discussed: • The paper provided detail of the Maternity and Neonatal staffing metrics, noting the reduction in vacancy rate and downtrend in sickness. • It was anticipated there would be a zero vacancy rate in the near future and there had been a reduction in acute maternity colleagues stating they felt unable to manage their workload. • Staffing fill rates were discussed. It was noted that this was linked to the Trust's integrated model of midwifery care, with community midwives coming to the acute site to support deliveries. The staffing model was based on an inpatient ward rather than an acute and community model. • A draft of the Birth Rate plus report was expected shortly. It would be shared through normal governance routes once it was finalised. • The Trust did not currently meet the standard for qualified in speciality (QIS) neonatal nurses, but there was an action plan in place to address this issue. • Good collaborative work was taking place with colleagues at Somerset Foundation Trust whilst their maternity unit was closed. • A query was raised around the replacement of the Retention Midwife who had left this role. It was noted that the need for the retention role had now altered, and the resource would be used in a different way whilst keeping the good work that had been achieved going. • It was highlighted that it was not always possible to support community and home births with the required number of two midwives. This was because the Trust needed to ensure the safety of all women in labour and available resource was allocated on this basis. The Trust was not generally outlier in this regard. • It was highlighted to the Trust board that the BAPM recommendations of the neonatal medical and nursing workforce is not met due to the shortfall in QIS

	neonatal nurses. The action plan around neonatal nursing levels is included in the Board papers for the Board to note. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also NOTED: • the mitigations taken within the maternity service to ensure safety and quality; • the ongoing service requirements of the Obstetrics and Gynaecology team; • the continuing falling levels in sickness rates within maternity staff; • the significant fall in vacancy rate for midwifery staff and further projected fall, which was likely to be evident by October 2025; • the action plan that had been developed to address the challenges in relation to QIS nurses in the Special Care Baby Unit; and • that workforce recommendations form part of the recommendations of the MSSP report.
	Annual Reports
118/09/25	Care Quality Commission Registration The Board received the Care Quality Commission (CQC) Registration report, circulated with the agenda pack. The Board AGREED the SATISFACTORY assurance that the annual CQC registration has been undertaken.
119/09/25	Safeguarding Children Annual Report The Board received the Safeguarding Children Summary Annual Report, circulated with the agenda pack. The report provided assurance on the work of the Safeguarding Children Team and how the Team was meeting its statutory and regulatory obligations, noting the complex mix of cases and high demand. The report presented limited assurance in respect of national changes due to the uncertainty of the national direction of travel in the future. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also took SATISFACTORY assurance that the safeguarding practice of Torbay and South Devon Foundation Trust staff, overseen by the Safeguarding Children's Team was in accordance with national and local legislation. This was 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.
120/09/25	Adult Social Care Local Account The Board received the Adult Social Care Local Account, circulated with the agenda pack.

	The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also took assurance that the Adult Social Care Local Account Summary had been developed through the appropriate governance and quality assurance processes and has been approved with no changes by the Local Authority.
	Governance
121/09/25	Board Assurance Framework The Board received the Board Assurance Framework (BAF), circulated with the agenda pack. The following was discussed: • The first version of the updated BAF was being presented to the Board for consideration. It had been significantly updated to provide more granular assurance around the delivery of the Trust's objectives. • It was noted that further work needed to take place to refine the BAF and ensure it was aligned to the Integrated Improvement Plan. It also needed to be reviewed by relevant Board sub committees. • It was suggested it would be helpful to provide a heat map which made it easy to understand where changes to assurance ratings had taken place. Action: EL • It was noted there was a need to review overdue risks, as some of them were now several years old. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also received and noted the BAF, BAF Highlight Report, Organisational Risk Map and Datix Summary.
122/09/25	Information: Legal and Regulatory Updates The Board received the Information: Legal and Regulatory Updates report, circulated with the agenda pack. The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed.
	CLOSING MATTERS
123/09/25	Any Other Business No further business was discussed.
124/09/25	Date and Time of Next Meeting: The next Board meeting in public was scheduled to take place at 12.30 pm on Wednesday 26 November 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. September Update: not yet completed.	Open
82/07/25	Patient Story – deep dive on the issues raised to be undertaken at the Quality Assurance Committee,	NM	September Update: update to be provided at the next meeting,	Open
82/07/25	Patient Story – consider how patient experience data and staff experience data across the Trust could be improved	NM/JP	September Update: included in the Plan for Better Care and Culture Plan.	Closed
93/07/25	Infection Prevention and Control Annual Report – letter of thanks to be written to the Infection Prevention and Control Team.	JT/CB	September Update: completed.	Closed
104/09/25	Chief Executive's Report – Pathology report to be presented to the next meeting to detail system, regional and national arrangements for the service.	ST	October Update: The decision has been taken at PAPC, that this business case will now move through November governance.	Open

106/09/25	Committee Chairs' Reports (QAC) – extension of Martha's Rule in the Emergency Department to be considered and solutions for an Emergency Department High Dependency Unit.	AJ/KL	November Update: Action will be reported through QAC 17/11/25. Recommend closure.	Open
106/09/25	Committee Chairs' Reports (BBF) – report to be presented to People Committee on the likely impact of standing down statutory and mandatory training in lieu of Epic Training. An Equality Impact Assessment to also be provided.	AJ/JP	November Update: Paper being presented to People Committee on 20/10/25.	Open
107/09/25	2025/26 Winter Plan – assurance document to be amended to articulate the risk attached to the plan.	AJ/SWS	November Update: assurance statement amended.	Open
108/09/25	Mortuary Annual Report – feedback to be provided to the national team around the Board's concern at the continued reference to 'Fuller' as part of the national enquiry.	KL		Open
111/09/25	Month 5 Finance Report – future reports to provide tracking of the Trust's underlying CIP position and progress made.	JC	October Update: see Month 6 Finance Report.	Open
112/09/25	Integrated Performance and Quality Report – provide data on the numbers of Torbay and South Devon no criteria to reside patients.	ST		Open
113/09/25	Our Plan for Better Care – October report to contain detail of the plans to build organisational capacity.	ST		Open
121/09/25	Board Assurance Framework – heat map to be provided in future reports.	EL		Open

Board of Directors

Chief Executive's report

Date of meeting	Date report produced
26.11.2025	18.11.2025

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:	20.11.2025
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, Safety and Patient Experience	
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
 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 continues to be 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. During my visits a consistent theme raised with me is how hard people are working and the impact on some teams on the vacancy freeze and especially in relation to administration posts. As we move towards a new Electronic Paper Record (EPR) we need to manage the transition carefully and ensure we keep our services safely running over the rest of this year.
3. 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. I also joined, participated in and/or hosted our Partnership Forum, our corporate induction, our preceptorship programme, our senior leaders briefing and Trust Talk in the past two months.
4. Since my September report I have spent time with our intensive care unit, Ainslie, Allerton, Cromie and Ella Rowcroft wards, day surgery, fracture clinic, surgical receiving unit, theatres, Teignmouth Hospital and Brixham Hospital as well as joining events celebrating Allied Health Professionals Day, our SAS doctors awards and our organ donor memorial event. We also held our annual members meeting, I met with our armed forces community and I also attended, with Kate Lissett, our medical staffing committee annual general meeting.
5. 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 was privileged to join local partners at the Torbay Baton of Hope events. I also visited Jack Sears Rehabilitation Centre in Paignton. Listening to the concerns and ideas of local people and communities is very important to me.
6. I continue to meet regularly with our local MPs, Steve Darling, Caroline Voaden and Martin Wrigley.

Business planning 2025/26

7. Our finances remain in a very challenging position and although there are some small signs of improvement, we will continue to face a significant financial challenge through the rest of this year and into 2026/27 and beyond. While we are still reporting the delivery of our plan for this year our underlying position is deteriorating due to the extent of one-off measures being used and the approach, we are taking through vacancy freeze is a time limited strategy as it will be impacting on areas that may not be where we would have chosen to save money.

8. I cannot underestimate therefore the importance of our planning for 2026/27 and being clear about what we can continue to do and how we will redesign our service model. We will need a radical plan if we are to meet the likely financial expectations that will be placed upon us.

Our future – our strategy

9. Last month we updated the Board on the work we have undertaken developing our strategy for the next 10 years.
10. Since this time, we have developed a draft document which will require more work before we share with wider stakeholders and our staff. However, it does provide a solid basis which we can shape and use to plan for 2026/27.
11. Our aim is to have a final strategy for Board sign off early in 2026 but we are now using the key principles, signature moves and enabling plans to ensure they are guiding us in the 2026/27 planning process.
12. This is an important moment for us as in reality we face a period of managed decline unless we can be clear about a bold and ambitious place-based plan for the people of Torbay and South Devon.

Planning for 2026/27

13. Our preliminary underlying position is at least £82 million. This deficit implies a very significant cost improvement programme (CIP) requirement alongside the challenges of growing demand for services, challenging performance targets and a range of workforce issues.
14. The planning workgroup has met weekly since August and progress includes:
 - the development of an elective care demand plan and demand and growth models including non-elective, community, CHC and adult social care
 - the first draft of the Medium Term Financial Plan (MTFP)
 - key themes from revised strategy identified and work taking place
 - additional support for specialist expertise in BI and workforce, as well as piloting a web-based capacity and demand tool
15. The first of many planning workshops has been held with care groups to establish the operating environment, principles and assumptions required for joined up working across financial, performance and workforce activity while we wait for national guidance. The next workshop takes place in November.
16. The Executive Team met with a cohort of senior clinical and operational leaders on 20 November 2025 to outline the scale of the challenge we face, the headlines from our strategy, and the opportunity this presents to build a bold plan.
17. More work is needed to create plans for research and development, education and learning and digital innovation.
18. We will need to dedicate time as a Board to be clear on the actions we will take in 2026/27 and to start planning for them now including community and staff engagement and how these link to the ICB commissioning intentions and our own emerging strategy.

Industrial action

19. The Board will be aware that resident doctor members of the British Medical Association (BMA) took part in its latest round of industrial action in its dispute with the government about pay and conditions from 7am, Friday 14 to 06.59am on Wednesday 19 November 2025.
20. This is a dispute between the government and the BMA about pay and conditions and is not a local dispute between our people and our organisation. We continue to respect people's right to take part in any action, and hope that an agreement is reached soon.
21. I would like to thank everyone who worked hard to plan for this industrial action, and for working hard to protect and maintain our services and ensure as many clinics and procedures ran as possible. In particular, I would like to recognise Dr Catherine Blakemore who ensured there was safe and sufficient consultant cover in place across our wards and services. During the industrial action between 23%-32% of resident doctors attended work each day.
22. Fewer appointments and procedures were cancelled this time than during previous industrial action, but we regrettably had to cancel 268 outpatient appointments, seven elective and 12-day case procedures. We would like to apologise to anyone whose care was affected, and we are working hard to rearrange all appointments.

Local government reorganisation

23. The Government's devolution and local government reform programme requires Devon to move away from the current two-tier system. All councils must submit proposals by 28 November 2025 and several competing models are under consideration:
 - Devon County Council's "New Devon" Proposal: A single unitary authority covering the whole county (excluding Plymouth and Torbay), with 16 Neighbourhood Area Committees to maintain local accountability. This option is presented as the most cost-effective, with projected annual savings of £28.6m and the shortest payback period.
 - District Councils' "4-5-1" Model: Three new unitary authorities—one for Torbay and South Devon (including South Hams, Teignbridge, and West Devon), one for Exeter and Northern Devon (East, Mid, North Devon and Torridge), and Plymouth remaining standalone. This model aims to balance financial sustainability with local accessibility and forecasts cumulative savings of £508m over 10 years.
 - City Councils' Four-Unitary Proposal: Plymouth, Exeter, and Torbay would each retain or expand their boundaries, with a fourth authority for the coast and countryside. Advocates argue this approach reflects economic growth drivers and local identity, though concerns remain about fragmentation and complexity.
24. Torbay Council has indicated a preference to remain a standalone unitary but is open to joining a larger grouping if required.

25. NHS organisations, including our organisation, will be statutory consultees in the next phase, and we are working with the ICB to ensure health and care integration is considered in any future structure.

Successes – our people and teams

Unveiling of our organ donor memorial

26. In September, we unveiled our much-awaited Organ Donor Memorial at Torbay Hospital, a lasting tribute to those who have given the gift of life through organ and tissue donation. The memorial, designed by Hospital Art Studio, is inspired by local seagrass beds—symbolising renewal and life—and features donor names and a commemorative poem.

27. The installation was completed ahead of Organ Donation Week, culminating in a moving event on 26 September attended by donor families, colleagues, and partners. The evening included readings, music, and a moment of honour led by NHS Blood and Transplant representatives. Feedback from families was overwhelmingly positive, describing the occasion as “humbling” and “a fantastic representation of the NHS.”

28. This project reflects our commitment to raising awareness of organ donation and supporting conversations that can save lives. It was made possible through collaboration across teams, donor family fundraising, and the dedication of our organ donation committee, medical and nursing colleagues and colleagues in estates.

SAS doctors awards

29. I was proud to join in celebrating the outstanding achievements of our Specialty, Specialist and Associate Specialist (SAS) doctors at the annual SAS Doctor Awards, held at Torbay Hospital on 16 October 2025. Now in their third year, these awards recognise the vital role SAS doctors play in delivering high-quality care and innovation across our services.

30. Award winners:

- Learning, Research and Development: Dr Helen Kimble
- Patient Safety and Quality Improvement: Dr Shyam Singam
- Making a Difference (Leadership and Management): Dr Niki Burke
- Respect, Teaching and Training: Dr Anita German

31. Dr Anita German was also named SAS Doctor of the Year for her exceptional impact on patient care and commitment to training and development.

32. In addition, Dr Niki Burke received a Special Recognition Award for her inspirational leadership as SAS Tutor and Advocate. Under Niki’s guidance, the Trust has achieved regional and national recognition against the SAS Charter. Niki has now stepped down from these roles to become Regional SAS Associate Dean for the South West, ensuring her influence continues at a wider level.

33. The awards, funded by NHS England, form part of our ongoing commitment to SAS doctors’ wellbeing, development and recognition.

Volunteer of the Year award launched

34. We have launched a new Volunteer of the Year Award to recognise and celebrate the outstanding contribution of our 396 registered volunteers. These individuals provide vital support across our services – from companionship on wards and in care homes to administrative assistance, mentoring, and creative activities that enhance patient experience.
35. Nominations are open until 27 November and can be submitted by staff or volunteers. A judging panel will shortlist three finalists, who will then go forward to a public vote. The winner will be announced at our annual Our People Celebration event in May.
36. This initiative reflects our commitment to valuing and recognising those who give their time and skills to help our communities thrive.

Working with our armed forces community

37. I am pleased to report that we have been awarded the Armed Forces Covenant Silver Award, recognising our commitment to supporting members of the armed forces community, including reservists, veterans, and their families. This achievement reflects our progress in implementing policies that promote flexible working for reservists, recruitment initiatives for veterans, and raising awareness of the Covenant across our organisation.
38. In addition, we marked Remembrance Day with a well-attended event at Torbay Hospital on 11 November. The ceremony included a two-minute silence, the laying of wreaths at our memorial, and participation from staff, volunteers, and representatives of local armed forces organisations. This annual event demonstrates our respect for those who have served and our ongoing commitment to the armed forces community.

Our Torbay and South Devon NHS Charity Christmas Appeal

39. Our Torbay and South Devon NHS Charity has launched its first public Christmas Appeal to make the festive season brighter for patients and staff. For nearly 30 years, gifts for inpatients on Christmas Day have been funded through ward and general funds; this year, the initiative is being promoted externally to increase visibility and support. Donations to the appeal can be made on the Charity's website: [Our Christmas appeal - Torbay and South Devon NHS Charity](#)
40. The Christmas Appeal aims to ensure every patient in hospital on Christmas Day receives a gift and to provide a small token of appreciation for more than 800 of our NHS people working on the day across acute, community, social care, estates and support services.
41. We are, as always, grateful for our eight Leagues of Friends who will continue with their own seasonal activities to support their areas.

Remembrance weekend for families

42. On 06–07 December, we will host our annual Remembrance Weekend for families who have experienced the loss of a baby or young child during pregnancy or early life. This event provides a gentle and supportive space for reflection and connection.
43. Crafting Session: Saturday 06 December, 10am–12pm, Bayview Restaurant, Torbay Hospital – creative activities for families of all ages.
44. Remembrance Service: Sunday 07 December, 13pm, All Saints Church, Babbacombe – includes reading of names and placing stars on a memorial tree, which will later be displayed in the hospital chapel throughout the festive season.
45. Organised by our maternity, chaplaincy and children's community nursing teams, this cherished tradition offers comfort and togetherness at a particularly emotional time of year.
46. We are grateful to All Saints Church for their continued support.

Partnering with Torquay Rotary Club

47. We have strengthened our community partnership with Torquay Rotary Club through two initiatives aimed at enhancing our environment and supporting wellbeing.
48. Heartsease Garden Improvements: The Heartsease Garden is a remembrance space located in the grounds of Torbay Hospital, created in partnership with the Miscarriage Association to provide a peaceful area for families to reflect and remember babies lost too soon. It features a memorial bench, plantings of violas (known as "Heartsease"), and a commemorative stone where families can place plaques. Rotary volunteers are working alongside our estates and facilities team to refresh planting, improve seating areas, and create a more tranquil space.
49. Crocus Planting: As part of Rotary's national campaign to raise awareness of polio eradication, hundreds of purple crocus bulbs have been planted across the Torbay Hospital grounds adding seasonal colour and reinforcing our commitment to community engagement.

Occupational Therapist becomes world champion

50. Jane Avery, Occupational Therapist, captained her crew from River Teign Rowing Club to win the Women's Supervets category at the World Pilot Gig Championships on the Isles of Scilly earlier this year. This prestigious event attracts more than 400 crews and showcases teamwork, resilience and commitment—values that are at the heart of the NHS. Jane's success reflects the dedication and wellbeing of our NHS people and offers an opportunity to celebrate the diverse talents within our workforce.

Medicine for members event - cancer

51. Thank you to everyone who attended last month's Medicine for Members' event which explored developments in cancer care and treatment. The session was led by Nicole Dorey, Consultant Clinical Oncologist and Clinical Service Lead for

Radiotherapy and Oncology who shared her expertise with the audience of our governors and our members.

52. Our medicine for members events are held twice a year, organised and hosted by our governors, and are an opportunity for our clinicians to showcase topics which are important to people and our communities. The next event will take place in April 2026.

Cancer community event

53. Last month, people living with cancer, and the friends and carers who support them, attended a new community cancer wellbeing event at Newton Abbot Racecourse to learn more about the support available to them.
54. The event was organised by our personalised care and cancer services teams, and brought together local organisations, NHS professionals, and community support groups to showcase the wide range of help available for people affected by cancer, including advice on physical activity, financial matters, and mental health and wellbeing.
55. It also provided an opportunity for people to meet others living with cancer as connecting with others can make a positive impact on someone's wellbeing and provides reassurance, comfort and a sense of belonging.

Priority areas

Cardiology

56. In April 2025, we made the difficult decision to close our Heart Failure Virtual Ward following the end of temporary funding arrangements with NHS Devon and in the context of our £41.5 million savings programme.
57. The Torbay Heart Campaign has questioned this decision as part of broader correspondence about cardiology services. I have acknowledged our disappointment at having to close the virtual ward and confirmed that we are reviewing how we deliver virtual wards to determine whether we adopt speciality-based wards or a single integrated virtual ward model. This review includes consideration of reinstating the Heart Failure Virtual Ward.
58. The Heart Campaign has asked the Board to respond to the following questions which were discussed at our Board meeting on 29 October and the answers below shared directly with the leaders of the campaign:
- From which budget the frailty service is being funded, and why equivalent funding was not secured to sustain the virtual cardiac ward?

The Frailty Hub was a key part of our annual plan for 2025/26. Opening this autumn, it is funded through a combination of repurposed budgets that already support older people and anticipated savings from this new way of caring for people with frailty. This approach ensures we make best use of existing resources while aligning with national priorities for urgent and community care.

In contrast, the Heart Failure Virtual Ward was supported by temporary, non-recurrent funding. We did not believe we could reduce costs sufficiently to sustain it within our financial envelope this year and permanent funding was not secured from the ICB. Continuing the service would have compromised other critical priorities.

- How the Trust justifies withdrawing support for cardiac patients while simultaneously investing in a new service for another patient group?

The decision reflects a strategic need to prioritise services that address the most pressing system challenges. The Frailty Hub is designed to improve care for older people, reduce avoidable hospital admissions, and support timely discharge – all of which are key national and local priorities. For the HFVW, we were not confident we could reduce costs to pay for it, whereas with the Frailty Hub we are confident that cost reductions can fund the investment.

While the HFVW delivered benefits, it could not be sustained within our financial position this year. We remain committed to cardiac care and will explore virtual models as part of future service redesigns when funding becomes available.

- What assurance can be given that patients with cardiac conditions will not be disadvantaged by this decision?

Cardiac patients continue to have access to established pathways, including specialist outpatient clinics, community nursing, and inpatient care when clinically required. The closure of the HFVW does not remove access to cardiac expertise; it reflects a temporary change while we focus on services that deliver the greatest impact for system flow and patient safety.

In parallel, the draft case for change for cardiology being led by NHS Devon will involve clinical engagement and aims to strengthen cardiac care across the system.

59. As Board will be aware, NHS Devon decided not to take the cardiology draft case for change and technical documents to the South West Peninsula Board on 16 October to allow time for clinical engagement. This decision followed a meeting between NHS Devon's CEO and Torbay and South Devon's three MPs, who expressed concern about the lack of clinical engagement. They felt this should take place before the board papers were published and not after, as originally planned.

60. The draft case for change for cardiology, cardiac surgery and cardiovascular disease was received from the ICB and shared with our clinicians. They have provided extensive comments back to the ICB and at the time of writing the final case for change has not been released.

61. The ICB are reviewing all comments and feedback and make relevant amendments before bringing its paper to a future South West Peninsula Board. NHS Devon will also review the programme timeline and share details soon, alongside updates for overview and scrutiny members, the Heart Campaign chair and MPs. I will provide any update verbally at the Board meeting.

62. The Heart Campaign continues to advocate for the retention of cardiac services at Torbay. We continue to receive several questions and FOI requests from the Heart Campaign which we are addressing.
63. I issued an open letter to the people of Torbay and South Devon reaffirming our commitment to keeping care safe, high quality and close to home. You can read my letter here: [An open letter to the people of Torbay and South Devon - Torbay and South Devon NHS Foundation Trust](#).
64. We became aware through social media posts that the Heart Campaign are planning a demonstration at Torbay Hospital on Saturday, 06 December in support of the Heart Campaign
65. We have advised them that while we respect and acknowledge their right to peaceful protest and appreciate the passion behind their campaign the Torbay Hospital is private NHS premises - created and maintained for public benefit. As such, while there is an implied licence for people to attend for treatment and to access our services, our sites are not public spaces and cannot be used for demonstrations or protests.
66. We have also clarified that to ensure safe access for patients, staff and emergency services, any protest activity must take place outside the boundary line of our sites.
67. We also understand that they are planning to use a drone to photograph the demonstration and we have requested that any drone use complies with Civil Aviation Authority regulations and does not compromise patient privacy, staff safety, or the security of the hospital site.
68. I am in ongoing and continual discussion with the campaign on these issues, including the Heart Failure Virtual Ward and the refurbishment of the Cardiac Catheter Laboratory.
69. As part of our long-term plans, I am pleased to confirm that the refurbishment of the cardiac catheter laboratories is included in our proposed capital programme for 2026/27. This investment will modernise our cath labs, enhance patient safety and experience, and ensure our clinical teams have the facilities and equipment needed to deliver high-quality care. However, we have not yet been notified of our capital allocation for 2026/27, so while this refurbishment remains a priority, delivery will depend on the funding we receive.

Critical infrastructure risks – funding secured

70. I am pleased to confirm that we have secured an additional £2.367 million from the national Estates Safety Fund to address urgent infrastructure risks at Torbay Hospital.
71. This funding will support essential works, including:
- Ventilation upgrades for cancer services
 - Improvements to water systems
 - Enhanced fire safety measures
 - Roof edge protection

72. This investment builds on the £7.3 million secured earlier this year, reinforcing our commitment to mitigating the most critical risks across our ageing estate. While this funding is a vital boost, it does not resolve all challenges, and significant long-term investment remains essential given delays to the New Hospital Programme.

73. I am very grateful colleagues for their efforts in minimising the impact of estate risks and for the advocacy of local MPs in securing this funding. The works will help maintain patient and staff safety while we continue to pursue the major capital investment required for modern facilities.

Teignmouth community hospital

74. Over the past decade, significant time and investment have been dedicated to developing an integrated model of community-based care for Teignmouth and surrounding areas. This included plans for a new Health and Wellbeing Centre to co-locate primary care, health and social care, and community services. However, escalating construction costs—from £8m to £19m—rendered the scheme unaffordable, and the project was formally halted in 2024 following extensive discussions with Devon ICB and NHS England.

75. Teignmouth Community Hospital faces serious challenges, including substantial maintenance backlog and fire safety risks identified in 2024, which led to closure of the first and second floors (2 rooms on the second floor). Renovation was assessed but deemed unfeasible due to projected costs of £23.3m.

76. While a large proportion of the building is not fit for purpose; some areas—such as physiotherapy and theatres—are assessed as fair or good quality.

77. The site is much valued by the local community and the staff who are based there and we recognise the importance of maintaining services that meet local needs. I recently toured the site with local MP, Martin Wrigley as well as hosting a Meet Joe session with around 40 colleagues at Teignmouth.

78. This was a challenging meeting for me as staff at the Hospital do not feel that we have a coordinated approach to our engagement or communication with them as several care groups utilise the site as well as facilities staff and the messaging at times has been ad hoc and not consistent. I have apologised to the teams that work at Teignmouth, that despite best efforts of our leadership teams, we have not managed this process as well as we should have with our key stakeholders and we are addressing this through a single task and finish group where overall accountability for this work will sit with the Families and Communities Care Group under the leadership of the Deputy Chief Executive. This will ensure a single leadership structure for managing the future of the site and our expectation is to have a wider set of options appraised and ready for the Board in early 2026. This will include a process for stakeholder engagement.

79. Notice has been given on leases for the GP surgery and Sure Start building to avoid restricting future options.

80. We remain committed to delivering a safe, evidence-based solution for Teignmouth that meets community needs and ensures transparency, engagement and effective mobilisation.

Dawlish Minor Injuries Unit (MIU)

81. Since we reopened Dawlish MIU in April 2024, we have experienced low and inappropriate attendances and ongoing staffing challenges. This has resulted in repeated closures due to the inability to staff the unit.
82. On 14 November we sent updates to Devon County Council's Health and Adult Social Care Overview and Scrutiny Committee and Dawlish Town Council, which had asked for confirmation on rumours that the MIU was closed until March 2026.
83. We have also responded to media enquiries and a request for an update from the chair of Dawlish Hospital's League of Friends about the closure rumours and that equipment had been moved from the MIU to another service.
84. We have also provided an update to the Dawlish MIU team.
85. We have confirmed that the MIU is not closed until March 2026, although there may be times when we must temporarily close the MIU at short notice if we are unable to provide safe staffing levels. We have also directed people to NHS England's recommendation about MIUs and confirmed that no decision about the future of any MIU or UTC will be made until the ICB has concluded its wider review of services.

NHS Devon review of MIUs and UTCs

86. As referenced above NHS England has set out a national requirement that MIUs should no longer be offered as standalone services by next April, unless they can be enhanced to meet urgent treatment centre (UTC) standards. Where this cannot happen, they will be replaced by alternative treatment pathways.
87. These standards include providing a service which is open seven days a week, 12 hours a day as a minimum; offering both booked and walk-in appointments; seeing both minor injuries and ailments; having a named senior clinical leader, supported by an appropriate multi-disciplinary workforce; having a basic consistent investigative and diagnostic offering on site; and can accept appropriate ambulance conveyances.
88. Full details can be read online at [NHS England » Urgent treatment centres – principles and standards](#)
89. Each Integrated Care Board (ICB) (the organisations responsible for commissioning local health services) is considering plans and timelines to review and designate remaining MIUs and alternative facilities to UTCs as appropriate by March 2026.
90. Devon's ICB is reviewing MIUs and Urgent Treatment Centres across Devon to ensure urgent care services are aligned with national standards and continue to meet the needs of our communities.
91. Its review will include an analysis of all MIU attendances across the full seven days of services, acknowledging that temporary closures will affect the numbers of users, along with the data for alternative treatment received at emergency departments, GP practices and/or a pharmacy.

92. It will be supported by a detailed equality and quality impact assessment (EQIA) that will determine impacts from right across the system, including local data on needs assessment, deprivation, transport, etc., and will support any decision-making about the location for future services.

93. The ICB will not make any decision about any MIU or UTC until it has concluded its review and there are no current proposals for any changes, but we are talking to them regularly about the challenges we face in safely staffing Dawlish MIU.

Winter 2025/26 Health Threats

94. National intelligence from UKHSA indicates that winter pressures are emerging earlier and with greater intensity than anticipated. While COVID-19 activity is currently declining, we are now entering a period where influenza, RSV, norovirus and cold weather impacts will concurrently drive demand across urgent and acute care.

95. Influenza activity is rising faster than the modelled baseline, particularly in children and young adults. This is expected to translate into increased admissions through December. RSV levels are also increasing and will place sustained pressure on paediatric capacity.

96. Norovirus is beginning to affect bed availability nationally, with a high likelihood of further escalation. Alongside this, cold weather alerts are now being issued in multiple regions and will compound pressure on EDs, ambulance services, and vulnerable groups.

97. COVID-19 is expected to continue declining but remains a background source of inpatient occupancy.

98. The combined effect of these factors, together with ongoing industrial action, is a projected rise in system pressure over the next 2–6 weeks.

99. We should therefore anticipate a challenging early winter period characterised by increased demand, reduced bed flexibility and workforce strain.

100. For us, this means we need to ensure:

- Early and proactive activation of winter escalation measures
- Strong paediatric surge capacity
- Clear respiratory and frailty pathways
- Robust infection prevention controls and outbreak management
- Enhanced operational coordination with the ICB
- Continuous monitoring of workforce resilience during industrial action

101. Our winter plans are in place, and our DIPC continues to monitor real-time intelligence from UKHSA and regional partners. A Board update can be provided monthly as the national situation evolves.

Care Quality Inspection of Adult Social Care in Torbay

102. The adult social care arrangements with Torbay Council underwent a Care Quality Commission (CQC) inspection in early 08 September 2025.

103. The draft inspection report has been received and is undergoing factual accuracy checks.

104. It is anticipated that the final inspection report will be published by the end of this calendar year. Our communications team is working closely with Torbay Council's communications team to ensure a robust plan is in place to share the report and the findings with staff, key stakeholders and the public once it is published.

Annual Members Meeting

105. Our Annual Members' Meeting took place in September at Torbay Hospital, providing an opportunity to celebrate achievements over the past year and share our challenges and future plans, including the rollout of the One Devon electronic patient record (Epic).

106. I would like to take this opportunity to formally thank our governors for their support with this key event and for the hard work of the Membership Committee in organising the event.

107. For those unable to attend, the papers, minutes and Q&A are available via this link: <https://www.torbayandsouthdevon.nhs.uk/about-us/board-meetings/>

National flu vaccination programme

108. At the time of writing, our staff flu vaccination rate is 44% Our winter flu vaccination campaign is progressing steadily, though uptake is currently below last year's rate, so continued focus is essential.

109. Key actions and highlights:

- Accessibility: roving vaccinators are visiting wards and community sites to make it easier for staff to get vaccinated without leaving their workplace.
- Prize draw incentive: to boost engagement, all staff vaccinated between 01 October and 30 November will be into a prize draw funded by our Torbay and South Devon NHS Charity.
- Inpatient vaccination: eligible inpatients are also being offered the flu vaccine as part of our commitment to reducing risk and protecting vulnerable patients.
- Communications: updates via ICONews, intranet, screensavers, and manager briefings are reinforcing the importance of vaccination and promoting the prize draw.

110. We encourage all staff to take advantage of roving clinics or visit the Vaccination Hub. Increasing uptake remains a priority to help minimise winter pressures and protect both patients and colleagues.

Website accessibility

111. For the first time since the compliance change from WCAG 2.1 to WCAG 2.2 our public website is scoring over 90% compliance – this has taken us into the top 30 NHS websites in the UK for accessibility.

112. Public sector websites must meet WCAG standards under UK accessibility regulations. WCAG 2.2 is the latest benchmark, and non-compliance risks legal challenge. Public sector websites are regularly audited by the Cabinet Office for compliance against the regulations.

113. WCAG 2.2 improves access for people with cognitive, visual, and motor impairments—ensuring our public website is usable by all, including older adults and those with disabilities. Accessibility features benefit everyone by making websites clearer, easier to navigate, and more consistent.

114. Improving our compliance shows our leadership in digital inclusion and reinforces our commitment to equity and transparency. We are seeking to make further improvements to put us in the best position to respond to any changes in future standards and ensures our digital information offer remains robust and inclusive.

Date of report	Date site assessed	Accessibility score %	Accessibility score description	Position in UK NHS	WCAG Level A compliance	WCAG Level AA compliance	WCAG Level AAA compliance
October 2025	06/09/2025	95.0%	Excellent	29	95.9%	95.3%	90.6%

National, regional and local issues and topics of interest

New NHS online hospital to give patients more control over their care

115. The NHS is setting up an 'online hospital' – NHS Online - in a significant reform to the way healthcare is delivered in England.

116. The innovative new model of care will not have a physical site, instead digitally connecting patients to expert clinicians anywhere in England. It will be rolled out over the parliament, with the first patients using the service from 2027.

117. That means patients can be seen faster, as teams triage them quickly through the NHS App and let them book in scans at times that suit them at Community Diagnostic Centres closer to home.

118. When a patient has an appointment with their GP they will have the option of being referred to the online hospital for their specialist care. They will then be able to book directly through the NHS App and have the ability to see specialists from around the country online without leaving their home or having to wait longer for a face-to-face appointment.

119. If they need a scan, test or procedure, they'll be able to book this in at a time that suits them at Community Diagnostic Centres closer to home. They'll be able to track their prescriptions and get advice on managing their condition from the comfort of their home.

120. NHS Online will provide a huge boost to patient waiting times, delivering the equivalent of up to 8.5 million appointments and assessments in its first three years – four times more than an average trust – while enhancing patient choice and control over their care.

121. Initially the focus will be on a small number of planned treatment areas with the longest waits. Over time this will be expanded to more treatment areas. Treatment areas will only be offered if the NHS knows it is clinically safe to do so remotely.

122. The 10 Year Health Plan will shift the NHS from analogue to digital and this is a bold new way of delivering care while embracing new tech, built on NHS values.
123. In the first instance, the service will build and scale tried-and-tested innovations already in place across the country such as AI and remote monitoring, with millions of patients already accessing online appointments and using the NHS App to manage their care.
124. Before NHS Online goes live, the NHS will learn from existing research on patient experience of online care over the last five years and build it into the programme as it develops. The programme is being developed with a commitment to patient partnership in design and delivery.
125. Connecting patients with specialists across the country means the same high-quality care available to everyone regardless of postcode, helping to reduce variation and inequalities. It will also help to spread out demand, with patients no longer held back by long local waiting lists.
126. Doctors will have new levels of flexibility, managing their time in a way that works better for them and their patients. NHS England and DHSC will work with clinical staff and their union representatives on how best to deliver this new model of care.

Local media update

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

Key media releases and responses

[Honouring the gift of life: seagrass meadow recognises local organ donors](#)

[Medicine for Members' event explores cancer treatment and support](#)

[New community cancer wellbeing event](#)

[Local NHS therapist rows her way to World Championship glory](#)

[Celebrating the incredible contribution of our SAS doctors](#)

[Lost little ones to be remembered at special service and craft morning in Torquay](#)

[Torquay Rotary Club and Torbay Hospital join forces to plant 1,000 crocuses](#)

[An open letter to the people of Torbay and South Devon](#)

[Further £2.367 million investment to improve safety across our sites](#)

Coverage

We are grateful to all the local and regional media who covered our work in October and November.

Trust Board of Directors

Resetting Recovery Support Programme Exit Criteria

Date of meeting	Date report produced
26th November 2025	6 th November 2025

Author(s)		Report approved by	
Name and title:	Joe Teape Chief Executive	Name and title:	Joe Teape Chief Executive
Phone:		Date:	19 th November 2025
Email:			

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

Executive summary

In November 2022, Torbay and South Devon NHS Foundation Trust and Royal Devon University Hospitals Foundation Trust were placed in Segment 4 of the National Oversight Framework (NOF) and as such entered the national Recovery Support Programme (RSP). At this time, Devon ICB and University Hospitals Plymouth NHS Trust had already been part of the RSP for 16 months.

Joint exit criteria were signed off by the NHSE Quality and Performance Committee for all four organisations in June 2023 with an initial target exit date of Q1 2024/25. This was subsequently revised to Q1 2025/26 due to delays in meeting the improvement trajectories.

Earlier this year, a self-assessment of progress against the exit criteria was undertaken by each Board with a view to determining readiness to exit the RSP programme. This Board determined that whilst demonstrable progress had been made, the organisation would benefit from remaining within the programme throughout 2025/26 with the associated support for further improvement.

At the same time, the national framework and segmentation criteria were changing which necessitated a reset of the exit criteria to align with the revised requirements.

The Trust has worked with the RSP Improvement Director and NHSE Southwest Region to agree the revised exit criteria which are attached to this report for endorsement. The Board will receive regular reports on progress with a view to exiting the RSP programme by the target date of Q1 2026/27.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	n/a

Appendices

TSD Revised Exit Criteria
Reporting Template – progress against revised exit criteria

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

The revised exit criteria have been agreed with the NHSE Recovery Support Programme and NHSE Regional Office

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 is asked to receive this report for information and note the ongoing monitoring of progress against exit criteria will be included in future CEO reports.

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

Continuing our improvement journey will provide continuing improved access to health and care services across Torbay and South Devon.

Exiting RSP will provide confidence to stakeholders.

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	All
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
Terms of authorisation, NHS England licence and regulations

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.

Revised RSP Exit Criteria 2025/26

Introduction and background

1. This report provides an update on the process of transition to the new National Oversight Framework (NOF) and the proposed requirements that will enable the Trust to exit the Recovery Support Programme (RSP).
2. In July 2021, Devon ICB and University Hospitals Plymouth were placed in Segment 4 of the National Oversight Framework (NOF). Following recommendations from the region's 2022/23 Quarter 2 segmentation review process, the NHSE Quality and Performance Committee (QPC) also approved Royal Devon University Healthcare Foundation Trust and Torbay and South Devon Foundation Trust entering segment 4 and the Recovery Support Programme (RSP) in November 2022.
3. QPC agreed new exit criteria for all four organisations in June 2023 with a target exit date of Q1 2024/25.
4. Over late 2023, risks to delivery of this target exit date began to emerge, particularly in finance and UEC where performance was challenging. The region moved to enhanced oversight with monthly System Improvement Assurance Group (SIAG) meetings and deep dives into areas of concern to closely support and scrutinise performance.
5. Progress was formally reviewed in March 2024 and a recommendation made to the June meeting of the QPC that based on the slower than anticipated pace of progress, the exit criteria be amended, and the exit date deferred to Q1 2025/26.
6. Earlier this year, the Trust Board undertook a self-assessment of organisational progress against the exit criteria with a view to determining readiness to exit the RSP Programme.
7. Whilst demonstrable progress was acknowledged, the Board determined that the organisation would benefit from remaining within RSP throughout 2025/26, with the associated support for further improvement. This formed part of the RSP recommendation to QPC and was accepted.
8. Revised exit criteria have since been set with a view to sufficient progress being made to enable the Trust to exit the RSP Programme in Q1 2026/27.

Revised Exit Criteria

9. The assessment domains in the new oversight framework differ from those that were in place at the time the Trust was originally placed in NOF4. Had they remained the same, then it is likely that the original exit criteria would have continued, and the previous reporting arrangements maintained.
10. It has therefore been important to align the revised RSP exit criteria to both the original rationale for segmentation as NOF4 and the new assessment domains so

that the Trust is treated fairly and equitably when the re-segmentation assessment is made.

11. The new oversight framework assessment domains are as follows:

- Access to services (elective, cancer, UEC and mental health care)
- Effectiveness and experience of care
- Patient safety
- People and workforce
- Finance and productivity
- Improving health and reducing inequality (*non-scoring*)

12. In setting the revised exit criteria, the previous NOF4 exit criteria were mapped to the previous domains (**Annex 1**) to enable continuity of assessment of the whole improvement journey.

13. The new exit criteria relate to three of the six new assessment domains and are outlined in **Table 1**.

Table 1: Revised RSP Exit Criteria (2025/26)

	Domain	Exit criteria
1	Access to services	<u>Urgent and emergency care</u> • 4-hour performance improvement against refreshed trajectory, month on month delivery over two quarters • Average Ambulance Handover Time performance against agreed trajectory, month on month delivery over two quarters • % patients spending longer than 12 hours in ED <10% of total attendances, month on month delivery over two quarters <u>Elective care</u> • Virtual Elimination of 65ww in line with trajectory • 52ww month on month improvement in line with trajectory over two quarters • % of waiting list >52ww month on month improvement in line with trajectory over two quarters • Month on month reduction of RTT waiting list in line with trajectory over two quarters • % of RTT patients receiving first OPA within 18 weeks in line with trajectory over two quarters
2	Effectiveness and experience of care	• The trust will ensure that its draft strategy aligns with the ICBs commissioning intentions, strategy and Medium-Term Plan • Developmental Well Led Review has been taken to the board and approved. • Priority actions in relation to the organisational well led review agreed with NHS England and built into the Trust's integrated improvement plan. • Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP.
5	Finance and productivity	• Delivery of 2025/26 financial plan and underlying financial position • The development of a medium-term financial plan which is agreed and signed off by the ICB and Region • Evidence of normalised run-rate reduction for 2 consecutive quarters • Evidence of delivery of the workforce plan, CIP plan, and Productivity opportunities for 2 consecutive quarters

14. The nature and wording of the exit criteria negate the need for further supporting measures and the evidence required to demonstrate progress will be obtained from Board reports as outlined in **Annex 2**.
15. It is also proposed that Annex 2 is updated monthly and included in the CEO Board report with any criteria off-track referred to the relevant Board sub-committee for detailed scrutiny, and assurance regarding remedial action, if required.

Assurance and Recommendations

1. The Board is asked to take satisfactory assurance at this stage that revised exit criteria has been agreed and will now be progressed through ongoing monitoring.

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

2. The Board is asked to receive this report for information and note the ongoing monitoring of progress against exit criteria will be included in future CEO reports.

TSD REVISED EXIT CRITERIA MEASURES

Previous RSP System Exit Criteria	Previous RSP System Measures	TSD revised exit criteria (2025/26)
1 Local Strategic Priorities • Delivery of phase 2 of the Acute Services Sustainability Programme • Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon	• Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July • Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024 • Draft Case for Change developed and socialised with key stakeholders during the summer of 2024 • Final Case for Change agreed and signed off by Boards by November 2024 • Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25) • Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services • Proposal for elimination of unwarranted duplication of 'specialised services' agreed, and implementation plans underway • Public consultation process and timeline agreed with Region	• The trust will ensure that its draft strategy aligns with the ICBs commissioning intentions, strategy and Medium-Term Plan
2 • Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions	• Review of the ICS strategy (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery • Revised NOF4 system architecture to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational	• Developmental Well Led Review has been taken to the board and approved. • Priority actions in relation to the organisational well led review agreed with NHS England and built into the Trust's integrated improvement plan. • Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators.

Previous RSP System Exit Criteria	Previous RSP System Measures	TSD revised exit criteria (2025/26)
for the whole population served by the system	boundaries including control of workforce, service investments, cost reductions and productivity improvements. - Development and delivery of organisational and system improvement plans with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: - Named SROs for organisational and system programmes - Clear accountability and reporting arrangements - Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed. - Review and adapt Devon Operating Model and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs - Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP.	This will include any CQC notices and requirements of MSSP.
3 People		
4 Quality of Care, Access and Outcomes U&EC – Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an	UEC - Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours) - Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average	UEC 4-hour performance improvement against refreshed trajectory, month on month delivery over two quarters - Average Ambulance Handover Time performance against agreed trajectory, month on month delivery over two quarters

Previous RSP System Exit Criteria	Previous RSP System Measures	TSD revised exit criteria (2025/26)
agreed system plan to sustain this improvement. Elective - Make demonstrable progress towards achieving national Elective and Cancer objectives, in line with agreed trajectories, sustained over 2 consecutive quarters and have in place an agreed system plan to sustain this improvement	- Improvements in line with agreed baseline and plan, over two quarters, in 4-hour performance & 12-hour breaches - Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories - Achieve and sustain a reduction in number of patients who no longer meet the "criteria to reside in hospital" - CQC confirmation of UHP compliance with Conditions on the trust's Licence - Meet and maintain the exit criteria for national Tier 1 for UEC. Elective - Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance. - Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance. - Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts	% patients spending longer than 12 hours in ED <10% of total attendances, month on month delivery over two quarters Elective - Virtual Elimination of 65ww in line with trajectory 52ww month on month improvement in line with trajectory over two quarters % of waiting list >52ww month on month improvement in line with trajectory over two quarters - Month on month reduction of RTT waiting list in line with trajectory over two quarters % of RTT patients receiving first OPA within 18 weeks in line with trajectory over two quarters
5 Preventing Ill health and Reducing Inequalities		
6 Finance and Use of Resources. - Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally - Deliver reductions in the run rate for each consecutive quarter	- Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: - Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) - The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England - A system-wide shared services programme is developed that has all appropriate back-office functions	- Delivery of 2025/26 financial plan and underlying financial position - The development of a medium-term financial plan which is agreed and signed off by the ICB and Region - Evidence of normalised run-rate reduction for 2 consecutive quarters - Evidence of delivery of the workforce plan, CIP plan, and Productivity opportunities for 2 consecutive quarters

Previous RSP System Exit Criteria	Previous RSP System Measures	TSD revised exit criteria (2025/26)
• To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones	within scope and includes accompanying timelines and delivery plans - o The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) - o The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25). • To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones • Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability. • Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.	





Self-Assessment Against Exit Criteria



Torbay and South Devon
NHS Foundation Trust

Key to Ratings
On track with clear evidence to meet the exit criteria on the planned date
Emerging risk of inability, or no clear evidence of the ability to meet the exit criteria on the planned exit date
Off track with high risk of failing to meet exit criteria by planned date
Exit criteria achieved and embedded
Resources just deployed, too early to tell

Self-Assessment Against Exit Criteria

Torbay and South Devon
NHS Foundation Trust

	Exit Criteria Measures	Suggested Evidence	Evidence Position RAG					
			Oct	Nov	Dec	Jan	Feb	Mar
Access to services								
1	UEC - 4-hour performance improvement against refreshed trajectory, month on month delivery over two quarters	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
2	UEC - Average Ambulance Handover Time performance against agreed trajectory, month on month delivery over two quarters	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
3	UEC - % patients spending longer than 12 hours in ED <10% of total attendances, month on month delivery over two quarters	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
4	Elective - Virtual Elimination of 65ww in line with trajectory	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
5	Elective - 52ww month on month improvement in line with trajectory over two quarters	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
6	Elective - % of waiting list >52ww month on month improvement in line with trajectory over two quarters	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
7	Elective - Month on month reduction of RTT waiting list in line with trajectory over two quarters	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
8	Elective - % of RTT patients receiving first OPA within 18 weeks in line with trajectory over two quarters	IPQR report to FPC and to Board mapping performance against MTFP trajectories						
Effectiveness and experience of care								
9	The trust will ensure that its draft strategy aligns with the ICBs commissioning intentions, strategy and Medium-Term Plan	Board paper to be presented in February 2026 with final draft strategy and reconciliation of key themes to ICB strategy, commissioning intentions and MTFP						
10	Developmental Well Led Review has been taken to the board and approved	Board paper and Board minute confirming receipt and endorsement						
11	Priority actions in relation to the organisational well led review agreed with NHS England and built into the Trust's integrated improvement plan	Slide deck for Board Development session; Board paper mapping Well-led recommendations to IIP workstreams; IIP progress reports to Board; exchange of letters with Region						
12	Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP	CQC action plans produced and approved with agreed monitoring arrangements in place MSSP improvement plan approved with agreed monitoring arrangements in place						
Finance and Use of Resources								
13	Delivery of 2025/26 financial plan and underlying financial position	Progress monitored via monthly finance reports to FPC and Board. Year-end forecast and full-term position confirmed in Board report						
14	The development of a medium-term financial plan which is agreed and signed off by the ICB and Region	Paper to Board confirming the MTFP submission (December 2025) and response from Region						
15	Evidence of normalised run-rate reduction for 2 consecutive quarters	Progress monitored via monthly finance reports to FPC and Board. Q4 summary report to Board						
16	Evidence of delivery of the workforce plan, CIP plan, and Productivity opportunities for 2 consecutive quarters	Progress monitored via monthly IIP and finance reports to Board. Q4 summary report to Board						

Trust Board

Board Assurance Framework

Date of meeting	Date report produced
26 November 2025	21 November 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, BAF Highlight Report, Organisational Risk Map (ORM), and Summary Datix Risk Register for the Board's review. The full Board Assurance Framework and Datix Risk Register are available in the Information Pack available on Diligent.

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 November Board Sub-Committees have reviewed those risks where they have been designated as the overseeing committee.

The Board has delegated detailed review of a number of risks to Board Sub-Committees.

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 following risks were approved onto the DRR at Risk Group:

1681 Incorrect Blood in Labelled Tube (16)

4036 Adoptive Records on IHCS (20)

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
Organisational Risk Map	Satisfactory	No change
Datix Summary Report	Satisfactory	No change

Appendices

Board Assurance Highlight Report
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	Limited
	2.2	Supporting Objective: Develop a strong executive team with clear accountabilities and objectives- aligned with IIP delivery milestones.	CEO	Nomination & Remuneration	Limited
	2.3	Supporting Objective: Robust governance processes and assurance embedded across the organisation - aligned with IIP delivery milestones.	DCG	Audit	Limited
	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	Limited
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	Limited
	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	LimitedSatisfactory
	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	Limited
	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	Limited
	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

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	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	Limited
	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	Limited
	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

Organisational Risk Map (ORM or Risk Map) – November 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, 2948, 2965, 4254, 4137, <u>4167</u> , <u>1681</u> , <u>4255</u> , 3502, <u>4312</u> , <u>4237</u> , <u>4299</u> , <u>4228</u>	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 <u>159</u> 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 ~~45~~ 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, 2353, 4214, ~~4240~~	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, 4036	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 104 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, 3519, 2307, 1069, 3485, 3484 , 2429, 3521, 2718, , 3823, , , , 3519 , 4201, 224200 , 4203, 4202 , 4239, 4197	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 186 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,, ~~2434~~ , , 3789, 3456, ~~4136~~ , 2037, 4077, 3956, ~~4163~~ 41 ~~3663~~ , 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 124 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)	~~3484: Failure of Acute Provider Collaborative to Deliver on Acute Sustainability Plan Programme~~	~~3484~~	~~160~~	Moderate	6	Up to 12	Strategy & Transformation	The median risk score for all risks held on Datix against this risk type is ~~046~~ however the median of risks scored above 13 is also ~~046~~ , with ~~0~~ 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~~ , 4178, 3783,	12	Low-Moderate	5	Up to 12	N/A	The median risk score for all risks held on Datix against this risk type is ~~109~~ however the median of risks scored above 13 is 16, with 2 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)	3955	~~129~~	Low	1	Up to 5	N/A	The median risk score for all risks held on Datix against this risk type is ~~12~~ there is 1 ~~of~~ risk 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 Nov 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, EGO 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 6th Nov 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	118
Risk(s) increased to 15 and above for review	1
Reduced, closed or suspended risk(s) rated at 15 and above to note	9
Risks requiring validation	37

Risk Heat Map

Likelihood/ Probability of Risk Occurring	1	2	3	4	5	
	Minimal	Minor	Moderate	Major	Catastrophic	Total
5 Almost Certain	5	4	30	16	3	58
4 Likely	2	11	85	43	7	148
3 Possible	4	24	95	93	19	235
2 Unlikely	1	14	41	40	12	108
1 Rare	3	3	15	17	7	45
Total	15	56	266	209	48	594

Current Risk score by month – rolling year (at the point of report date – taken as preceding month)

Current Risk Score	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Very High (15-25)	25	28	30	29	33	31	32	32	34	32	29	23
High (13-19)	90	96	91	95	88	82	84	88	94	93	96	87
Moderate (6-12)	520	544	603	586	578	581	580	583	576	582	592	405
Low (1-5)	64	69	78	83	92	94	94	97	98	99	104	72
Total number of risks	699	737	794	793	791	788	790	799	802	804	821	587

The total number of risks reduction in Oct 25 due to medical device risks being removed from datix.

Escalation of Very High & High level risks (updated 06th Nov 25)

There are currently 37 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
2996	Financial Sustainability Risk Rating for 24/25 and 25/26	25	↔	28/09/2025	Financial Risk	
3684	Tower Block External Structural Condition (CD No 2)	25	↔	31/12/2025	Service/ Business Interruption Risk	[23/10/2025] Further Tower Risk Summit meeting held 16th October 2025. Board paper to outline next steps will be produced for October board with a full report to December BBF and Trust Board A monitoring group is being established to ensure that actions from this meeting are being managed to the timeline.

4001	Pharmacy Aseptic Services - Risk to Provision of Systemic Anti-Cancer Treatments	20	↔	31/10/2025	Clinical Safety Risk	
1083	Inability to maintain/operate the estate in accordance with customer needs, NHS HTMs & Stat/Mand reqts within allotted funding	25	↔	28/11/2025	Financial Risk	[28/10/2025] Current recruitment / finance restrictions are adversely affecting resource available to deliver PPM and reactive work. Gaps in controls updated
1159	Current IT Systems and Infrastructure Will Not Meet Future Demands.	20	↔	16/01/2026	Information and Technology Risk	
2965	Access to an Emergency Theatre for Obstetric Cases	20	↔	28/11/2025	Clinical Safety Risk	[09/10/2025] The risk score likelihood (with controls in place) was initially set at almost certain post iQAAP's audit in May 24. This was in response to the concerns raised by the auditor at the time around the AHU annual verification report and the poor condition of the AHU. On review today this risk has been reduced to Likely rather than almost certain, as with the controls in place there has been no breakdown of the AHU in the past 12 months (although there has been some extensive maintenance required)
4254	Torbay localities CES and TEC supply and support.	20	↔	28/11/2025	Clinical Safety Risk	[24/10/2025] Additional effect added: Patients sustaining pressure damage or deterioration of existing pressure damage due to lack of service or repairs or unavailability of required equipment.
3867	Clinical Coding Retention and Recruitment	20	↔	01/12/2025	Financial Risk	
1697	Insufficient Permanent Workforce Capacity to Meet Patient Need (Overarching Risk).	20	↔	27/06/2025	Workforce Risk	

1815	Non-Compliance With the National Cancer Waiting Time Targets.	20	↔	31/10/2025	Performance Risk	.
3249	Automated Dispensing System (Pharmacy)	16	↔	28/01/2026	Performance Risk	[28/10/2025] New robot installation has started with expected switch on date December 22nd. Refilling will take place over the subsequent 3 weeks.
2957	Radiation Safety (Staff/Public) : Inadequate Management Controls (Regulatory Compliance)	16	↔	27/12/2025	Health and Safety Risk	[27/10/2025] This high level risk is linked to other lower level risks which are linked in the details. These are being progressed and this risk will be updated in line with these as developments are made.
1947	Principal Overarching Risk (Medical Device Rolling Replacement Programme) (MDRRP)	16	↔	23/01/2026	Clinical Safety Risk	[10/10/2025 13:36:06 Alan Johnston] In accordance with the Executive direction issued in September 2025, this Medical Devices Rolling Replacement Programme (MDRRP) linked risks all closed risks have been unlinked and link risks recorded in Description.
2037	SACT Nursing Capacity on RGDU and Turner Ward (N&M Workforce Risk)	16	↔	30/04/2025	Workforce Risk	
1681	Incorrect Blood In Labelled Tube.	16	↔	30/07/2025	Clinical Safety Risk	
4136	Shortage of Therapeutic Radiographer and Support Workforce (Radiotherapy)	16	↔	31/10/2025	Workforce 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	↔	28/11/2025	Clinical Safety Risk	
3456	Single Site Specialist for Breast Radiotherapy	16	↔	01/11/2025	Workforce Risk	

3783	Extension and Non Replacement of the Patient Transport Ambulance Fleet	16		11/12/2025	Communication and Reputational Risk	
3869	The Oncology Information System (OIS) - Mosaic end of life Support	16	↔	14/11/2025	Information and Technology Risk	[20/10/2025] Pre-production MosaiQ version 2.86 has been build and tested. Deployment of local stations and Horizon-based interface testing is in progress. The Weekend of 8-9 November is scheduled for the upgraded, training is scheduled for the week of the 20-24 October 2025. There are still computers and monitor to be purchased to complete the project, however, they are not critical to go Clinical with this new MosaiQ platform, it is worth mentioning that it is expected to go Clinical with the MosaiQ version 2.86 from the 10th of November 2025.
3664	Lack of Security Cover at Community Sites	16	↔	28/11/2025	Health and Safety 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	
2801	Excessive Storage of Flammable Items in Corridors for Prolonged Periods	15	↔	31/10/2025	Health and Safety Risk	
3789	Lack of Capacity due to Inadequate Staffing Levels- Haematology (Workforce Risk)	15	↔	12/10/2025	Service/ Business Interruption Risk	
4124	Vulnerability of Buildings and Occupants to the Effect of an RTC	15	↔	28/11/2025	Health and Safety Risk	[23/10/2025] ACOM have completed Hostile Vehicle mitigation survey and will present the traffic and pedestrians report and recommendations in November 2025.

3839	BAU Support of Systems NOT Replaced By Epic	15	↔	28/11/2025	Information and Technology Risk	
4036	Adoptive Records on IHCS	15	↔	31/01/2025	Information Governance Risk	
3460	Compromise or Failure of Cloud Hosted IT Services or Systems	15	↔	14/11/2025	Information and Technology Risk	
3502	Increasing Acuity Within UTC Patients	15	↔	01/04/2026	Clinical Safety Risk	[01/10/2025] increase in numbers of referrals from PPG without calls noted today marks a change in GP contracts regarding online consultations being open so yet to assess the effect this has but ongoing risk with recent patients attending outside of scope
3733	Failure to Ensure Effective Processes in Place to Support Safe Working with Ionising Radiation for Both Staff and Patients	15	↔	03/11/2025	Health and Safety Risk	
3774	Services that are "fragile" or have gone beyond fragility into "crisis" (Overarching Strategic Risk)	15	↔	30/09/2025	Strategy and Transformation Risk	
3823	Patient safety capacity/ PSIRF - compliance	15	↔	28/11/2025	Service/Business Interruption Risk	[28/10/2025] Patient Safety Managers roles have been adapted to incorporate the patient safety investigator workload. Monitoring to see whether this is an adequate redirection of resource, will review in 1 month
3944	Safe Care Requires a Hierarchy of Controls to Prevent and Control/ Manage the Spread of Infectious Diseases. (Overarching Risk)	15	↔	15/01/2026	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	

4178	Sustainability of Dawlish MIU	15		31/10/2025	Communication and Reputational Risk	
2920	Activity Dataset Non-Compliance for Community Setting	15		31/12/2025	Information and Technology Risk	

Trust Board

Actions arising from Developmental Well-led Review – Strengthening Governance arrangements

Date of meeting	Date report produced
26th November 2025	18 th November 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**:

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 'false assurance'

- 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 with a follow-up paper to the Board, in committee, in September 2025 which mapped all the recommendations to the Integrated Improvement Plan workstreams and articulated key actions for the Board.

The commitment to revise the Board Committee structures and confirm the Board development programme for the next 12 months were further explored in a Board Workshop session on 29th October resulting in outline agreement to revised arrangements to meet the Well-led Review recommendations.

This paper summarises the proposed future Board committee structures and arrangements for Board development over the next 12 months and seeks approval of the same.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
3	SATISFACTORY	N/A
4	SATISFACTORY	N/A

Appendices

Annex 1: Current Board Committee structure
 Annex 2: Proposed revised Board Committee structure
 Annex 3: Proposed membership and terms of reference for revised Committees
 Annex 4: Proposed revised template for Committee reports
 Annex 5: Proposed revised Balance Scorecard (included in an illustrative format)
 (proposed IPQR will follow when finalised)
 Annex 6: Revised Calendar for Board and sub-committees from January 2026
 Annex 7: Board Assurance Framework supporting objectives
 Annex 8: Supplemental Executive governance and revised reporting templates

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

Discussed at Board Development session on 29th October and agreed in principle, with the detail included in this paper remitted to the Director of Corporate Governance to develop further with Chair and Chief Executive.

Key recommendations and actions requested

The Board is asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Board takes satisfactory assurance that the proposed revised governance arrangements and outline Board Development Programme satisfy the relevant recommendations of the Well-led Review. Further assurance should be taken from the proposed review of the revised arrangements to be presented to the Board 6-months post-implementation.

It is further requested that the Board approve the governance proposals and documentation included hereto (**Annex 2-7**) and **delegate finalisation of these to the Chair and Chief Executive**; noting that the Terms of Reference for Governor Nomination & Remuneration Committee are included for the Board's oversight and recommendation to the Council of Governors who must approve these.

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	All
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

Well-Led Review/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.

1. Introduction and background

1. 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.
2. 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'
3. 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.
4. The findings were presented to the Board in a Development session in August 2025 with a follow-up paper to the Board, in committee, in September 2025 which mapped all the recommendations to the Integrated Improvement Plan workstreams and articulated key actions for the Board.
5. Opportunities to strengthen Board committees and arrangements for future Board development were further considered at a Board workshop on 29th October.
6. This report builds on the discussions to date and summarises the proposed changes for endorsement by the Board.

2. Summary of relevant Well-led Review recommendations

7. The Well-led review made a number of observations regarding the structure of Board committees, reporting arrangements, and quality of information.
8. It identified the opportunity to streamline and rationalise the oversight meetings and Board Committees to deliver a more focused system of governance.
9. The review also acknowledged the need for:
 - a. delegations to be clarified to provide assurance that decisions are made in the right place within the organisation's governance structures
 - b. better information flows, based on high-quality, reliable data
 - c. strengthened Board and Committee reports to improve risk management and assurance, and support effective decision-making

10. The key recommendations are summarised in **Table 1**.

Table 1: Well-led recommendations – Governance and Board development

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

3. Proposed changes to the Board Committee structures, supported by changes to Executive governance

11. Proposed changes to the Board committee structures have been considered in the context of:

- The need to effectively discharge the Trust's statutory functions
- The need for comprehensive scrutiny and assurance of all key organisational risks
- The inter-relationship between functions relating to people, quality, performance and finance
- Avoiding unnecessary duplication
- The requirement for optimal alignment with national and local reporting timescales to ensure the most up-to-date information is available

12. This has resulted in proposed changes to the number of committees together with amendments to the membership, terms of reference, frequency of meetings and when in the monthly business cycle they are held.

13. Current Committee structures are outlined in **Annex 1**.

The proposed revised structures, as agreed at a Board Development on 29 October 2025, are outlined in **Annex 2**.

14. The proposed membership and Terms of Reference for the revised Committees are outlined in **Annex 3** with the associated report templates in **Annex 4**.

15. The intended effect of the changes articulated with Annex's 1-3 inclusive is to improve the quality of decision making, strengthen oversight and assurance, whilst reducing administrative burden and bureaucracy. It is proposed that all (non-mandatory) current Committees are stood down, with the work undertaken by them split as follows: the scope of Quality and People Committees will be merged, Finance and Operations will cover the work of the former Finance and Performance and Building a Brighter Future Committees; with Strategy being overseen by the Board. The actions arising from existing Committee workstreams will be referred accordingly to ensure continuity.
16. **Annex 5** contains the updated IPQR and proposed balanced scorecards to provide a more comprehensive set of information to underpin the function of the committees and better inform Board decision-making going forward.
17. Based on the proposed changes, a draft outline calendar for Board and Committees from January 2026 is included as **Annex 6**. Diary invites will be updated once the revised arrangements have been agreed.
18. Due to the changes to the Board and Committee structures, the Board Assurance Framework supporting objectives have been re-allocated, as outlined, **Annex 7**.

Additional information to support the Board's oversight of the revised Governance arrangements (Annex 8)

NEW Governance SOP (including revised report writing template & information pack cover sheet)

The introduction of this revised Board, Committee and assurance meeting report writing SOP within the Executive governance structures (hereafter "SOP") will streamline and improve the discipline of reporting throughout the organisation. It is recognised that to be truly effective support in the form of training will also be required. The Committee are asked to specifically note that reports must not exceed 6 pages (in totality), if additional information is to be provided it should be contextual and provided as a point of reference; it should not be necessary to read the information pack to understand the ask of the report.

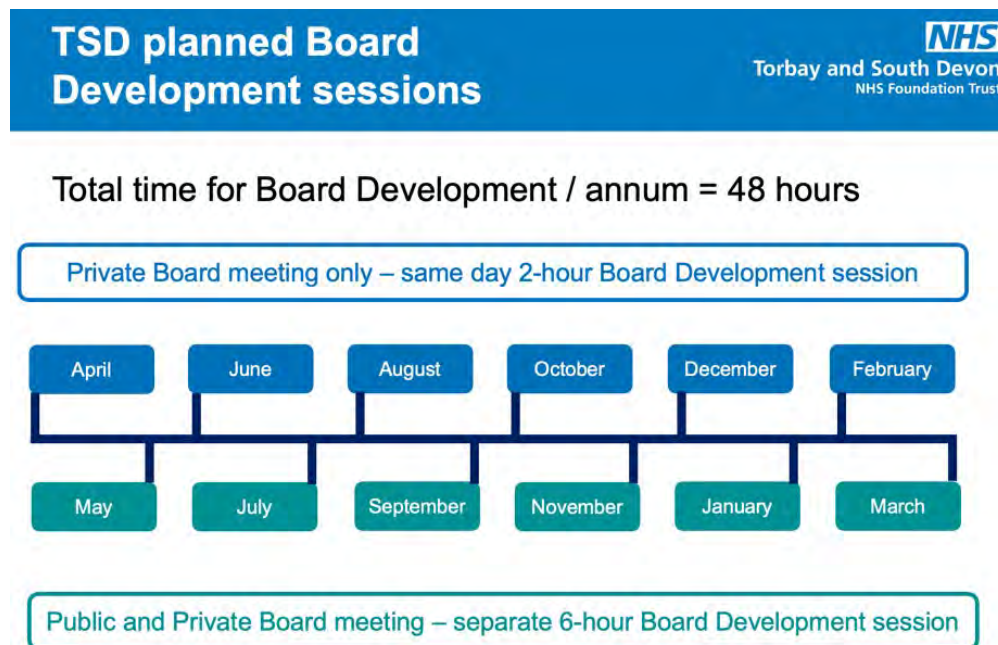
You will note that as an interim measure, the Assurance report template is now structured with a number of drafting notes and suggested wording to assist the author to deliver a report in the form required. This will take time to work well as it is well established that writing a succinct report takes far more time and discipline than writing a long report. One of the observations which we will however all be familiar with is that our reports often include such a volume of information that it is difficult to answer the primary question of a report: *(Why am I presenting this? What do I need to tell the reader, what does this mean, why am I telling them (what is the purpose), what does the reader need to do (action/note etc), have I given them the necessary information to make a good decision and is it accessible?)*

It is recommended Board take **SATISFACTORY** assurance that the measures described herein and articulated within the enclosed attachments will effectively implement the recommendations contained within the Well Led review and workstream 1.1 and 1.3 of the Integrated Improvement Plan; noting that implementation and third party check and challenge, which will be provided by a scheduled internal audit will communicate the measures effectiveness.

4. Board Development proposals

19. Within its annual cycle of meetings, the Board currently allocates 48 hours per annum to 'Board Development meetings'. These alternate between whole day sessions and 3 hour sessions as outlined in **Figure 1**.

Figure 1: Board Development sessions



20. These development sessions are used for a number of purposes including:
- Workshops aligned to strategy development and emerging business imperatives prior to formal papers being taken to the Board for decision
 - Delivering statutory and mandatory training
 - Addressing common development needs arising from individual PDRs
 - Deep dives into key organisational risks that require involvement of all Board members (and therefore not delegated to any Board Committee)
21. Development sessions create the opportunity for structured, open debate of key issues outside of formal, minuted meetings. They are most effective when their purpose is clearly articulated with objectives and any pre-reading circulated in advance.
22. Appropriate facilitation and attendance of subject-matter experts may be important, depending on the issue to be considered.
23. Alignment of development sessions with the annual business cycle of the Trust is essential to give both structure and time for effective debate and informed decision-making.
24. Alignment with the NHS leadership competency framework for board members
- Figure 2:**

The competency domains reflect the [NHS values](#) and the following diagram shows how they are aligned:

Working together for patients*	Compassion
Building a trusted relationship with partners and communities	Creating a compassionate, just and positive culture
Respect and dignity	Improving lives
Promoting equality and inclusion and reducing health and workforce inequalities	Setting strategy and delivering long term transformation Driving high quality sustainable outcomes
Commitment to quality of care	Everyone counts
Driving high quality and sustainable outcomes Setting strategy and delivering long term transformation	Promoting equality and inclusion and reducing health and workforce inequalities Creating a compassionate, just and positive culture
Providing robust governance and assurance	

*Wherever the word "patient" is used in this document, this refers to patients, service users and carers.

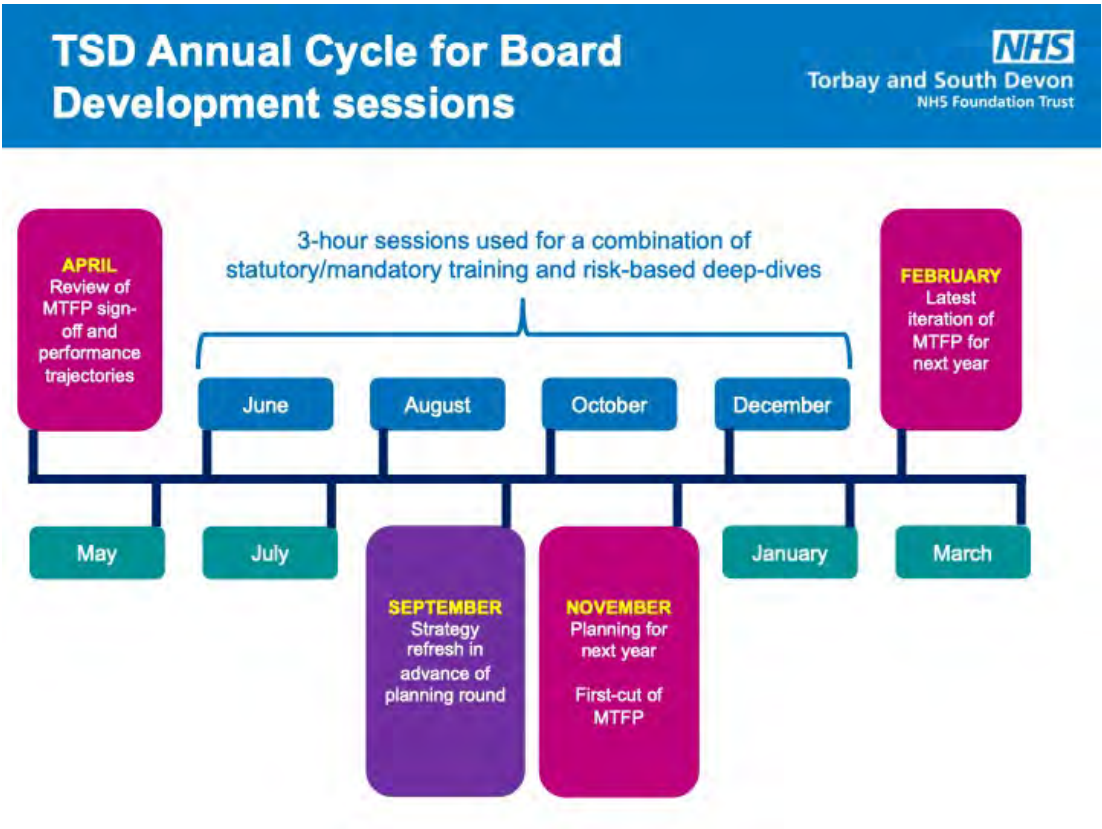
The competency domains are aligned to [Our NHS People Promise](#), [Our Leadership Way](#) and the [Seven Principles of Public Life](#) (Nolan Principles). A high-level summary of the values and concepts from these documents is in Appendix 1.



Further detail can be found here: <https://www.england.nhs.uk/long-read/nhs-leadership-competency-framework-for-board-members/>

25. **Figure 1**, as previously discussed, outlines the key fixed points in the business cycle and suggests that the 3-hour sessions in June, August, October and December are used for a combination of statutory/mandatory training and risk-based deep-dives.
26. This would leave 4 whole-day sessions in May, July, January and March for Board development aligned to outcomes from NED and Executive PDRs together with team effectiveness and organisational development priorities.

Figure 3: Outline schedule for Board Development sessions



- 27. Statutory and mandatory training requirements would be programmed in for the year with risk-based deep-dives agreed quarterly, in advance, between the Chair, Chief Executive, Board Committee Chairs, and the appropriate lead Executive Director.
- 28. The subject-matter for the 4 whole-day sessions will be determined 2 months in advance by the Chair and Chief Executive.
- 29. It is proposed that these arrangements commence from the beginning of the new financial year (April 2026).
- 30. In the intervening period, the proposed Board development sessions and content are as outlined in Table 1.

Table 1: Proposed Board Development sessions (November 2025 – April 2026)

Date	Time	Venue	Development session – subject area
28th November	9am – 4pm	Seminar Rooms 1&2 Horizon Centre	Planning for 2026/27 – MTFP; Adult Social Care
23 rd January	9am – 4pm	Seminar Room 5, Horizon Centre	
25 th February	12.30 pm - 2.30 pm	Boardroom, TSD	Planning update – MTFP submission
27 th March	9am – 4pm	Seminar Rooms 1&2 Horizon Centre	

It is recommended Board take **SATISFACTORY** assurance that the measures described herein and articulated within the enclosed attachments will effectively implement the recommendations contained within the Well Led review and workstream 1.1 and 1.3 of the Integrated Improvement Plan; noting that implementation and third party check and challenge, which will be provided by a scheduled internal audit will communicate the measures effectiveness.

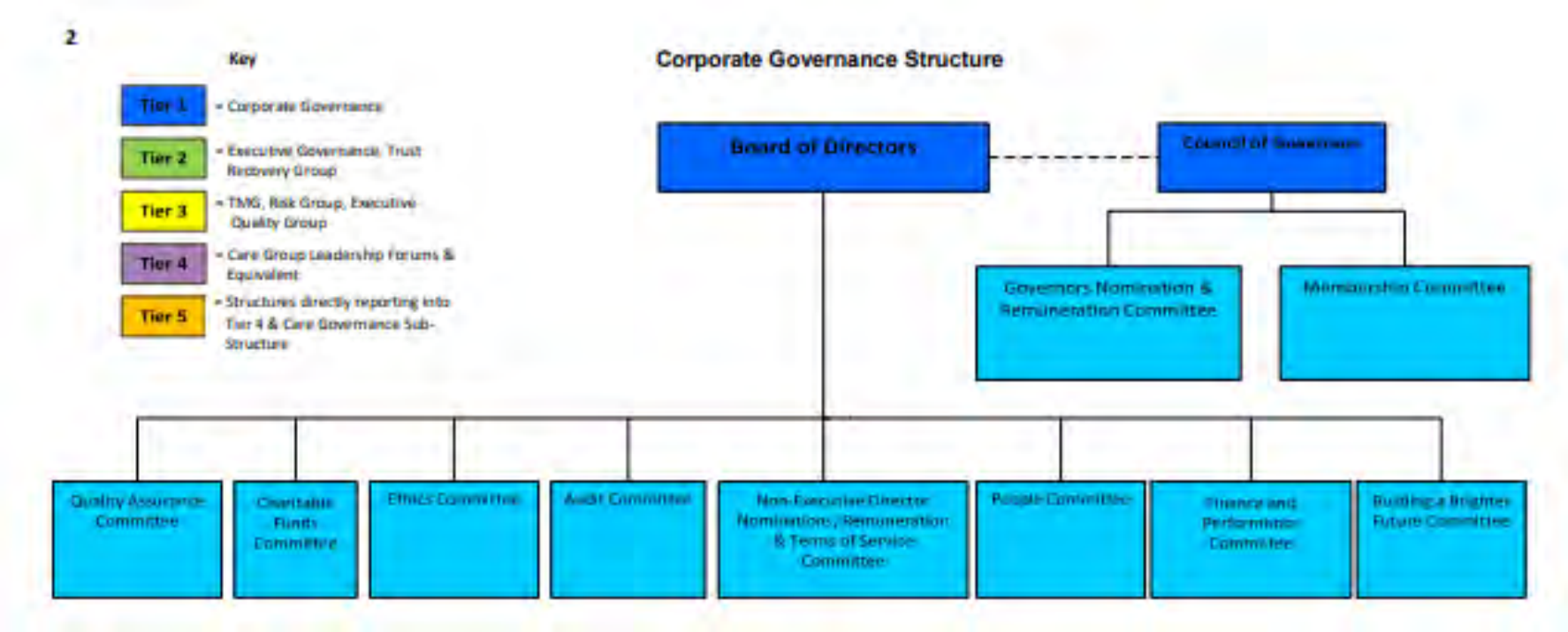
5. Assurance and Recommendations

This report includes the following assurance recommendations:

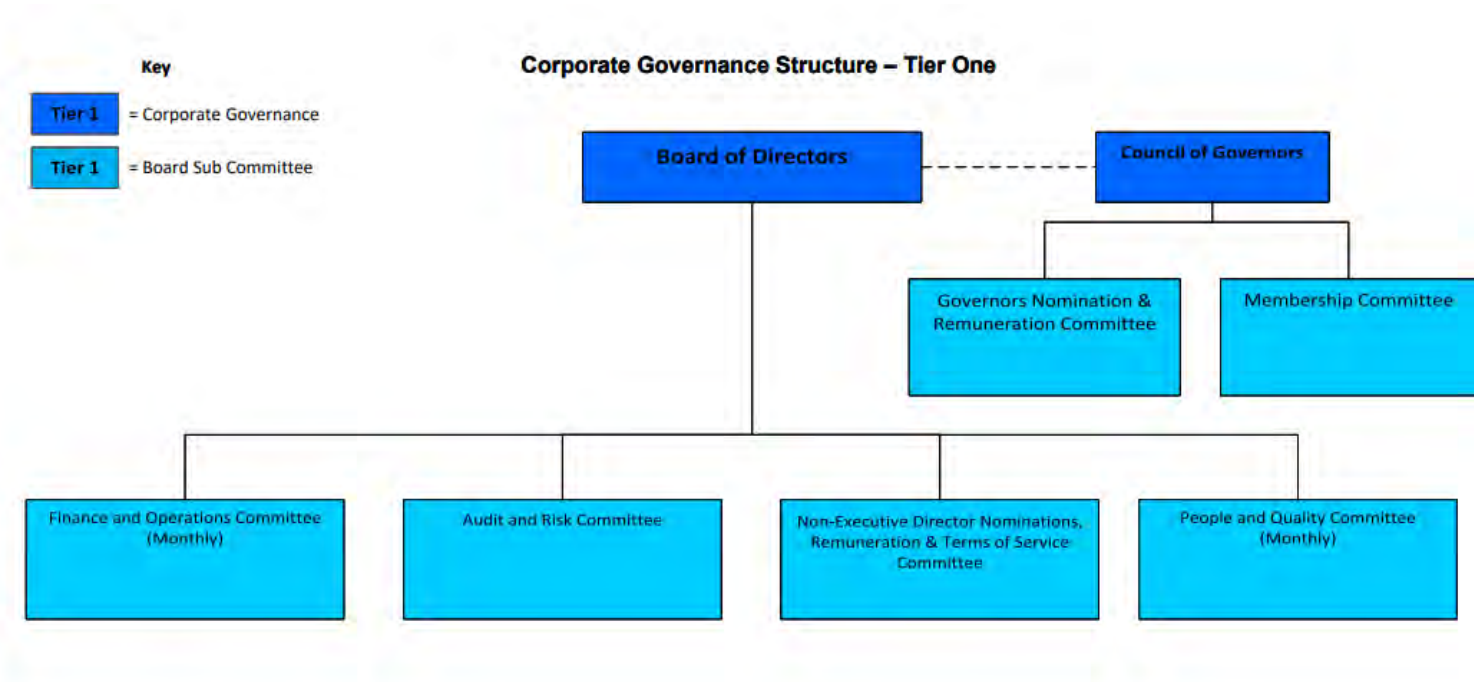
Section	Assurance (Limited/Satisfactory/Significant)	Trend from previous report
3	SATISFACTORY	N/A
4	SATISFACTORY	N/A

It is recommended that, noting the above, THAT the Board AGREE the overarching assurance rating and take **SATISFACTORY** assurance as to those matters reviewed.

Current Board Structure



Proposed Board Structure



Note - Charity is not a Committee – The Trust is a Corporate Trustee

Note – Strategy and Planning will be stood up for 4 – 6 months each year

Audit and Risk Committee Terms of Reference

Version:	1.0
Approved by:	Board of Directors
Date approved:	Xxx
Date issued:	xxxx
Review date:	Xxxx
Tier:	1
Relevant documentation to read in conjunction:	Governance Manual and appendices Conflicts of Interest Policy Fit & Proper Persons SOP Risk Policy, Risk Strategy and SOP

Audit and Risk Committee

Terms of Reference

1. Constitution

- 1.1. The Audit and Risk Committee (the ARC) has been convened under the authority of the Board of Directors (a Tier 1 Governance meeting of Torbay and South Devon NHS Foundation Trust (the "Trust")); to whom the the ARC shall remain accountable.
- 1.2. The Board of Directors retain the authority to disband ARC at any time in the best interests of the Trust.
- 1.3. This is a Tier1 governance meeting in accordance with the Trust's governance framework.
- 1.4. ARC will adhere to, and be cognisant of the Trust values at all times.
- 1.5. These Terms of Reference shall be published on the Trust's intranet and public website.

2. Powers

- 2.1. In accordance with the delegated authority outlined above, the ARC is authorised to seek any information it requires from any member of staff, who shall be under a positive obligation to co-operate with any request made by the ARC.
- 2.2. The Committee is authorised by the board to obtain outside legal or other independent professional advice
- 2.3. The ARC may request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary in the best interests of the Trust.
- 2.4. The ARC derives its power from the Board of Directors and has no powers, other than those specifically delegated in these terms of reference.

3. Purpose

- 3.1. The purpose of the ARC is to have primary responsibility for reviewing the effectiveness of the framework in place for the identification and management of risks and associated controls, corporate governance and assurance frameworks.
- 3.2. The ARC will have close working relationships with the Quality and People Committee which has responsibility for oversight and monitoring of clinical risks.
- 3.3. The ARC will have a working relationship and due regard with respect to the Integrated Care System's oversight and assurance mechanisms.
- 3.4. The ARC shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities (including any subsidiary companies of the Trust) both generally and in support of the statement of internal control. In addition the ARC shall:
 - 3.4.1. Ensure independence of external and internal audit;
 - 3.4.2. Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the ARC; and

3.4.3. Monitor corporate governance (e.g. compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3.5. The duties of the ARC will be driven by the Trust's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however this will be flexible to new and emerging priorities and risks.

3.6. The ARC will promote local level responsibility and accountability.

4. Duties and Responsibilities

4.1 The duties of the ARC are to receive thematic reports and provide an assurance report to the Board, in the prescribed form and using the assurance methodology prescribed by the Trust, as issued from time to time (including but not limited to the Board Assurance Framework), as relates to the Committees purpose: In addition to the duties specified herein, the ARC shall have oversight of:

- 4.1.1 Compliance with legal, regulatory, and national standards; and
- 4.1.2 Receive necessary or desirable (statutory, regulatory or other) reports, aligned to the Committee's purpose, on behalf of the Board of Directors; and
- 4.1.3 Alignment with the relevant overarching NHS policy, procedure or guidance as pertains to those matters aligned to the Committees purpose.

Governance, risk management and internal control

4.2 The ARC shall review the adequacy and effectiveness of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisations objectives. In particular, the ARC will review the adequacy and effectiveness of:

- 4.2.1 All risk and control related disclosures statements, together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board and/or the Council of Governors.
- 4.2.2 Statements within the quality account.
- 4.2.3 External audit assurance of the quality account (if applicable).
- 4.2.4 The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks, the appropriateness of the above disclosure statements; and the adequacy and effectiveness of risk appetite/risk appetite governance.
- 4.2.5 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting; as well as receiving reports on upcoming legal and regulatory requirements.
- 4.2.6 The policies and procedures for all work related to fraud and corruption as required by NHS Counter Fraud Authority.

- 4.2.7 In carrying out this work the ARC will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.
- 4.2.8 This will be evidenced through the ARC's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.
- 4.2.9 As part of its approach, the ARC will have effective relationships with other committees so that it understands processes and linkages. However, these other committees must not usurp the ARC's role.

Internal Audit

- 4.3 The ARC shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards as issued from time to time and provides appropriate independent assurance to the ARC, Chief Executive (as Accountable Officer) and the Board. This will be achieved by:
 - 4.3.1 Considering the provision of the internal audit service, the costs involved and any questions of resignation and dismissal.
 - 4.3.2 Reviewing and approving the annual internal audit workplan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.
 - 4.3.3 Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
 - 4.3.4 Ensuring that the internal audit function is adequately resourced and has appropriate experience and standing within the organisation.
 - 4.3.5 Overseeing the continued independence of the internal auditor.
 - 4.3.6 Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit (Statutory Audit)

- 4.4 The ARC shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the ARC will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:
 - 4.4.1 Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board and/or Council of Governors when appropriate).
 - 4.4.2 Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

- 4.4.3 Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- 4.4.4 Reviewing all external audit reports, including the report to those charged with governance, (before submission to the Board and/or the Council of Governors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- 4.4.5 Ensuring that there is in place a clear policy for the engagement of external auditors.

Other Assurance Functions

- 4.5 The ARC shall review the findings of other significant assurance functions, both internal and external, and consider the risk implications for the governance of the Trust, including its subsidiaries.
- 4.6 These may include, but will not be limited to, any reviews by Department of Health and Social Care arms-length bodies or Regulators / Inspectors (eg Care Quality Commission, NHS Resolution Scheme etc), and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies etc).
- 4.7 The ARC will review the adequacy of the clinical audit function.
- 4.8 In addition, the ARC will review the work of other committees within the organisation, whose work can provide relevant assurance to the ARC's own areas of responsibility. This will particularly include the Trust's Quality and People Committee, Board Committees and any other risk management and assurance committees or ARCs that are established.
- 4.9 The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:
 - 4.8.1 fitness for purpose of the assurance framework
 - 4.8.2 completeness and 'embeddedness' of risk management in the organisation
 - 4.8.3 effectiveness of governance arrangements
 - 4.8.4 appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.
- 4.9 This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

Counter Fraud

- 4.10 The ARC shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority standards and shall review the outcomes of work in these areas.
- 4.11 With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter

fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

- 4.12 The ARC will refer any suspicions of fraud, bribery and corruption to the NHS Counter Fraud Authority.

Management

- 4.13 The ARC shall request and review reports, evidence and assurances from directors and managers on the overall management of governance, risk and internal control.

- 4.14 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of the Trust's Standing Orders, in order to provide assurance in relation to the appropriateness of decisions and to derive future learning.

Financial Reporting

- 4.15 The ARC shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.
- 4.16 The ARC should ensure that the systems for financial reporting to the Trust, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.
- 4.17 The ARC shall review the annual report and financial statements before submission to the Trust, focusing particularly on:
- 4.17.1 The wording in governance disclosures and other disclosures relevant to the Terms of Reference of the ARC.
 - 4.17.2 Changes in, and compliance with, accounting policies, practices and estimation technique.
 - 4.17.3 Unadjusted misstatements in the financial statements.
 - 4.17.4 Significant judgements in preparation of the financial statements.
 - 4.17.5 Significant adjustments resulting from the audit.
 - 4.17.6 Letter of representation.
 - 4.17.7 Explanations for significant variances.

Information Governance (IG)

- 4.18 To receive regular updates on IG compliance (including uptake and completion of data security training), data breaches and any related issues and risks.
- 4.19 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security and Protection Toolkit and relevant reports and action plans.
- 4.20 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security and Protection Toolkit.
- 4.21 To provide assurance to the Board that there is an effective framework in place for the management of risks associated with information governance.

Cyber Security and Digital Resilience

- 4.22 Incident Response and Resilience: Seek assurance as to the resilience of digital services, including defending against and recovering from external threats and reviewing incidents to ensure continuous improvement and safeguard future occurrences.
- 4.23 Providing regular reports or a highlight report to the Trust Board on cyber security matters, significant issues, and the committee's work.
- 4.24 Review and recommend the organisation's digital, data, and technology strategies, and ensuring robust and effective cyber security policies are in place and aligned with national standards.

Systems for raising concerns

- 4.25 The ARC shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently through the Trust's procedures; including but not limited to: Whistleblowing, Freedom to Speak Up Guardian or Local Counter Fraud Specialist.

5. Membership and attendance

- 5.1 The ARC's membership shall reflect those individuals outlined in Appendix 1.
- 5.2 Other staff may be invited by the Chair to attend all or part of any meeting.
- 5.3 If any member of the ARC has been disqualified from participating on an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.
- 5.4 Members will possess between them knowledge, skills and experience in: accounting, risk, management, internal, external audit; and technical or specialist issues pertinent to the Trust's business. When determining the membership of the ARC, active consideration will be made to diversity and equality.
- 5.5 The Chair will be appointed by the Board on account of their specific knowledge, skills and experience making them suitable to chair the ARC.
- 5.6 The Chair of the ARC shall be independent and therefore may not chair any other committees.
- 5.7 Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management will have full and unrestricted rights of access to the ARC and its Chair.
- 5.8 The Chief Executive (in their capacity as Accounting Officer for the Trust) shall be invited to attend meetings. They should also attend when the ARC considers the annual report and accounts.
- 5.9 Other executive directors/managers should be invited to attend, particularly when the ARC is discussing areas of risk or operation that are the responsibility of that director/manager.
- 5.10 Representatives from other organisations (for example, NHS Counter Fraud Authority); and other individuals may be invited to attend on occasion.

5.11 Th

- 5.12 At least once a year the ARC should meet privately with the external and internal auditors.
- 5.13 Members unable to attend an ARC meeting should inform the Secretary to the ARC as soon as possible in advance of the meeting, except in extenuating circumstances.
- 5.14 Unless otherwise determined by the Chairman, the duration of appointments to this ARC shall be for a continuous term, with annual review; for the avoidance of doubt, no member may continue to attend following the completion of their Non-Executive or Executive role at the Trust.
- 5.15 Governor and Devon ICS representatives may be invited to attend as observers.

6. Attendance

- 6.1 A register of attendance will be maintained and the Chair of the ARC will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the ARC, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement in collaboration with the Trust Chair and noting that the Board of Directors must approve changes to these Terms of Reference.

7 Administration

- 7.1 The ARC shall be supported by a nominated Secretary whose duties in this respect will include:
 - 7.1.1 In consultation with the Chair, develop and maintain an annual reporting schedule to the ARC;
 - 7.1.2 Collation of papers and drafting of the agenda for agreement by the Chair of the ARC;
 - 7.1.3 Taking the notes of the meeting and keeping a record of matters arising and issues to be carried forward;
 - 7.1.4 Advising on scheduled agenda items;
 - 7.1.5 Agreeing and circulating the action schedule following each meeting;
 - 7.1.6 Maintaining a record of attendance.

8. Meetings

- 8.1 Meetings will be held on the following basis:
 - 8.1.1 Meetings will be held at least on a quarterly basis.
 - 8.1.2 In the absence of the Chair, a Non-Executive Director shall be nominated to act as Chair;
 - 8.1.3 Items for the agenda must be sent to the meeting administrator a minimum of 5 days prior to the meeting: urgent items may be raised under another business;
 - 8.1.4 The agenda will be sent out 5 days prior to the meeting date, together with the action schedule and other associated papers;
 - 8.1.5 An action schedule will be circulated to members following each meeting and must be duly completed and returned to the meeting

administrator for circulation with the following meeting's agenda and associated papers.

- 8.1.6 Notwithstanding the above, a meeting may be duly convened at short notice by the Secretary, at the request of the Chair, to meet Trust requirements; in such event provisions 8.1.3 – 5 may be disapplied.

9. Reporting

- 9.1 The ARC will provide a report in the form of a prescribed template to the Board of Directors to demonstrate that the work undertaken fulfills the purpose for which the ARC was constituted.
- 9.2 The ARC will receive reports as per the meeting work plan.

10. Quorum

- 10.1 The quorum necessary for the transaction of business shall be 3 Non-Executive members .
- 10.2 A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the ARC.
- 10.3 Deputies will not count towards the quorum.

11. Review

- 11.1 The Terms of Reference shall be reviewed on an annual basis and ratified by the Board of Directors.

12. Monitoring Effectiveness

- 12.1 In order that the ARC can be assured that it is operating effectively in discharging its responsibilities at set out in these terms of reference and, if necessary, to recommend any changes to the Terms of Reference, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the ARC.
- 12.2 The purpose and duties, as prescribed above, were fulfilled.
- 12.3 Appropriate level of attendance by members to ensure effective meetings was achieved.

Appendix 1
MEMBERS AND ATTENDEES

Membership
Non-Executive Chair of this Committee
Finance and Operations Committee Chair or representative
Quality and People Committee Chair or representative
NED to be confirmed by Chair
Attendance
Director of Corporate Governance & Trust Secretary
Chief Finance Officer
Chief Nursing Officer
External Audit Representatives
Internal Audit Representatives
Counter Fraud Specialist

FINANCE AND OPERATIONS COMMITTEE

Terms of Reference

Version:	1.0
Approved by:	Board of Directors
Date approved:	xxxx
Date issued:	xxxx
Review date:	xxxx
Tier:	1
Relevant documentation to read in conjunction:	

Finance and Operations Committee Terms of Reference

1. Constitution

- 1.1. The Finance and Operations Committee ("F&OC") has been convened under the authority of the Board of Directors (a Tier 1 Governance meeting of Torbay and South Devon NHS Foundation Trust (the "Trust")); to whom F&OC shall remain accountable as a Board Sub-Committee.
- 1.2. The Board of Directors retain the authority to disband F&OC at any time in the best interests of the Trust.
- 1.3. This is a Tier 1 governance meeting in accordance with the Trust's governance framework.
- 1.4. F&OC will adhere to, and be cognisant of the Trust values at all times.
- 1.5. These Terms of Reference shall be published on the Trust's intranet and public website.

2. Powers

- 2.1. In accordance with the delegated authority outlined above, F&OC is authorised to seek any information it requires from any member of staff, who shall be under a positive obligation to co-operate with any request made by the Committee.
- 2.2. F&OC may request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary in the best interests of the Trust.
- 2.3. F&OC derives its power from the Board of Directors and has no powers, other than those specifically delegated in these terms of reference.

3. Purpose

- 3.1. The purpose of F&OC is to provide assurance to the Board on:
 - 3.1.1. Financial performance, management and transformation;
 - 3.1.2. Operational performance, productivity and sustainability;
 - 3.1.3. The performance of the Trust in delivering the current financial and operational plan in year; and
 - 3.1.4. Recommend the draft annual (financial and operational) plan as well as any relevant strategies for implementation, for approval to the Trust Board of Directors.
- 3.2. F&OC will promote local level responsibility and accountability.

4. Duties and Responsibilities

- 4.1. The duties of the F&OC are to:
 - a) Receive thematic reports and provide an assurance report to the Board, in the prescribed form and using the assurance methodology prescribed by the Trust, as issued from time to time (including but not limited to the Board Assurance Framework), as relates to the Committees purpose, that:
 - a) Performance is being measured in a way that is appropriate and assess actual performance against those metrics; aligned to the Trust's

- escalation reporting contained within the balanced score card and Integrated Quality and Performance Report;
- b) Effective financial management, transformation and operational strategies, governance, and controls are in place;
- c) The operational plan is being delivered on trajectory, assessing any risk arising to delivery and reporting to the Board;
- d) Effective risk management is in place with regard to the application of the Trust's risk management framework;
- e) Maintain oversight of the development of the Trust's Digital Strategy; updates on its delivery; support digital innovation and oversee realisation of benefits associated with digital investments including the electronic patient record.
- f) There is alignment with the relevant overarching NHS strategies, operational, planning, oversight and Integrated Care System (ICS) plans/guidance;
- g) Ensure compliance with legal, regulatory, and national standards; and
- h) Receive necessary or desirable (statutory, regulatory or other) reports, aligned to the Committee's purpose, on behalf of the Board of Directors.

Oversee in year Delivery

- a) By exception - delivery of in-year financial performance against plan including risk and mitigation issues for exception reporting;
- b) By exception - delivery of activity against plan and trajectory of performance;
- c) Overview of the cost improvement programme in year and future years;
- d) Overview of performance against 104ww, 78ww and 62day cancer trajectories;
- e) Overview of delivery by Care Group (including productivity, innovation and improvement);
- f) Overview of delivery of and all related policies and procedures related to emergency preparedness;.
- g) Overview of management of the estate aligned to sustainability and the Trust's green plan;
- h) By exception - delivery of capital programme;
- i) Review of cash flow forecasting, exception reports related to cash;
- j) Group and approval of capital cash support requests to NHS England;
- k) recommendation to the Board for Devon ICS cash support requests; and
- l) By exception - review of ICS in year delivery and receipt of ICS updates on financial framework and governance

Oversee annual Planning Assurance

- m) Oversight of annual operational and financial plan;
- n) Review of achievement against national planning expectations;
- o) Alignment of workforce assumptions;
- p) Review of capital plan;
- q) Review of cash requirements and forecasting;
- r) Review of Devon ICS plan position and Trust contribution;
- s) Financial Strategy Assurance;
- t) Development of Financial Strategy;
- u) Review of Long-Term Financial model underpinning the strategy (including the allocation of financial resources – capital and revenue);
- v) Alignment to Trust strategy;
- w) Alignment to NHS long term plan and financial recovery

Board Assurance Framework & Risk Management: the Committee will:

- a) Assure the Board that effective risk management is in place with regard to the application of the Trust's risk management framework;and
- b) Review of assigned BAF objectives, risks and mitigations to manage risks within a target tolerable risk level

5. Membership and attendance

5.1. F&OC's membership shall reflect those individuals outlined in Appendix 1.

5.2. The Chair will be appointed by the Board.

5.3. Other Non-Executive Directors, staff of the Trust or professional advisers appointed by the Trust may be invited by the Chair to attend all or part of any meeting.

6. Attendance

6.1. A register of attendance will be maintained and the Chair of F&OC will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of F&OC, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

7. Administration

7.1. F&OC shall be supported by a nominated Secretary whose duties in this respect will include:

- a) In consultation with the Chair, develop and maintain an annual reporting schedule to F&OC;
- b) Collation of papers and drafting of the agenda for agreement by the Chair of F&OC;
- c) Taking the notes of the meeting and keeping a record of matters arising and issues to be carried forward;

- d) Advising on scheduled agenda items;
- e) Agreeing and circulating the action schedule following each meeting;
- f) Maintaining a record of attendance.

8. Meetings

8.1. Meetings will be held on the following basis:

- a) Meetings will be monthly.
- b) In the absence of the Chair, a Non-Executive Director shall be nominated to act as Chair;
- c) Items for the agenda must be sent to the meeting administrator a minimum of 7 days prior to the meeting; urgent items may be raised under another business;
- d) The agenda will be sent out 5 days prior to the meeting date, together with the action schedule and other associated papers;
- e) An action schedule will be circulated to members following each meeting and must be duly completed and returned to the meeting administrator for circulation with the following meeting's agenda and associated papers.
- f) Notwithstanding the above, a meeting may be duly convened at short notice by the Secretary at the request of the Chair to meet Trust requirements; in such event provisions 8.1c – d may be disapplied.

9. Reporting

9.1. F&OC will provide a report in the form of a prescribed template to the Board of Directors to demonstrate that the work undertaken fulfills the purpose for which F&OC was constituted.

9.2. F&OC will receive reports as per the meeting work plan.

10. Quorum

10.1. The quorum necessary for the transaction of business shall be 3; with a minimum of two Non-Executive and one Executive members present.

10.2. A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by F&OC

10.3. Deputies will not count towards the quorum.

11. Review

11.1. The Terms of Reference shall be reviewed on an annual basis and ratified by the Board of Directors.

12. Monitoring Effectiveness

12.1. In order that F&OC can be assured that it is operating effectively in discharging its responsibilities at set out in these terms of reference and, if necessary, to recommend any changes to the Terms of Reference, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of F&OC.

- 12.1.1. The purpose and duties, as prescribed above, were fulfilled.
- 12.1.2. Appropriate level of attendance by members to ensure effective meetings was achieved.

Appendix 1
MEMBERS AND ATTENDEES

Membership
CHAIR TO CONFIRM NED ALLOCATION
CHAIR TO CONFIRM NED ALLOCATION
CHAIR TO CONFIRM NED ALLOCATION
CHAIR TO CONFIRM NED ALLOCATION
CHIEF FINANCE OFFICER
CHIEF OPERATING OFFICER
CHIEF STRATEGY AND PLANNING OFFICER
Attendance
DIRECTOR OF CORPORATE GOVERNANCE & TRUST SECRETARY
DEPUTY CHIEF OPERATING OFFICER
CFO TO CONFIRM
COO TO CONFIRM
CSPO TO CONFIRM

Governors' Nomination and Remuneration Committee

Terms of Reference

Version:	2.0
Approved by:	Board of Directors / Council of Governors
Date approved:	Xxx/xxx
Date issued:	xxxx
Review date:	Xxxx 2026
Tier:	1
Relevant documentation to read in conjunction:	Governance Manual and appendices Conflicts of Interest Policy Fit & Proper Persons SOP Risk Management and Strategy Policy

GOVERNORS' NOMINATIONS, REMUNERATION AND TERMS OF SERVICE COMMITTEE ('GNRC')

Terms of Reference

1. Constitution

- 1.1. The Governors' Nomination and Remuneration Committee (the "GNRC") has been convened under the authority of the Board of Directors Torbay and South Devon NHS Foundation Trust (the "Trust"); to whom the GNRC shall remain accountable.
- 1.2. The Board of Directors retain the authority to disband the GNRC at any time in the best interests of the Trust.
- 1.3. This is a Tier 1 governance meeting in accordance with the Trust's governance framework.
- 1.4. The GNRC will adhere to, and be cognisant of the Trust values at all times.
- 1.5. These Terms of Reference shall be published on the Trust's intranet.

2. Powers

- 2.1. In accordance with the delegated authority outlined above, the GNRC is authorised to seek any information it requires from any member of staff, who shall be under a positive obligation to co-operate with any request made by the Committee.
- 2.2. The GNRC may request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary in the best interests of the Trust.
- 2.3. The GNRC derives its power from the Board of Directors and has no powers, other than those specifically delegated in these terms of reference.

3. Purpose

- 3.1. The purpose of the Committee is to advise and / or make recommendations to the Council of Governors relating to:
 - 3.1.1. the evaluation of the performance of the Chair and Non-Executives. In fulfilling this role the Committee will make reference to the Code of Governance for NHS Provider Trusts; NHS England Your Statutory Duties – A Reference Guide for NHS Foundation Trust Governors; and NHSE Chair and NED Appraisal Framework
 - 3.1.2. the remuneration, allowances and other terms and conditions of the Chair and Non-Executives; and
 - 3.1.3. determining and directing the process for recruitment, re-appointment or removal of the office of the Chair and other Non-Executive Directors.
- 3.2. The Committee will promote local level responsibility and accountability.

4. Duties and Responsibilities

- 4.1. The duties of the GNRC are to:
 - 4.1.1. on a regular and systematic basis monitor the performance of the Chair and other Non-Executive Directors and make reports thereon to

the Council of Governors when requested to do so, or when in the opinion of the Committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors;

4.1.2. consider and make recommendations to the Council of Governors as to the remuneration and allowances and terms and conditions of the office of the Chair and Non-Executive Directors;

4.1.3. consider Non Executive Directors' succession planning having regard to the Non-Executive re-appointment process every three years;

4.1.4. determine the processes for the selection of candidates for office of the Chair or other Non-Executive Directors of the Trust having first consulted with the Board of Directors as to these matters and having regard to such views as may be expressed by the Board of Directors.

4.2. This process will include;

4.2.1. preparing a description of the role and responsibilities

4.2.2. determining the arrangement for attracting applicants

4.2.3. conducting a selection process and other assessment arrangements

4.2.4. making a recommendation to the Council of Governors

4.3. engage with the Trust's workforce services to seek candidates for office and to advise on the recruitment selection process up to making a recommendation to the Council of Governors. In doing so the Committee shall be at liberty to seek open and fair advice and assistance from persons other than members of the Committee or of the Council of Governors such as external organisations recognised as experts in recruitment;

4.4. to make recommendations to the Council of Governors of the candidate for appointment as Chair or other Non-Executive Director, as the case may be.

4.5. Any other relevant matter as may arise from time to time, requiring detailed Non-Executive oversight, under the direction of the Chair.

5. Membership and attendance

5.1. The GNRC's membership shall reflect those individuals outlined in Appendix 1.

5.2. Other staff may be invited by the Chair to attend all or part of any meeting.

5.3. The Committee will be chaired by the Chair of the Trust. If the Chair is absent the Senior Independent Director will act as deputy for the Chair.

5.4. The term of office for Governor members (except Lead Governor) of the Committee shall be (3) three years. At the expiry of the Governor term of office, the Committee shall invite expressions of interest from the governor category they represent. If more than one expression of interest is received, an election will be held in which all Governors will be entitled to vote. In such circumstances, those Governors will circulate a short supporting statement. In the event of a tie the Chair will decide the Governor member. A Governor may be re-appointed to the Committee.

5.5. In discharging its responsibilities the Chief Executive of the Trust may be invited to attend the meeting of the Committee.

- 5.6. For the appointment of the Chair to the Trust, the Committee may seek the services of an Independent Assessor(s). The Independent Assessor will not be a member or have a vote on the Committee.
- 5.7. For all appointments and matters relating to remuneration, the Committee will seek advice from the professional workforce services of the Trust and/or external professional support.
- 5.8. Devon ICS representatives may be invited to attend.

6. Attendance

- 6.1. A register of attendance will be maintained and the Chair of the GNRC will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the GNRC, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

7. Administration

- 7.1. The GNRC shall be supported by a nominated Secretary whose duties in this respect will include:
 - a) In consultation with the Chair, develop and maintain an annual reporting schedule to the GNRC;
 - b) Collation of papers and drafting of the agenda for agreement by the Chair of the GNRC;
 - c) Taking the notes of the meeting and keeping a record of matters arising and issues to be carried forward;
 - d) Advising on scheduled agenda items;
 - e) Agreeing and circulating the action schedule following each meeting;
 - f) Maintaining a record of attendance.

8. Meetings

- 8.1. Meetings will be held on the following basis:
 - a) Meetings will be held as required, but at least twice a year.
 - b) In the absence of the Chair, a Non-Executive Director shall be nominated to act as Chair;
 - c) Items for the agenda must be sent to the meeting administrator a minimum of five [5] days prior to the meeting: urgent items may be raised under another business;
 - d) The agenda will be sent out three [3] days prior to the meeting date, together with the action schedule and other associated papers;
 - e) An action schedule will be circulated to members following each meeting and must be duly completed and returned to the meeting administrator for circulation with the following meeting's agenda and associated papers.
 - f) Notwithstanding the above, a meeting may be duly convened at short notice by the Secretary at the request of the Chair to meet Trust requirements; in such event provisions 8.1c – e may be disapplied.

9. Reporting

9.1. The GNRC will provide a report in the form of a prescribed template to the Council of Governors to demonstrate that the work undertaken fulfills the purpose for which the GNRC was constituted.

9.2. The GNRC will receive reports as per the meeting work plan.

10. Quorum

10.1. The quorum necessary for the transaction of business shall be four [4] members; including the Chair or their nominated deputy.

10.2. A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the GNRC.

10.3. Deputies shall be permitted for Governors; for Non-Executive members deputies may be permitted and counted towards the quorum, where such delegation mitigates a conflict of interest.

11. Review

11.1. The Terms of Reference shall be reviewed on an annual basis and ratified by the Board of Directors and Council of Governors.

12. Monitoring Effectiveness

12.1. In order that the GNRC can be assured that it is operating effectively in discharging its responsibilities at set out in these terms of reference and, if necessary, to recommend any changes to the Terms of Reference, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the GNRC:

12.1.1. The purpose and duties, as prescribed above, were fulfilled.

12.1.2. Appropriate level of attendance by members to ensure effective meetings was achieved.

Appendix 1
MEMBERS AND ATTENDEES

Membership
Trust Chair
Trust Senior Independent Director
Lead Governor
Four Public Governors *
Two Staff Governors
Attendance
Director of Corporate Governance and Trust Secretary

*Membership shall preferably include one Governor from each constituency however this shall not be mandatory.

Non-Executive Directors Nomination, Remuneration and Terms of Service Committee

Terms of Reference

Version:	2.0
Approved by:	Board of Directors
Date approved:	Xxxx
Date issued:	Xxxxx
Review date:	Xxxxx 2026
Tier:	
Relevant documentation to read in conjunction:	Governance Manual and appendices Conflicts of Interest Policy Fit and Proper Persons SOP Risk Management and Strategy Policy

Non Executive Director Nomination, Remuneration and Terms of Service Committee

Terms of Reference

1. Constitution

- 1.1. The Non-Executive Nomination, Remuneration and Terms of Service Committee (the "Committee") has been convened under the authority of the Board of Directors; to whom the Committee shall remain accountable.
- 1.2. The Board of Directors retain the authority to disband the Committee at any time in the best interests of the Trust.
- 1.3. This is a Tier 1 governance meeting in accordance with the Trust's governance framework.
- 1.4. The Committee will adhere to, and be cognisant of the Trust values at all times.
- 1.5. These Terms of Reference shall be published on the Trust's intranet and public website.

2. Powers

- 2.1. In accordance with the delegated authority outlined above, the Committee is authorised to seek any information it requires from any member of staff, who shall be under a positive obligation to co-operate with any request made by the Committee.
- 2.2. The Committee may request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary in the best interests of the Trust.
- 2.3. The Committee derives its power from the Board of Directors and has no powers, other than those specifically delegated in these terms of reference.

3. Purpose

- 3.1. The purpose of the Committee is to consider and review current and future requirements applicable to:
 - 3.1.1. strategic portfolio changes relevant to the posts covered by the Committee's remit;
 - 3.1.2. the performance of and the setting of salaries, terms of service and allowances for the posts covered by the Committee's remit;
 - 3.1.3. To consider and approve proposed employment tribunal settlements.
 - 3.1.4. the Trust's senior management succession planning arrangements and talent management process;
 - 3.1.5. senior managerial competence relating to leadership capability; and
 - 3.1.6. the allowances as may be payable to Foundation Trust Governors.
- 3.2. The Committee shall meet each year for the purpose of reviewing the performance development reviews of Executive Directors.
- 3.3. The Committee will meet at other times for the following purposes as determined by the Chair of the Committee:

- 3.3.1. To keep up to date with relevant national and local developments;
- 3.3.2. To inform the Committee of changes, both local and national, which may impact on the Committee;
- 3.3.3. To proactively seek best practice and bring to the attention of the Committee;
- 3.3.4. To review remuneration policies, including having oversight of those applicable to staff employed on very senior manager terms and conditions;
- 3.3.5. To consider proposals for changes in terms and conditions of employment;
- 3.3.6. To consider any matter relating to the continuation in office of any Executive Director and Very Senior Manager including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their employment contract;
- 3.3.7. To consider any in-year variations of salaries and terms and conditions of employment of Executive Directors who are subject to the annual review process carried out by the Committee;
- 3.3.8. To oversee the process for the nomination of the Chief Executive for approval by the Board (and ratification by the Council of Governors);
- 3.3.9. To oversee the process for the appointment of other Executive Directors Company Secretary and Very Senior Managers; and
- 3.3.10. For the avoidance of doubt the Chair will be responsible for the identification and nomination of chairs of all Board Committees and Board post holders ie Senior Independent Director and Vice Chair; the Board as a collective holds a right of veto for any such appointments.

3.4. The Committee will promote local level responsibility and accountability.

3.5. This is a Tier 1 Committee, in accordance with the Trust's governance framework.

4. Duties and Responsibilities

4.1. The duties of the Committee are to:

- 4.1.1. Set remuneration for all Executive Directors and Very Senior Managers, including from time to time setting remuneration levels of interim posts, and including pension rights and any compensation payments. (See Appendix 1 for schedule of employees covered by the Committee's remit.) No director or manager shall be involved in any decisions as to their own remuneration. The Chief Executive shall attend to present their recommendations for Executive Director remuneration (but not their own) and other employees as listed in Appendix 1.
- 4.1.2. In recommending such a policy, take into account all factors which it deems necessary including:
 - 4.1.2.1. Observing all legal and contractual obligations as they affect individual post holders;
 - 4.1.2.2. Acting in accordance with the Trust's Standing Orders, Constitution, Terms of Authorisation and the Code of Governance for NHS Provider Trusts issued by NHS England;

- 4.1.2.3. Having regard to any directions made by the Secretary of State in so far as they apply to the Trust;
- 4.1.2.4. Have regard to the guidance in any directives on pay and conditions of employment as issued by the Department of Health in so far as they apply to the Trust;
- 4.1.2.5. Take into account the financial state of the Trust;
- 4.1.2.6. Have regard for legislation on discrimination when considering levels of pay / terms and conditions; and
- 4.1.2.7. Consider the relationship between the remuneration of these posts and that of other grades of staff employed by the Trust. This may include reference to the level of pay awards granted under national pay systems eg. Agenda for Change.

The objective of such a policy shall be to ensure that rewards are fair and appropriate to individual's contributions – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff.

- 4.1.3. Recommend the scope and detail to be included in the annual report concerning basic salary and elements relating to performance including an explanation of the criteria on which performance is based.
- 4.1.4. Ensure that the criteria presented for the annual review of:
 - 4.1.4.1. Increases in basic salaries;
 - 4.1.4.2. Additional bonuses based on performance / achievement of objectives; and
 - 4.1.4.3. Changes in terms and conditions of employment

are applied objectively to the determination of the award for each Executive Director.
- 4.1.5. Review the ongoing appropriateness and relevance of the remuneration policy.
- 4.1.6. Consider all proposed changes to the senior management structure and approve job descriptions for post holders covered by the Committee's remit.
- 4.1.7. Consider changes within the Executive Directors and Very Senior Managers pension schemes which may be required on an ad-hoc basis, and which may arise at times of appointment or promotion.
- 4.1.8. Ensure that contractual terms on termination, and any payments made, are fair ensuring value for money, and that the duty to mitigate loss is fully recognised; taking account of such national guidance and legal obligations including seeking approval from the Treasury for termination of payments as may be appropriate.
- 4.1.9. Within the terms of the agreed policy and in consultation with the Chair and / or Chief Executive as appropriate, determine the total individual remuneration package, including benefits, of each Executive Director, other Very Senior Managers.
- 4.1.10. Review and note annually the remuneration trends across the NHS.

- 4.1.11. Oversee any major changes in employee benefits structures for postholders covered by the Committee's remit.
- 4.1.12. Oversee any major changes to the process for ensuring compliance with the Fit and Proper Person Regulations.
- 4.1.13. Monitor the evaluation process for the performance of the Chief Executive.
- 4.1.14. Agree the policy for authorising claims for expenses from the Chief Executive and Chair.
- 4.1.15. Ensure that all provisions regarding disclosure of remuneration are set out in the Annual Report.
- 4.1.16. Be exclusively responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who advise the Committee and to obtain reliable, up to date information about remuneration in other NHS Trusts. The Committee shall have full authority to commission any reports or surveys which it deems necessary to help it fulfil its obligations.
- 4.1.17. Regularly review the structure, size and composition (including the skills, knowledge and experience) of the Board of Directors and make recommendations to the Board with regard to any changes and appropriate process.
- 4.1.18. Ensure that there is a formal, rigorous and transparent procedure for the appointment of new Executive Directors to the Board which fit the criteria set out by the Committee in particular. The same procedure shall apply to the appointment of Very Senior Managers and the Trust Secretary.
- 4.1.19. To consider candidates from relevant backgrounds.
- 4.1.20. To use open advertising or the services of external advisers to facilitate the search.
- 4.1.21. Keep under review the leadership needs of the Trust, with a view to ensuring the continued capability of the organisation.
- 4.1.22. Set the allowances as may be payable to Foundation Trust Governors.
- 4.1.23. Consider and approve the establishment of all new posts requiring VSM status and to verify justification if such posts fall outside the Very Senior Manager pay framework applicable.
- 4.1.24. Consider and approve all proposals for existing or new posts to be re-classified as Very Senior Manager posts. In considering such proposals, the Committee shall receive supporting information, which will include relevant national benchmarking data and confirmation that the Trust's standard HR assessment against national provisions and remuneration assessment processes, Agenda for Change and Doctors and Dentists pay frameworks, have been undertaken and exhausted.
- 4.1.25. Any other relevant matter as may arise from time to time, requiring detailed Non-Executive oversight, under the direction of the Chair.

5. Membership and attendance

- 5.1. The Committee's membership shall reflect those individuals outlined in Appendix 2.
- 5.2. The Chair will be appointed by the Board; it is anticipated that this will be the Chair of the Board of Directors.
- 5.3. The Chief Executive will be expected to attend all meetings of the Committee but shall not be present when discussing the appointment or remuneration of the Chief Executive, nor take part in the decision-making process.
- 5.4. Only members of the Committee have the right to attend Committee meetings, however if a Committee member is unable to attend at short notice, the Chair may nominate another Non-Executive Director to attend and deputise in their place. In such circumstances the Non-Executive Director attending in place of the Committee member will assume the same powers as the Committee member and their attendance will count towards the quorum.
- 5.5. Other individuals may be invited to attend for all or part of any meeting at the request of the committee. It is expected that a senior workforce representative and the Trust Secretary will attend all meetings in an advisory capacity.
- 5.6. The Board shall appoint the Committee Chair who shall be an independent Non-Executive Director. In the absence of the Committee Chair and / or an appointed deputy, the remaining members present shall elect a chair for the meeting.
- 5.7. Unless otherwise determined by the Chair, the duration of appointments to this Committee shall be for a continuous term, with annual review; for the avoidance of doubt, no member may continue to attend following the completion of their Non-Executive or Executive role at the Trust.

6. Attendance

- 6.1. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

7. Administration

- 7.1. The Committee shall be supported by a nominated Secretary whose duties in this respect will include:
 - 7.1.1 In consultation with the Chair, develop and maintain an annual reporting schedule to the Committee;
 - 7.1.2 Collation of papers and drafting of the agenda for agreement by the Chair of the Committee;
 - 7.1.3 Taking the notes of the meeting and keeping a record of matters arising and issues to be carried forward;
 - 7.1.4 Advising on scheduled agenda items;
 - 7.1.5 Agreeing and circulating the action schedule following each meeting;
 - 7.1.6 Maintaining a record of attendance.

8. Meetings

8.1. Meetings will be held on the following basis:

- 8.1.1 Meetings will be held as required and at least twice a year
- 8.1.2 In the absence of the Chair, a Non-Executive Director shall be nominated to act as Chair;
- 8.1.3 Items for the agenda must be sent to the meeting Secretary a minimum of 5 (five) days prior to the meeting: urgent items may be raised under another business;
- 8.1.4 The agenda will be sent out 3 (three) days prior to the meeting date, together with the action schedule and other associated papers;
- 8.1.5 An action schedule will be circulated to members following each meeting and must be duly completed and returned to the meeting administrator for circulation with the following meeting's agenda and associated papers.
- 8.1.6 Notwithstanding the above, a meeting may be duly convened at short notice by the Secretary at the request of the Chair to meet Trust requirements; in such event provisions 8.1c – d may be disapplied.

9. Reporting

- 9.1. The Committee will provide a report in the form of a prescribed template to the Board of Directors to demonstrate that the work undertaken fulfills the purpose for which the Committee was constituted.
- 9.2. The Committee will receive reports as per the meeting work plan.

10. Quorum

- 10.1. The quorum necessary for the transaction of business shall be three (3) members, including the Chair or their nominated deputy.
- 10.2. A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.
- 10.3. Deputies shall count towards the quorum.

11. Review

- 11.1. The Terms of Reference shall be reviewed on an annual basis and ratified by the Board of Directors.

12. Monitoring Effectiveness

- 12.1. In order that the Committee can be assured that it is operating effectively in discharging its responsibilities at set out in these terms of reference and, if necessary, to recommend any changes to the Terms of Reference, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee.
 - 12.1.1. The purpose and duties, as prescribed above, were fulfilled.
 - 12.1.2. Appropriate level of attendance by members to ensure effective meetings was achieved.

APPENDIX 1

SCHEDULE OF POSTS COVERED BY THE COMMITTEE'S REMIT*

Executive Directors

Chief Executive
Deputy Chief Executive
Chief Finance Officer
Chief Nurse
Chief People Officer
Chief Strategy and Planning Officer
Chief Operating Officer
Chief Medical Officer
Director of Corporate Governance and Trust Secretary

Committee's other duties:

Director of Corporate Governance and Trust Secretary for:

- appraisal
- board recommendation – appointment/dismissal

Very Senior Managers for remuneration comprising:

Executive Directors
Any other post paid at Very Senior Manager level

Executive Directors for:

- succession planning
- talent management

Senior Managers (Band 8d and above) for:

- monitoring the level and structure of remuneration for senior management (for this purpose deemed to be band 8d and above)

Posts subject to payment of allowances:

Deputy Chief Executive
Governors (expenses)

*This list is not exhaustive and may vary as posts change within the organisational structure

Appendix 2
MEMBERS AND ATTENDEES

Membership
Chair
Vice-Chair
Senior Independent Director
Chair – People Committee
CHAIR TO CONFIRM
Attendance
Chief Executive
Chief People Officer
Director of Corporate Governance and Trust Secretary

QUALITY AND PEOPLE COMMITTEE Terms of Reference

Version:	1.0
Approved by:	Board of Directors
Date approved:	xxx
Date issued:	xxx
Review date:	xxx
Tier:	1
Relevant documentation to read in conjunction:	

Quality & People Committee Terms of Reference

1. Constitution

- 1.1. The **Quality & People Committee** ("QPC") has been convened under the authority of the Board of Directors (a Tier 1 Governance meeting of Torbay and South Devon NHS Foundation Trust (the "Trust")); to whom QPC shall remain accountable as a Board Sub-Committee.
- 1.2. The Board of Directors retain the authority to disband QPC at any time in the best interests of the Trust.
- 1.3. This is a Tier 1 governance meeting in accordance with the Trust's governance framework.
- 1.4. QPC will adhere to, and be cognisant of the Trust values at all times.
- 1.5. These Terms of Reference shall be published on the Trust's intranet and public website.

2. Powers

- 2.1. In accordance with the delegated authority outlined above, QPC is authorised to seek any information it requires from any member of staff, who shall be under a positive obligation to co-operate with any request made by the Committee.
- 2.2. QPC may request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary in the best interests of the Trust.
- 2.3. QPC derives its power from the Board of Directors and has no powers, other than those specifically delegated in these terms of reference.

3. Purpose

- 3.1. The purpose of QPC is to provide assurance to the Board on:
 - 3.1.1. the quality of care, ensuring systems are in place to achieve high standards and comply with regulations like the CQC framework; giving due consideration to the experience of those who use our services;
 - 3.1.2. all people related matters, including workforce strategy, staff engagement, health and wellbeing, and equality, diversity, and inclusion (EDI).; and recommend the draft annual (financial and operational) plan as pertains to quality, safety and people, as well as any relevant strategies for implementation, for approval to the Trust Board of Directors.
- 3.2. QPC will promote local level responsibility and accountability.

4. Duties and Responsibilities

- 4.1. The duties of the QPC are to:
 - a) Receive thematic reports and provide an assurance report to the Board, in the prescribed form and using the assurance methodology prescribed by the Trust (including but not limited to the Board Assurance Framework), as issued from time to time, as relates to the Committees purpose, that:

- b) Performance is being measured in a way that is appropriate and assess actual performance against those metrics; aligned to the Trust's escalation reporting contained within the balanced score card and Integrated Quality and Performance Report;
- c) Effective quality, safety and people strategies, governance, and controls are in place;
- d) There is alignment with the NHS People Plan and Integrated Care System (ICS) Workforce Strategy;
- e) There is alignment between the quality, safety and people workstreams to ensure that they jointly promote a quality focussed, safe patient/service user and workforce environment for all, noting their reciprocal nature;
- f) The workforce supply, development, wellbeing, and organisational culture strategies and implementation plans are appropriate in line with NHS and Trust values;
- g) Monitor and oversee employee relation performance, themes arising from significant employee issues, appeals, and union negotiations.
- e) Ensure compliance with legal, regulatory, and national standards;and
- f) Receive necessary or desirable (statutory, regulatory or other) reports aligned to quality, safety and people services on behalf of the Board of Directors.

4.2 With respect to quality and safety:

- a) Recieve reports on clinicial governance structures and escalation reporting;
- b) Review the adequacy of the clinical audit function;
- c) Review significant incidents, complaints, deaths, and external inspection reports.
- d) Monitor clinical outcomes, patient safety, experience, and risk management.
- e) Ensure compliance with legal, regulatory, and national quality standards; and
- f) Promote a culture of patient-centered improvement.

4.3 With respect to people services:

- a) Monitor staff engagement, retention, culture, and the effectiveness of HR policies;
- b) Review learning, development, leadership development, and skills initiatives;
- c) Ensure robust plans for staff health, wellbeing, and employee assistance programs;
- d) Oversee the development and delivery of Equality, Diversity & Inclusion (EDI) strategies;

- e) Review results from the annual staff survey and other workforce data, themes arising from concerns raised (such as Freedom to Speak Up); and
- f) Informed by the above oversee the strategies, methodologies and procedures to both engage with our staff and act on their feedback.

4.4 Board Assurance Framework & Risk Management: The Committee will:

- a) Assure the Board that effective risk management is in place with regard to the application of the Trust's risk management framework as well as relevant patient and service user frameworks (such as the The Patient Safety Incident Response Framework (PSIRF);
- b) Review assigned BAF objectives, risks and mitigations to manage risks within a target tolerable risk level

5. Membership and attendance

- 5.1. QPC's membership shall reflect those individuals outlined in Appendix 1.
- 5.2. The Chair will be appointed by the Board.
- 5.3. Other Non-Executive Directors, staff of the Trust or professional advisers appointed by the Trust may be invited by the Chair to attend all or part of any meeting.

6. Attendance

- 6.1. A register of attendance will be maintained and the Chair of QPC will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of QPC, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

7. Administration

- 7.1. QPC shall be supported by a nominated Secretary whose duties in this respect will include:
 - a) In consultation with the Chair, develop and maintain an annual reporting schedule to QPC;
 - b) Collation of papers and drafting of the agenda for agreement by the Chair of QPC;
 - c) Taking the notes of the meeting and keeping a record of matters arising and issues to be carried forward;
 - d) Advising on scheduled agenda items;
 - e) Agreeing and circulating the action schedule following each meeting;
 - f) Maintaining a record of attendance.

8. Meetings

- 8.1. Meetings will be held on the following basis:
 - a) Meetings will be monthly.
 - b) In the absence of the Chair, a Non-Executive Director shall be nominated to act as Chair;

- c) Items for the agenda must be sent to the meeting administrator a minimum of 7 days prior to the meeting: urgent items may be raised under another business;
- d) The agenda will be sent out 5 days prior to the meeting date, together with the action schedule and other associated papers;
- e) An action schedule will be circulated to members following each meeting and must be duly completed and returned to the meeting administrator for circulation with the following meeting's agenda and associated papers.
- f) Notwithstanding the above, a meeting may be duly convened at short notice by the Secretary at the request of the Chair to meet Trust requirements; in such event provisions 8.1c – d may be disapplied.

9. Reporting

9.1. QPC will provide a report in the form of a prescribed template to the Board of Directors to demonstrate that the work undertaken fulfills the purpose for which QPC was constituted.

9.2. QPC will receive reports as per the meeting work plan.

10. Quorum

10.1. The quorum necessary for the transaction of business shall be 3; with a minimum of two Non-Executive and one Executive members present.

10.2. A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by QPC

10.3. Deputies will not count towards the quorum.

11. Review

11.1. The Terms of Reference shall be reviewed on an annual basis and ratified by the Board of Directors.

12. Monitoring Effectiveness

12.1. In order that QPC can be assured that it is operating effectively in discharging its responsibilities at set out in these terms of reference and, if necessary, to recommend any changes to the Terms of Reference, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of QPC.

12.1.1. The purpose and duties, as prescribed above, were fulfilled.

12.1.2. Appropriate level of attendance by members to ensure effective meetings was achieved.

Appendix 1
MEMBERS AND ATTENDEES

Membership
CHAIR TO CONFIRM NED ALLOCATION
CHAIR TO CONFIRM NED ALLOCATION
CHAIR TO CONFIRM NED ALLOCATION
CHAIR TO CONFIRM NED ALLOCATION
CHIEF NURSING OFFICER
CHIEF MEDICAL OFFICER
CHIEF PEOPLE OFFICER
Attendance
DIRECTOR OF CORPORATE GOVERNANCE & TRUST SECRETARY
CNO TO CONFIRM
CMO TO CONFIRM
CPO TO CONFIRM

Committee Chairs' Report - January 2025

[Committee]

REPORTS RECEIVED BY COMMITTEE:

The Board are asked to note that the following reports were received by the Committee and are escalated for their attention:

[TITLE] – [ASSURANCE RATING] [ACTION FOR THE BOARD]

- ...
- ...
- ...

The full Committee pack reviewed can be found on Diligent here:

[LINK TO MEETING]

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 Committee NOTING the following risks, mitigations, actions and successes:

ALERT:

ADVISE:

ASSURE:

RISK:

**CELEBRATE
OUTSTANDING:**

DRAFTING NOTES FOR COMPLETION OF THE COMMITTEE CHAIRS REPORT:

Reports noted and escalated to the Board

This report is the primary source of Board assurance as to the exercise of delegation held by its Board Sub-Committees. It is intended that the relevant Committee will undertake the detailed analysis and escalate matters of note to the Board, as well as articulating risk of note. The Board will then receive their recommendation (as Board Sub-Committees do not make formal approvals) and accordingly note, receive or approve based on the recommendation of the Sub-Committee.

ACTION FOR THE BOARD is therefore to: Note the action required, i.e. – Board to note information, review as being escalated or approve.

Assurance recommendation

In summarising the assurance position overall, Committee Chairs should complete this report, utilising the following headings:

- **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)
- **ADVISE:** Advise the Board of where assurance is absent or limited and this is being reviewed
- **ASSURE:** Inform the Board where positive assurance has been received
- **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

Chairs should advise the Board where assurance is absent or limited and assure the Board when assurance is satisfactory or significant. Chairs should also ALERT the Board to any matters to referred to another sub-committee.

Thematic Report – [November] 2025

[THEME]

[Committee]

REPORTS PRESENTED TO THE COMMITTEE:

The Committee are asked to receive and note the following reports:

- **[TITLE] – [ASSURANCE RATING]**
- ...
-

ASSURANCE RECOMENDATION:

ALERT:

ADVISE:

ASSURE:

RISK:

**CELEBRATING
OUTSTANDING:**

DRAFTING NOTES: THEMATIC REPORT

This covering report is intended to be completed by the relevant Executive Director (or their delegate), providing a snapshot of the papers presented and themes arising, for debate, oversight and challenge by the Committee.

Assurance recommendation

In summarising the assurance position overall , aligned to the reporting themes for the Committee the following headings should be utilised:

- **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)
- **ADVISE:** Advise the Board of where assurance is absent or limited and this is being reviewed
- **ASSURE:** Inform the Board where positive assurance has been received
- **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

APPENDIX 2**CURRENT REPORTING THEMES LIST, BY COMMITTEE**

Current Themes for reporting (to be reviewed by the Committees), based on the previously agreed themes from Committee development sessions in January 2025.

Audit	Executive/ Lead
• Internal Audit	• Internal auditor
• External Audit	• External auditor
• Governance	• DCG
• Cyber Security (new)	• COO
• Compliance (formerly BBF)	• DCG
• Risk Management	• DCG
Finance & Operations Committee	
• Financial Position	• CFO
• Performance/Monitoring Effectiveness/NOF 4 controls	• COO
• Productivity	• CFO/COO
• Capital and Estates	• CPSO/COO
• Infrastructure Improvement (formerly BBF)	• CPSO/COO
• Change Management/Transition (formerly BBF)	• COO
• NHS Demolition and Buildings (formerly BBF)	• CPSO
• Green Plan (formerly BBF)	• COO
People & Quality Committee	
• Education Workforce Development	• CPO
• Culture and Learning	• CPO
• Public Health/Health inequalities	• CMO
• Clinical and other services	• CNO/CMO
• Fundamental standards of care reporting	• CNO/CMO
Referred to Board:	
• Strategy (formerly BBF)	• CPSO
• Strategic Programme Oversight (formerly BBF)	• CPSO

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

	Planned Care Balanced Scorecard - Month 7 2025/26																									
	Torbay and South Devon NHS Foundation Trust																									
Reporting requirement	Metric	Data level	Target March 2026	13 month trend	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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trajectory October 2025	Data Source	
	Quality																									
Mandated to report to Board	CQC safe inspection score (annual)	ICO																								
Oversight Framework	Hospital standardised Mortality Rate (HSMR) 4 mths in arrears	ICO																								
Oversight Framework	SHMI - rolling 12 months (100 is national benchmark)	ICO																								
Supporting measure	Never Events	Care Group																								
Supporting measure	Reported incidents - death	Care Group																								
Supporting measure	Reported incidents - severe	Care Group																								
Supporting measure	Reported incidents - moderate	Care Group																								
Supporting measure	All incidents	Care Group																								
BAF	Medication incidents resulting in moderate or more severe harm	Care Group																								
BAF	All medications incidents	Care Group																								
CNO	Number of incidents open after 6 weeks	Care Group																								
	Patient Safety Incident Investigation (PSII)	Care Group																								
BAF	Falls per 1000 bed days	Care Group																								
	Rates of Healthcare Assoc Infection: MSSA																									
Oversight Framework	Rates of Healthcare Assoc Infection: MRSA	Care Group																								
Oversight Framework	Rates of Healthcare Assoc Infection: C-Diff	Care Group																								
Oversight Framework	Rates of Healthcare Assoc Infection: E-Coli	Care Group																								
Supporting measure	Infection control bed closures	ICO																								
Supporting measure	Hand hygiene	Care Group																								
Supporting measure	28-day readmission rate																									
Oversight Framework	Number inpatients acquiring new pressure ulcer																									
Supporting measure	Catheter acquired UTI																									
Supporting measure	QUESTT																									
Supporting measure	Formal complaints received	Care Group																								
Supporting measure	FFT numbers of responses																									
Supporting measure	FFT results																									
Supporting measure	Compliance with complaints acknowledge in 3 days																									
Supporting measure	Compliance with complaints closed in 6 months																									
Fundamental standards of care	Carers views recorded in Ax																									
Trust Quality Plan	Duty of candour compliance (within 10 days)	Care Group																								
NHSE reporting	Mixed Sex Accommodation breaches	ICO																								
Mandated to report to Board	Safer staffing fill rate- Registered Nurse																									
Mandated to report to Board	Safer staffing fill rate- Skilled, non-registered																									

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

Planned Care Balanced Scorecard - Month 7 2025/26																									
Torbay and South Devon NHS Foundation Trust																									
Reporting requirement	Metric	Data level	Target March 2026	13 month trend	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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trajectory October 2025	Data Source
Mandated to report to Board	CHPPD: registered																								
Trust Quality Plan	CHPPD: skilled, non registered																								
Trust Quality Plan	Mental Capacity Act - % of patients who required and had a full MCA on admission																								
Trust Quality Plan	Sepsis 6 compliance																								
Fundamental standards of care	Nutrition audit compliance																								
Supporting measure	VTE compliance																								
Supporting measure	Service accreditation score																								
Supporting measure	% out of date clinical policies																								
Supporting measure	CAS alerts opened and closed																								
Supporting measure	Rolling annual recruitment to research studies																								
Supporting measure	CPS completed within 24 hrs - weekday	Care Group																							
Supporting measure	CPS completed within 24 hrs - weekend	Care Group																							
National Reporting	Fractured NOF time to theatre <36 hours	ICO																							

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

Planned Care Balanced Scorecard - Month 7 2025/26				Torbay and South Devon Health Foundation Trust NHS																					
Reporting requirement	Metric	Data level	Target March 2026	13 month trend	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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trajectory October 2025	Data Source
	Performance																								
Operational Plan 2025/26	RTT 78-weeks actual patients waiting	Care Group																							
Operational Plan 2025/26	RTT 65-weeks actual patients waiting	Care Group																							
Supporting measure	RTT 65-week total cohort remaining - clear by end Nov 2025 (adm&non-adm)	Care Group																							
Operational Plan 2025/26	RTT 52-weeks actual patients waiting	Care Group																							
Oversight Framework	RTT percentage of patients waiting over 52 weeks	Care Group																							
Supporting measure	RTT 52-week total cohort remaining- clear by Mar 2026 (adm&non-adm)	Care Group																							
Oversight Framework	Percentage of patients waiting less than 18 weeks	Care Group																							
Supporting measure	Total waiting list size (RTT)	Care Group																							
Operational Plan 2025/26	Clock stops in the month (RTT)	Care Group																							
Supporting measure	Follow-ups past 6 weeks to be seen by date	Care Group																							
Supporting measure	RTT Wait for first appointment <18 weeks	Care Group																							
Supporting measure	Validation	Care Group																							
Supporting measure	Clinic letter timeliness - % specialties within 4 working days	Care Group																							
Oversight Framework	Under 18s elective waiting list growth	Care Group																							
Supporting measure	Theatre Utilisation (capped)	ICO																							
Supporting measure	#NOF prompt surgery - one month in arrears	ICO																							
Supporting measure	Percent of patients cancelled on the day for elective operations	ICO																							
Supporting measure	Cancelled patients not treated within 28 days of cancellation	ICO																							
Operational Plan 2025/26	Diagnostics (MRI,CT,NOUS,Dexa, Audiology,Flow rates,colonoscopy, Flexi Sig,Cystoscopy,Gastroscopy)	Care Group																							
Oversight Framework	Percentage of emergency department attendances admitted, transferred or discharged within four hours	ICO																							
Operational Plan 2025/26	Final Care team (planned care) % within 4 hours (type1)	Care Group																							
UEC Recovery	95% 4-hour A&E for children	ICO																							
Supporting Measure	95% 4-hour A&E for children - Final Care team (planned care- type 1)	Care Group																							
UEC recovery	24 hours CYP mental health - ED	ICO																							
Oversight Framework	ED attendances (%) spending over 12 hours in the dept.	Emergency Dept																							
Supporting measure	T&O - Admitted minutes mean time in dept (hh:mm)	Care Group																							
Supporting measure	Surgical - Admitted minutes mean time in dept (hh:mm)	Care Group																							
UEC recovery	24+ hours mental health in ED	Emergency Dept																							
Supporting measure	Cancer 2 week wait	Care Group																							
Supporting measure	Cancer - Patient waiting longer than 104 days from 2ww	Care Group																							
Oversight Framework	Cancer FDS: Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Care Group																							
Supporting measure	Cancer 31-day wait from decision to treat to treatment	Care Group																							
Oversight Framework	Cancer Percentage of patients treated within 62 days of referral	Care Group																							
Supporting measure	Bed Occupancy	ICO																							
Supporting measure	Pre-noon acute hospital discharge	Care Group																							
Supporting measure	Pre-5pm acute hospital discharge	Care Group																							
Supporting measure	Number of patients >7 days LoS (daily average)	ICO																							
Supporting measure	Number of extended stay patients >21 days (daily average)	ICO																							
Supporting measure	No Criteria To Reside - acute	Care Group																							
Supporting measure	No Criteria to reside - Torbay registered GP practices	Care Group																							
Supporting measure	No Criteria to reside - South Devon registered GP practices	Care Group																							
Supporting measure	Non-face-to-face outpatient appointments	Care Group																							
Supporting measure	Patient-initiated-follow-up (PIFU)	Care Group																							
Supporting measure	Advice and Guidance	Care Group																							

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

Planned Care Balanced Scorecard - Month 7 2025/26																							
Torbay and South Devon 																							
Reporting requirement	Metric	Data level	Target March 2026	13 month trend	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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Supporting measure	Outpatient - Did Not Attend (DNA)	Care Group																					
Supporting measure	Outpatient clinic room utilisation - Bookwise	Care Group																					
Oversight Framework	Readmission band rate	Care Group																					

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

	Planned Care Balanced Scorecard - Month 7 2025/26																								
	Torbay and South Devon NHS NHS Foundation Trust																								
Reporting requirement	Metric	Data level	Target March 2026	13 month trend	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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Trajectory October 2025	Data Source
	Workforce																								
Operational Plan 2025/26	Achievement review	Care Group																							
Operational Plan 2025/26	Mandatory training	Care Group																							
Oversight Framework	Sickness	Care Group																							
Operational Plan 2025/26	Turnover	Care Group																							
Oversight Framework	NHS staff survey engagement theme score	Care Group																							
	Productivity																								
Oversight Framework	Implied productivity	Care Group																							
Operational Plan 2025/26	Day cases v 24/25 ytd	Care Group																							
Operational Plan 2025/26	Elective inpatient admissions v 24/25 ytd	Care Group																							
Operational Plan 2025/26	Admitted Patient Care Total	Care Group																							
Operational Plan 2025/26	Outpatient - first appointment v24/25 ytd	Care Group																							
Operational Plan 2025/26	Outpatient - first appointment with procedure ytd	Care Group																							
Operational Plan 2025/26	Outpatient - follow-up with procedure v 24/25 ytd	Care Group																							
Operational Plan 2025/26	Outpatient Appointment Total	Care Group																							
Operational Plan 2025/26	ERF Income Grand Total (% above 2019/20) ytd	Care Group																							
Operational Plan 2025/26	CIP delivery - cash figure £	Care Group																							
Operational Plan 2025/26	Recurrent/non recurrent CIP	Care Group																							
Supporting measure	Assessment of residual risk in £ to plan	Care Group																							
Supporting measure	CIP variance from plan ytd delivery – cumulative	Care Group																							
Supporting measure	CIP variance from plan Forecast year end position at current month	Care Group																							
Operational Plan 2025/26	Month budget - plan (£m)	Care Group																							
Operational Plan 2025/26	Month budget - actual (£m)	Care Group																							
Operational Plan 2025/26	Month variance (£m)	Care Group																							
Operational Plan 2025/26	Annual budget - plan (£m)	Care Group																							
Operational Plan 2025/26	Annual forecast outturn (£m)	Care Group																							
Operational Plan 2025/26	Annual forecast outturn variance (£m)	Care Group																							
Operational Plan 2025/26	Day Case Theatre - TIF activity	Care Group																							
	Meeting monthly trajectory																								
	Not meeting monthly trajectory																								

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

January	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting							Board Public/ Private																Board Dev				QPC	F&OC	Audit			
Publication Dates		Board papers published																		QPC papers published	F&OC papers published	Audit papers published								Board papers published		
February	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting				Board Private / Board Dev																				QPC	F&OC							
Publication Dates																	QPC papers published	F&OC papers published									Board papers published					
March	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting				Board Public/ Private							Charity													QPC	F&OC		Board Dev					
Publication Dates				Charity papers published													QPC papers published	F&OC papers published									Board papers published					
April	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting	Board Private/ Board Dev																											QPC	F&OC	Audit		
Publication Dates																					QPC papers published	F&OC papers published	Audit papers published									
May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting						Board Public/ Private																					QPC	F&OC	Audit (Annual rpt review)			
Publication Dates	Board papers published																			QPC papers published	F&OC papers published	Audit papers published							Board papers published			
June	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting			Board Private/ Board Dev													Board Private (Annual rpt review)	Charity							QPC	F&OC	Audit (Annual Report review)						
Publication Dates									Charity papers published	Board papers published					QPC papers published	F&OC papers published	Audit papers published										Board papers published					
July	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting	Board Public/ Private																							Board Dev				QPC	F&OC	Audit		
Publication Dates																					QPC papers published	F&OC papers published	Audit papers published							Board papers published		
August	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting						Board Private/ Board Dev																					QPC	F&OC				
Publication Dates																																Board papers published
September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting		Board Public/ Private								Charity																Board Dev				QPC	F&OC	
Publication Dates		Charity papers published																				QPC papers published	F&OC papers published									
October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting							Board Private/ Board Dev																				QPC	F&OC	Audit			
Publication Dates		Board papers published																				QPC papers published	F&OC papers published	Audit papers published						Board papers published		
November	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting				Board Public/ Private																Board Dev					QPC	F&OC						
Publication Dates																												Board papers published				
December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting		Board Private/ Board Dev									Charity																					
Publication Dates	Charity papers published								7 QPC papers published	7 F&OC papers published					7 QPC papers published	7 F&OC papers published															Board papers published	
January	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Meeting						Board Public/ Private																Board Dev				QPC	F&OC	Audit				

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

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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	<u>QPCQAC</u>	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	<u>QPCQAC</u>	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	<u>QPCQAC</u>	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	<u>QPCQAC</u>	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	<u>QPCQAC</u>	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	<u>QPCQAC</u>	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	<u>QPCQAC</u>	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	<u>QPC</u> People	Limited
	2.2	Supporting Objective: Develop a strong executive team with clear accountabilities and objectives- aligned with IIP delivery milestones.	CEO	Nomination & Remuneration	Limited
	2.3	Supporting Objective: Robust governance processes and assurance embedded across the organisation - aligned with IIP delivery milestones.	DCG	Audit	Limited
	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	<u>QPC</u> People	Limited
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	<u>F&OC</u> 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	<u>F&OC</u> 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	<u>F&OC</u> BBF	Limited
	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	<u>F&OC</u> 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	<u>F&OC</u> FPC	Satisfactory

Tab 3.1 Actions arising from Developmental Well Led Review - Strengthening Governance Arrangements

	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	<u>F&OC</u> <u>FPG</u>	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	<u>QPC</u> <u>People</u>	<u>Limited</u> <u>Satisfactory</u>
	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	<u>QPC</u> <u>People</u>	Limited
	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	<u>QPC</u> <u>People</u>	Limited
	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	<u>QPC</u> <u>People</u>	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	<u>Board</u> <u>BBF</u>	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	<u>QPC</u> <u>People</u>	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	<u>F&OC</u> <u>BBF</u>	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	<u>QPC</u> <u>QAC</u>	Satisfactory

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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	<u>QPCQAC</u>	Limited
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	<u>F&OCBBF</u>	Limited
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	<u>F&OCBBF</u>	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	<u>QPCQAC</u>	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	<u>F&OCFPG</u>	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	<u>F&OCFPG</u>	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	<u>F&OCFPG</u>	Limited

* Assurance rating from Board papers to be used

Document type	Standard Operating Procedure (SOP)
Document title	Board, Committee and assurance meeting report SOP
Version number*	1
Author	Director of Corporate Governance & Trust Secretary
Date issued	TBC
Interim review date	
Scheduled review date	

Standard Operating Procedure (“SOP”)

Board, Committee and assurance meeting report writing SOP

The purpose of this SOP is to:

1. Standardise report writing
2. Improve report writing/ quality
3. Implement assurance rating system
4. Provide a clear, accessible source of information to support efficient information flows and good decision making
5. Facilitate report authors to deliver the primary purpose of a report by asking themselves the following: *Why am I presenting this? What do I need to tell the reader, what does this mean, why am I telling them (what is the purpose), what does the reader need to do (action/note etc), have I given them the necessary information to make a good decision and is it accessible?*

Principles:

1. Enclosed as **Appendix 1** is the standard form Board, Committee and assurance meeting report which must be used for any written report submitted within the Trust governance framework; for assurance, oversight and decision making purposes.
2. Any paper which is submitted in a different format or in contravention with this SOP will be rejected.
3. When completing the report template all sections must be completed, drafting notes must be deleted.
4. Each sub-section of the report must be given an assurance rating.
5. Considering the assurance rating for each section, an overall assurance rating must be given (to be agreed or revised by the recipient Committee or governance meeting).
 - a. It is acknowledged that there may be occasions where an assurance rating is not relevant, any deviation and the rationale for this should be stated.
6. All papers must be approved for release by the relevant and accountable Executive Director prior to submission to a Board, Board Sub-Committee or Executive Committee meeting.
 - a. For the avoidance of doubt, unless an exception has been granted by the Chief Executive and Trust Secretary, all papers submitted to the Board or its Sub-Committees must first be approved by the Executive Committee; with the approval of the exception of papers for the Nominations & Remuneration Committee or the Council of Governors.
7. All papers submitted to meetings within Tier 3 and below (see Governance Manual), must be approved for release by either the relevant Executive Director or their Deputy, with the ability to delegate; for the avoidance of doubt, the relevant Executive directors retains accountability for assurance reports within the operational Trust governance (Tiers 2- 5).
8. Papers must not exceed **8** pages in length, in totality, including the covering sheet (2 of the 6 pages). If further information is required or contextually helpful, it must be circulated within a supporting information pack, to ensure meeting papers remain concise.
 - a. The supporting information pack shall be circulated in a separate pdf document, with a covering sheet following the standard form enclosed – **Appendix 2**.
 - b. If supporting information is to be provided it should be contextual and provided as a point of reference; it should not be necessary to read the information pack to understand the ask of the report.
9. In line with best practice, reports should be written in Arial font size 12, left hand justified only.
10. Where acronyms are used their use must be explained on the first use (i.e. – “BAF” meaning Board Assurance Framework”).
11. Reports should be presented with single spacing and a 6 pt spacing between each paragraph.
12. Where reports are due to be published on the Trust website, or issued in the public domain, the document should assess for accessibility (such as using the Word document accessibility checker) to ensure that all information presented is open, honest, transparent and accessible to all.



Appendix 1- Report meeting template



Appendix 2 - Supporting Information Pack Cover Sheet

Board/Committee name

XXXX

Date of meeting	Date report produced

Author(s)	Report approved by
Name and title:	Name and title:
	Date:

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

Executive summary

DRAFTING NOTE

DRAFTING NOTE

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

Appendices

DRAFTING NOTE

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

Commented [EL1]: Authors are reminded that all reports must not exceed 8 pages in totality (2 of the 8 being the cover sheet) and MUST be written in accordance with the Trust's Board, Committee and assurance meeting report SOP, a copy of which can be found on ICON:

Corporate > Corporate Governance & Publications

DRAFTING GUIDANCE:
Authors are asked to consider to the primary purpose of a report by asking themselves the following: Why am I presenting this? What do I need to tell the reader, what does this mean, why am I telling them (what is the purpose), what does the reader need to do (action/note etc), have I given them the necessary information to make a good decision and is it accessible?

Commented [EL2]: Amend

Commented [EL3]: Report title

Commented [EL4]: Please complete all boxes in this section, drafting notes are provided throughout

Commented [EL5]: Drafting notes in comment boxes must be removed prior to submission

Commented [EL6]: Please list any appendices to the main report

DRAFTING NOTE

Commented [EL7]: State where the report has been seen and consultation with any stakeholders prior to presentation at this meeting.

Key recommendations and actions requested

DRAFTING NOTE

Commented [EL8]: Detail action required (for information/receive and note/approve) and level of assurance report provides – SUGGESTED wording below:

How does this report further our Trust strategy?

DRAFTING NOTE

The Board/Committee (delete as appropriate) are asked to AGREE the overarching assurance rating and take NO/LIMITED/SATISFACTORY/SIGNIFICANT assurance as to those matters reviewed.

How does the report support the Triple Aim

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

Commented [EL9]: Provide explanation of intended outcome and strategic alignment

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	
Risk	

DRAFTING NOTE

Commented [EL10]: Please describe the primary risks arising from the matters outlined in the paper, the mitigations (actions) to be or being taken and what the residual risk will be having taken that into account

Risks lodged on Datix:

DRAFTING NOTE

Commented [EL11]: Where appropriate, please note whether the risk is already included on Datix, whether there is any risk item for escalation or whether/how the intended outcomes of the report mitigate risk

External Standards affected by this report and associated risks

DRAFTING NOTE

Commented [EL12]: Laws or regulations
Care Quality Commission
Terms of authorisation, NHS England licence and regulations
National policy, guidance

TEXT

Commented [EL13]: Report title

1. Introduction and background

Commented [EL14]: Relevant context, why is it being presented, where has it come from (governance meeting/ escalation/other)

TEXT

2. Purpose of report

TEXT

Commented [EL15]: Why is the report being presented - what is the ask, to consider a proposal, provide a briefing etc

3. [Sub-section]

Commented [EL16]: Main body of the report - outline risks/ actions. Each section MUST include an assurance recommendation. This form should follow the suggested wording below:

TEXT

It is recommended the Board/Committee (delete as appropriate) take (assurance level) assurance that xxx (action description). This is based on xxx (assurance given) noting the risks identified and the work being undertaken to mitigate these. Further assurance should be taken from xxx (assurance given)

4. [Sub-section]

TEXT

Commented [EL17]: Main body of the report - outline risks/ actions. Each section MUST include an assurance recommendation. This form should follow the suggested wording below:

5. [Sub-section]

It is recommended the Board/Committee (delete as appropriate) take (assurance level) assurance that xxx (action description). This is based on xxx (assurance given) noting the risks identified and the work being undertaken to mitigate these. Further assurance should be taken from xxx (assurance given)

TEXT

6. Assurance recommendations and summary

TEXT

This report includes the following assurance recommendations:

Commented [EL18]: Main body of the report - outline risks/ actions. Each section MUST include an assurance recommendation. This form should follow the suggested wording below:

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

It is recommended the Board/Committee (delete as appropriate) take (assurance level) assurance that xxx (action description). This is based on xxx (assurance given) noting the risks identified and the work being undertaken to mitigate these. Further assurance should be taken from xxx (assurance given)

DRAFTING NOTE

Commented [EL19]: SUGGESTED TEXT:

It is recommended that, noting the above, THAT the Committee AGREE the overarching assurance rating and take NO/LIMITED/SATISFACTORY/SIGNIFICANT assurance as to those matters reviewed.

FOLLOWED BY:
Detail action required (for information/receive and note/approve) and level of assurance report provides

DRAFTING NOTE: PLEASE DELETE PAGE

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/Committee/meeting]

Items for Information
Date

REPORTS PRESENTED TO THE BOARD FOR INFORMATION

The following reports are provided to the [Board/Committee/meeting] for information:

- [TITLE]]
- ...
-

Board of Directors

Operational Performance Report

Date of meeting	Date report produced
26 th November 2025	8 th November 2025

Author(s)		Report approved by	
Name and title:	Sam Wadham-Sharpe Deputy Chief Operating Officer	Name and title:	Adel Jones Deputy Chief Executive and Chief Operating Officer
Phone:		Date:	13 th November 2025
Email:	s.wadham-sharpe@nhs.net		adeljones@nhs.net

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

This report provides a consolidated update on key operational performance issues and measures to provide the necessary assurance to the Board in respect of the key performance indicators measured to enable exit from the national RSP. This report will cover performance detail on the progress on the exit measures for UEC performance and Elective performance. Due to the inter-dependencies and the national scrutiny still applied, the performance detail for both cancer performance and diagnostic performance has also been included.

This report summarises the outputs Care Group Delivery Review meetings, led by the Executive Directors and attended by the Care Group senior leadership, which took place on 14th October 2025 and scrutinised performance against key indicators in the Care Group Balanced Scorecards. Scrutiny was undertaken on the key performance indicators, the reasons for any over or under performance, action plans in place and timeframes for any required recover. Assurance ratings were agreed based on delivery and evidence of improvement plans to deliver the required level of performance and reviews of current trends in performance data.

Executive summary		
Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
UEC 4 Hour Performance and Ambulance Handover	Limited	
UEC 12 Hour Performance	Satisfactory	

RTT 65 week waiters	Limited	
RTT 18 week, RTT 52 week total waiting list size, % first appointment within 18 weeks	Satisfactory	
Cancer Performance	Limited	
Diagnostic Performance	Limited	

Appendices

None

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

Executive Committee
Finance and Performance Committee

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take Assurance is limited against delivery of the 4-hour performance and the 45-minute ambulance handover targets. Satisfactory assurance can be provided on 12-hour performance.

Assurance is limited against delivery of the 65 weeks wait elimination standard. Satisfactory assurance can be provided on all other RTT metrics within the exit criteria, noting the risks articulated.

Assurance is limited against delivery of the cancer performance targets but not the expected recovery in September and October. Limited assurance can be provided on diagnostic performance, with plans in place to recover the position against the 10% target.

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

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	
People and Culture	
Strategy and Business Intelligence	
Finance	
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.

Operational Performance Report

October 2025

Introduction and background

1. This report provides a consolidated update on key operational performance issues and measures to provide the necessary assurance to the Board in respect of the key performance indicators measured to enable exit from the national RSP. This report will cover performance detail on the progress on the exit measures for UEC performance and Elective performance. Due to the inter-dependencies and the national scrutiny still applied, the performance detail for both cancer performance and diagnostic performance has also been included.
2. This report summarises the outputs Care Group Delivery Review meetings, led by the Executive Directors and attended by the Care Group senior leadership, which took place on 14th October 2025 and scrutinised performance against key indicators in the Care Group Balanced Scorecards. Scrutiny was undertaken on the key performance indicators, the reasons for any over or under performance, action plans in place and timeframes for any required recover. Assurance ratings were agreed based on delivery and evidence of improvement plans to deliver the required level of performance and reviews of current trends in performance data.
3. Due to the nature of the national performance reporting schedule, this report will provide the nationally reported performance position for September 2025 in UEC, and August 2025 in all elective metrics. The paper will also include detail on the forecasted positions in each of these performance domains for October and November where available.
4. Business Planning is underway to develop the Trust's Operating Plan for 2026/27. Planning guidance has not yet been published but work is progressing under a set of assumptions regarding the performance requirements in 2026/27 and the need to reduce operating costs.
5. The revised exit criteria have been described to the Torbay and South Devon NHS Foundation Trust Board in the paper presented by the Chief Executive titled Resetting Recovery Support Programme Exit Criteria. As these criteria are to be measured from October 2025, all future iterations of this paper will provide a clear position of performance against all performance metrics contained within the access to services domain which are

	Domain	Exit criteria
1	Access to services	<u>Urgent and emergency care</u> • 4-hour performance improvement against refreshed trajectory, month on month delivery over two quarters • Average Ambulance Handover Time performance against agreed trajectory, month on month delivery over two quarters • % patients spending longer than 12 hours in ED <10% of total attendances, month on month delivery over two quarters

National Benchmarking

Acute Provider	Elective proportion waiting within 18 weeks	 Elective proportion waiting over 52 weeks	Cancer faster diagnosis	Cancer 62-day combined	Diagnostics proportion waiting over 6 weeks	A&E 4-hour performance	A&E 12-hour performance
	Rank out of 118	Rank out of 118	Rank out of 118	Rank out of 118	Rank out of 117	Rank out of 118	Rank out of 110
	Aug 2025	Aug 2025	Aug 2025	Aug 2025	Aug 2025	Sep 2025	Sep 2025
Torbay And South Devon NHS Foundation Trust	69.5%	1.9%	62.3%	64.5%	37.1%	68.3%	9.7%
	12	46	113	94	102	83	59

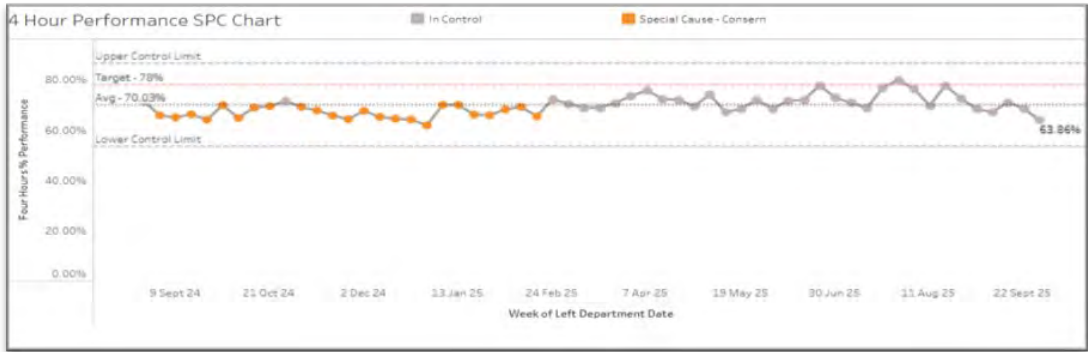
Integrated Performance Dashboard of Key Performance Metrics													Torbay and South Devon Health Foundation Trust																	
RAG rated against monthly Operational Plan trajectory													Target March 2026	13 month trend		Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Operational Plan trajectory Sept 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	1823	1998hrs	
Average handover time (mins)													45 mins		56	106	139	109	95	84	62	47	36	52	45	32	38	60	38mins	
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	05:51	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	655	No trajectory	
Percentage of patients waiting over 12 hours in ED													6.1%		7.9%	11.6%	14.8%	12.6%	12.8%	13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.2%	
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%	68.4%	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%	21.4%	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%	8.0%	5%	

155 of 300

is detailed below and has been revised to take account of the delays to the emergency department building works, the increases in demand and the impacts of the ambulance timely handover process. Despite the revised trajectory, the Trust remains committed to meeting the 78% performance requirements by the end of FY25/26. Future reporting will cover performance achievement against both the original and revised trajectories.

Measure	October	November	December	January	February	March
A&E 4 Hr Performance %	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%

9. The expected October 4-hour performance is that the Trust will not meet the revised trajectory with a forecasted performance of ~68.01%. The chart below demonstrates the improvements made in 4-hour performance in the first two quarters of FY25/26 in comparison to FY24/25, recognising the decline in performance in September and October 2025.

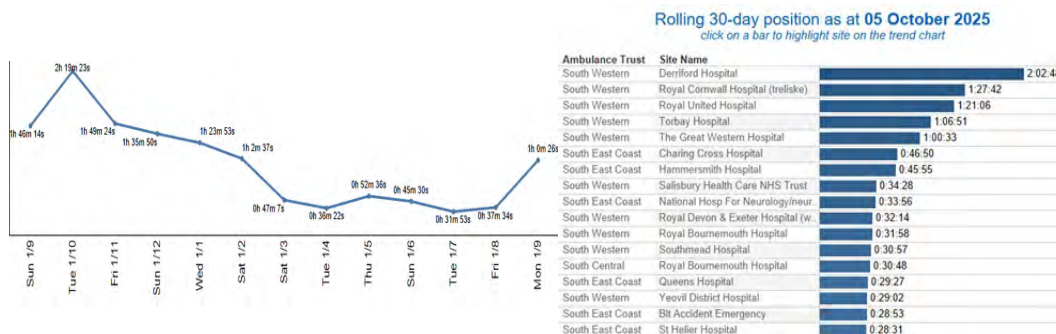


10. In September 2025, the ICO managed 10,524 all type UEC attendances. The Emergency Department recorded 7,060 type 1 attendances which was 5th consecutive month of more than 7000 attendances. The current all type UEC demand growth in FY25/26 is 5.97% against a planned increase of 2%, with the majority of growth being experienced in type 1.
11. The number of patients waiting longer than 12 hours for admission or discharge in the emergency department rose from 426 in August 2025 to 655 in Sept 2025. 363 were >75 yrs of age which will be a key performance and quality indicator for the delivery of the new frailty programme. Despite the worsening in performance, the Trust achieved the RSP exit measure of fewer than 10% of UEC attendances waiting longer than 12 hours in the emergency department for the 7th consecutive month. The October forecast for this performance measure is to improve to 568 patients which would meet the RSP exit criteria and the national standard.

Ambulance Handover Delays

12. The total number of ambulance conveyances to the Trust in September 2025 was 2396 which was a 10% increase September 2024 (2173), which was the 4th highest number of monthly conveyances on record. The average ambulance handover time worsened in September to 60 minutes and 26 seconds, which did

not meet the trajectory of 38 minutes. The charts below demonstrate the Trust ambulance handover performance over the past 12 months and the Trust position in the South West ranking for 30 day rolling ambulance handovers as of 5th October 2025.



13. The Trust implemented the 45-minute Ambulance Timely Handover Process (THP) on 6th October 2025. The initial review of the impacts of THP in October is that it has resulted in an increase in ambulance demand. October 2025 conveyances were a 7% increase on September 2025 and were the highest on record, and an increase of 18% when compared to October 2024. Despite the increases in demand, the additional focus on ambulance handovers is forecasted to result in a significant improvement in October 2025 average ambulance handover times back to the performance achieved in July and August 2025.

A joint piece of work is being undertaken with SWASFT currently aiming to manage ambulance demand and growth. Focus areas will be

- HCP referrals conveyance increase daily at 16:00
- SWASFT shift changeover conveyance increase daily at 19:00
- Pathways not currently available to SWASFT with evidence base of impact
- Opening of the frailty unit and SWASFT engagement

14. October was a period of reviewing and refreshing the UEC plans with a view to commencing a right care period (not just a week) in Mid-November. The current UEC improvement programme has been refreshed ahead of winter pressures with a summary of key actions below.

Brilliant Basics

- o ED flow co-ordination, rapid assessment processes and minors/paediatric pathways
- o AMU and ED flow – assessment processes
- o Focus on surge and escalation space
- o Internal professional standards, time to clerk and PTWR

Improvement Programme

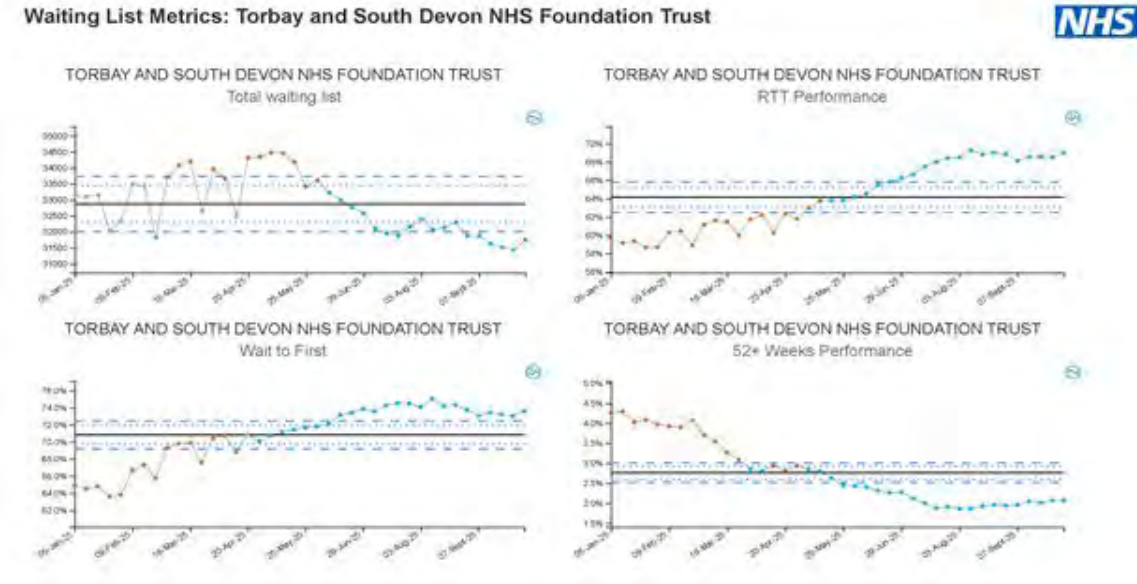
- o Internal professional standards – particularly surgical and W&C
- o Weekend discharge and planning focus Ward improvement programme – COO as SRO
- o Frailty Unit implementation
- o Demand Management Focus with SWASFT

15. The Board is asked to note that assurance is **limited** against delivery of the 4-hour performance and the 45-minute ambulance handover targets. **Satisfactory** assurance can be provided on 12-hour performance.

Elective Care - RTT

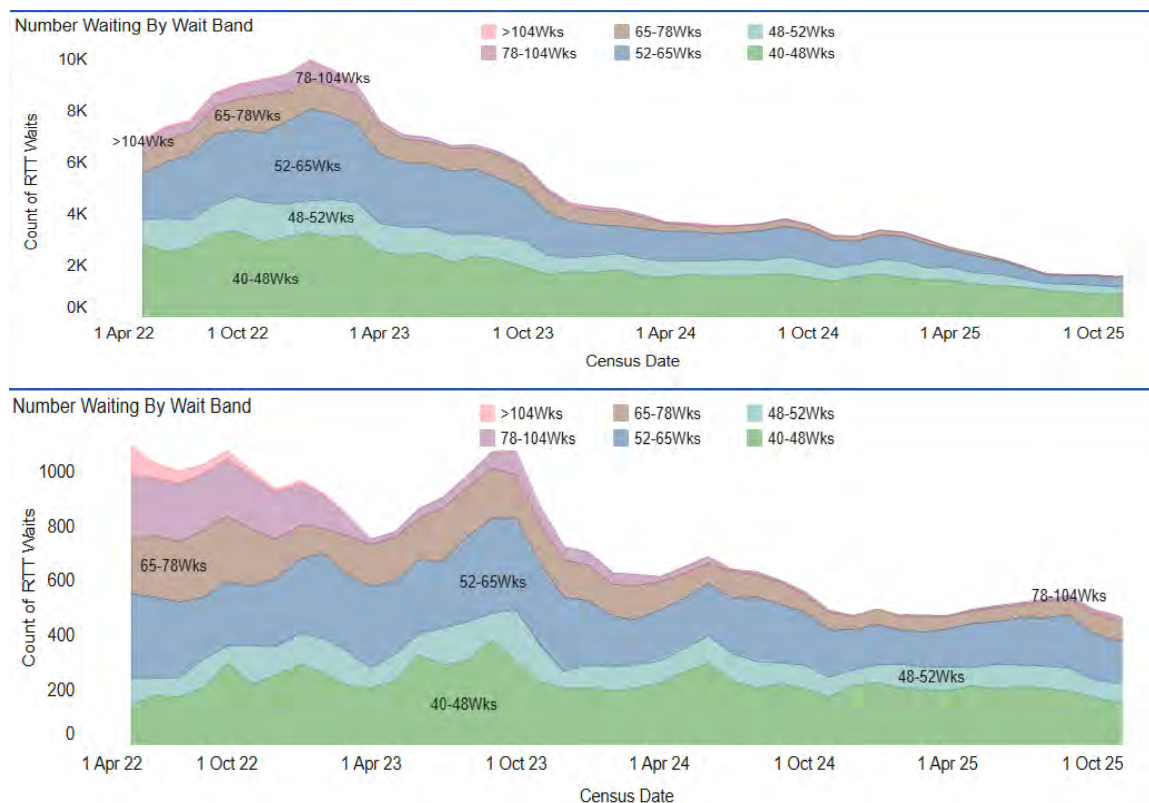
Integrated Performance Dashboard of Key Performance Metrics															Torbay and South Devon NHS Foundation Trust				
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Operational Plan trajectory Sept 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	13	0		
RTT 65 week wait incomplete pathway	0		368	285	242	239	229	204	215	141	145	126	95	97	105	110	43		
RTT 52 week wait incomplete pathway	268		1761	1651	1451	1276	1265	1238	1209	931	914	805	740	615	618	615	673		
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%	68.9%	64.2%		
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%	73.0%	67.7%		
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%	68.0%	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%	64.0%	75.5%		
Cancer: No of patients waiting >62 days to start treatment	138		90	85	78	77	110	95	94	111	133	225	223	220	257	176	138		
Cancer: % of patients > 62 days to start treatment	tbc		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%	7.9%	tbc		

16. The Trust has continued to make good progress on the RTT performance measures detailed within the RSP exit criteria. The Trust has continued to meet the key performance standards for; the total size of the RTT waiting list, RTT 18-week performance, the % of RTT patients receiving first OPA within 18 weeks, and the % of the total RTT waiting list with a wait time more than 52 weeks. The progress and achievement can be seen in the charts below



17. The charts detail the finalised August position and the forecasted September position which has been submitted nationally as part of the required weekly submissions. It should be noted that while the Trust has achieved each of these standards in all months up to September, there is a clear plateau of the progress against each of these metrics heading into the autumn. There is a risk to each of these performance metrics as winter approaches and they are being monitored closely to ensure maintenance of performance.

18. The elective recovery fund (ERF) has been reviewed by the planned care group and adjusted within month 5. This has been a requirement to reduce the amount of additional ad-hoc activity being provided through the elective recovery fund to support the Trust financial position. Activity has been reduced in ENF, OMFS, Colorectal surgery, Upper GI, Gynaecology and Urology will cease in October. While this has supported an improvement of £438k within the planned care financial position, there has been a clear impact on the performance in some of these specialities, particularly wait for first appointment in ENT and colorectal surgery.
19. While the Trust has met all the standards detailed above, it has not met the required trajectory for patients waiting longer than 65 weeks for treatment on an RTT pathway. 106 patients waited longer than 65 weeks for treatment in September which was a worsening of performance from August. The October position is expected to improve to 96, however this will miss trajectory which should be zero.
20. A national mandate of clearance of 65 week waits by 21st December 2025 is in place. The current risk forecast for 21st December is ~40 patients with the vast majority of this risk being orthopaedic arthroplasty patients. As the charts demonstrate below, the proportion of the waiting list in excess of 40 weeks for orthopaedics is significantly in excess of all other specialities. The top chart shows the total Trust waiting list by waiting time cohort and the bottom chart shows the orthopaedic waiting list broken down in the same way.

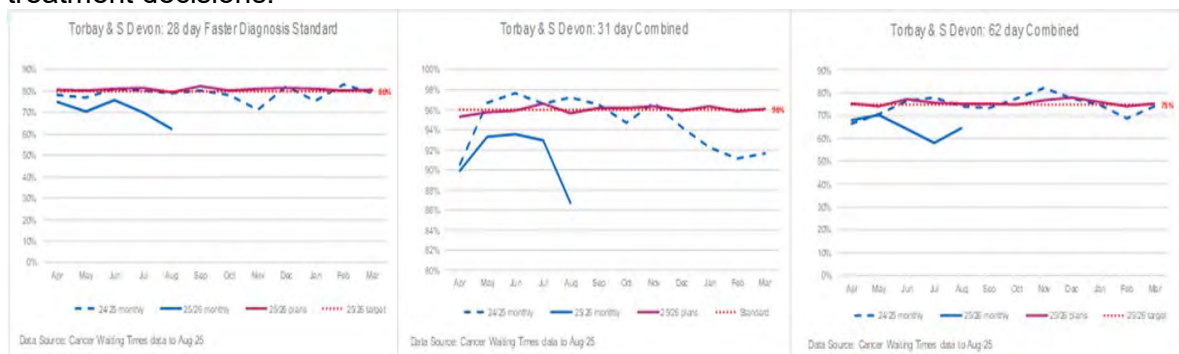


21. An action plan to support achievement of the national mandate has been created with a focus on maximising capacity, use of SWAOC and waiting list validation. A revised forecast will be available by the 18th November.

22. The Board is asked to note that assurance is **limited** against delivery of the 65 weeks wait elimination standard. **Satisfactory** assurance can be provided on all other RTT metrics within the exit criteria, noting the risks articulated.

Cancer and Diagnostics

23. The core cancer standards of 28-day faster diagnostic, 31-day decision to treat to treatment and 62-day referral to treatment have not been met and have been a declining position since June 2025. The reasons for this have been demand and capacity issues predominantly within dermatology, urology and colorectal services. Dermatology have experienced an 18% increase in TWW referrals this summer in comparison to the previous year and capacity issues within the diagnostic pathways of urology (prostate) and colorectal have caused delays to treatment decisions.



24. While the performance challenges have been experienced through the summer, the current forecasts and performance monitoring expects performance to return to national standard within October 2025. It should be noted that the internal trajectories for 28-day faster diagnosis and 62-day referral to treatment exceed the national standard and it is expected that the Trust will meet these trajectories in November 2025.
25. Diagnostic performance (DM01) has remained a challenge throughout FY25/26 with a performance of ~37% of patients waiting over 6 weeks for their diagnostics. Improvements have been made in several modalities however these have been offset by continued challenges in both non obstetric ultrasound and flexi cystoscopy.
26. An improvement of ~8% is expected in October performance following a deep dive into the waiting list which has identified that patients referred to the community diagnostic hub (CDC) had not been recorded correctly, leading to reporting of a performance position more negative than the actual numbers. The Trust is aiming to rectify this for the final September submission, and this will be completed for the October submission at the latest.
27. A diagnostic improvement plan is in place which has delivered improvements across many of the DM01 modalities in Q2. The outstanding issues for non-obstetric ultrasound are being addressed by a re-profiling of the CDC capacity. It should be noted that referral rates for non-obstetric ultrasound have increased in the region of 30% this financial year due to the ICB ceasing an independent provider contract. A commencement date for the additional capacity at the CDC

is waited from the provider InHealth and is being managed through monthly contract meetings.

28. The Board is asked to note that assurance is **limited** against delivery of the cancer performance targets but not the expected recovery in September and October. **Limited** assurance can be provided on diagnostic performance at present but plans are in place to recover and the Trust still plans to meet the 10% end of year target.

Assurance and Recommendations

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
UEC 4 Hour Performance and Ambulance Handover	Limited	
UEC 12 Hour Performance	Satisfactory	
RTT 65 week waiters	Limited	
RTT 18 week, RTT 52 week total waiting list size, % first appointment within 18 weeks	Satisfactory	
Cancer Performance	Limited	
Diagnostic Performance	Limited	

Integrated Performance Focus Report (IPR)



Torbay and South Devon
NHS Foundation Trust

November 2025: Reporting period October 2025 (Month 7)

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Working with you, for you

Oversight Framework - Introduction

National Oversight Framework:

The Draft Oversight Framework was published in April 2025. In August, the first assessment against this framework reflecting performance to end of Q1 was released to Trusts and published.

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 has been published.

To inform this report, the National Oversight Framework 2025/26 metrics have been reviewed alongside existing Operational Plan commitments to ensure alignment of metrics and performance trajectories. Where the operational plan trajectories are not being met these are be reviewed through the monthly Care Group Review meetings and Executive Oversight group. In the Performance section of this IPR focus report, exception reports have been created where these metrics are not being met reflecting the review and risks discussed through the Governance meetings.

These reports are part of the monthly assurance process with care groups and the Executive Committee.

System performance governance and reporting:

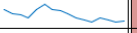
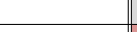
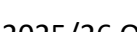
Monthly meetings remain in place to review system progress and Trust level reports against Oversight Framework and additional performance assurance metrics.

- 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.

Weekly performance oversight:

The Trust is no longer required to report again the Tier 1 oversight with Region performance team for planned care. However, the continues to attend 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

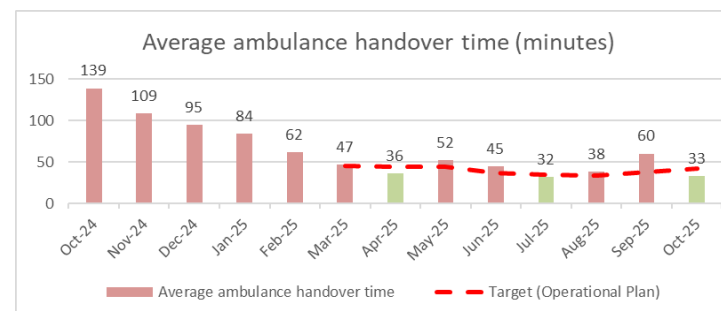
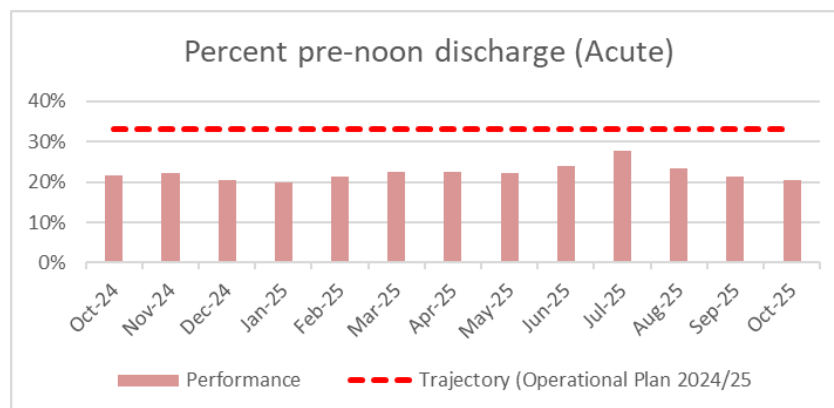
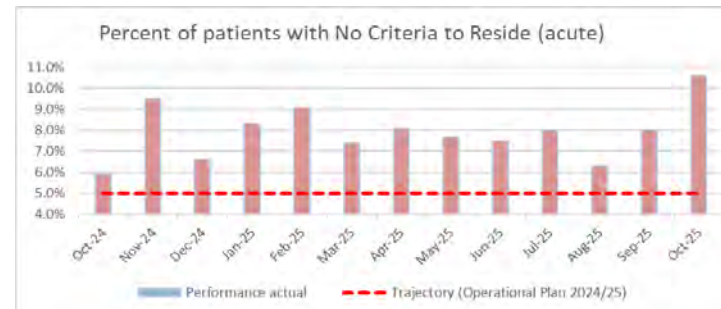
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Operational Plan trajectory Oct 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			4343	3275	3108	2532	1625	1268	839	1530	1159	725	943	1823	810	2562hrs
Average handover time (mins)	45 mins		139	109	95	84	62	47	36	52	45	32	38	60	33	42mins
Total average time in ED (hours/minutes)			06:44	06:18	06:17	06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		979	854	793	818	677	615	415	688	494	457	426	655	585	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		14.8%	12.6%	12.8%	13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	9.0%
UEC 4-hour target (RAG against local trajectory to national target)	78%		68.7%	67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	70.3%
% patient discharges pre-noon	33%		21.5%	22.3%	20.4%	19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		5.9%	9.5%	6.6%	8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	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

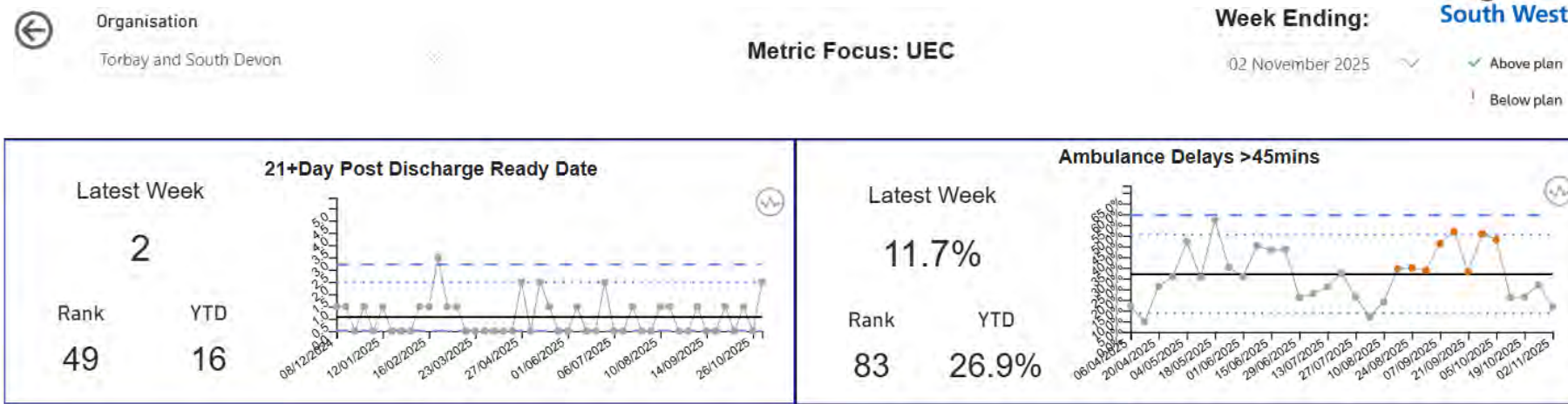
Not meeting monthly trajectory



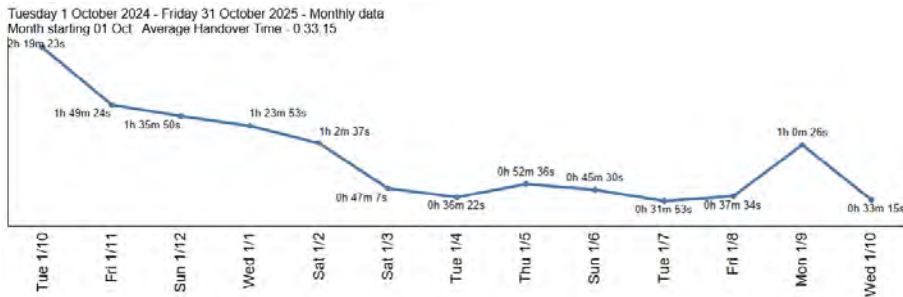
Urgent and Emergency Care Performance Summary - NHS England monitoring report

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.

The latest report highlights ambulance handover delays and the recent weekly ranking of 83 out of 123 trusts (as of 2 November 2025); last month report we reported a ranking of 117 out of 123 Trusts (as of 28th September 2025).



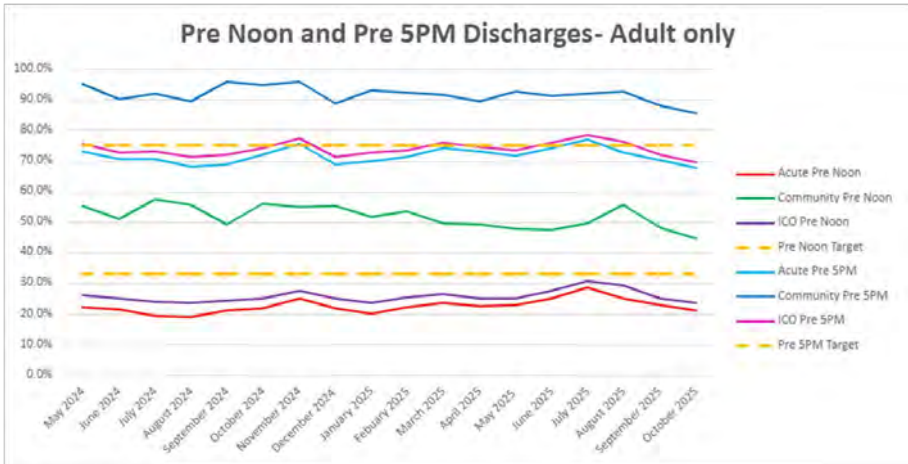
Exception report: Average Ambulance Handovers time: Urgent and Emergency Care

Performance	Operational update																																																																																		
The total number of ambulance conveyances to the ED in October was 2526, which is the highest number of conveyances by SWAST the organisation has seen in a month period. October's handover average was 33 mins 15 sec- and was 1hr 26 sec in September. Average handover time – rolling 30 day (as at 3 November 2025) Rolling 30-day position as at 02 November 2025 <i>click on a bar to highlight site on the trend chart</i> <table><tr><th>Ambulance Trust</th><th>Site Name</th><th>Time</th></tr><tr><td>South Western</td><td>Derriford Hospital</td><td>0:48:47</td></tr><tr><td>South Western</td><td>Royal Cornwall Hospital (triliske)</td><td>0:38:54</td></tr><tr><td>South Western</td><td>Royal United Hospital</td><td>0:35:16</td></tr><tr><td>South East Coast</td><td>St Helier Hospital</td><td>0:29:55</td></tr><tr><td>South Western</td><td>Southmead Hospital</td><td>0:29:42</td></tr><tr><td>South Western</td><td>The Great Western Hospital</td><td>0:29:21</td></tr><tr><td>South Western</td><td>Torbay Hospital</td><td>0:29:13</td></tr><tr><td>South Western</td><td>Royal Bournemouth Hospital</td><td>0:29:13</td></tr><tr><td>South Central</td><td>Royal Bournemouth Hospital</td><td>0:28:56</td></tr><tr><td>South East Coast</td><td>National Hosp For Neurology/neur.</td><td>0:28:36</td></tr><tr><td>South East Coast</td><td>Queens Hospital</td><td>0:28:27</td></tr><tr><td>South Western</td><td>Yeovil District Hospital</td><td>0:28:20</td></tr><tr><td>South Western</td><td>Royal Devon & Exeter Hospital (w</td><td>0:26:18</td></tr><tr><td>South East Coast</td><td>Kingston Hospital</td><td>0:24:48</td></tr><tr><td>South East Coast</td><td>Princess Royal University Hospital</td><td>0:24:39</td></tr><tr><td>South Western</td><td>Bristol Royal Infirmary</td><td>0:24:32</td></tr><tr><td>South Western</td><td>Poole Hospital</td><td>0:24:24</td></tr></table>	Ambulance Trust	Site Name	Time	South Western	Derriford Hospital	0:48:47	South Western	Royal Cornwall Hospital (triliske)	0:38:54	South Western	Royal United Hospital	0:35:16	South East Coast	St Helier Hospital	0:29:55	South Western	Southmead Hospital	0:29:42	South Western	The Great Western Hospital	0:29:21	South Western	Torbay Hospital	0:29:13	South Western	Royal Bournemouth Hospital	0:29:13	South Central	Royal Bournemouth Hospital	0:28:56	South East Coast	National Hosp For Neurology/neur.	0:28:36	South East Coast	Queens Hospital	0:28:27	South Western	Yeovil District Hospital	0:28:20	South Western	Royal Devon & Exeter Hospital (w	0:26:18	South East Coast	Kingston Hospital	0:24:48	South East Coast	Princess Royal University Hospital	0:24:39	South Western	Bristol Royal Infirmary	0:24:32	South Western	Poole Hospital	0:24:24	Ambulance handovers remain a key focus for the Trust and Timely Handover Process (THP@45) has been implemented 24/7 from 06/10/25- although it has caused unprecedented challenge across the whole organisation it has had a positive impact on the Category 2 response times seen across the S&W SWAST locality. The number of handovers over 45mins has reduced from 938 in September to 467 in October. October's average ambulance handover time was 33 mins, the second-best performance since April 2023. Average ambulance handover time Tuesday 1 October 2024 - Friday 31 October 2025 - Monthly data Month starting 01 Oct. Average Handover Time - 0:33:15 0h 19m 23s <table><tr><th>Date</th><th>Time</th></tr><tr><td>Tue 1/10</td><td>1h 48m 24s</td></tr><tr><td>Fri 1/11</td><td>1h 35m 50s</td></tr><tr><td>Sun 1/12</td><td>1h 23m 53s</td></tr><tr><td>Wed 1/1</td><td>1h 2m 37s</td></tr><tr><td>Sat 1/2</td><td>0h 47m 7s</td></tr><tr><td>Sat 1/3</td><td>0h 36m 22s</td></tr><tr><td>Tue 1/4</td><td>0h 52m 36s</td></tr><tr><td>Thu 1/5</td><td>0h 45m 30s</td></tr><tr><td>Sun 1/6</td><td>0h 31m 53s</td></tr><tr><td>Tue 1/7</td><td>0h 37m 34s</td></tr><tr><td>Fri 1/8</td><td>1h 0m 26s</td></tr><tr><td>Mon 1/9</td><td>0h 33m 15s</td></tr><tr><td>Wed 1/10</td><td>0h 33m 15s</td></tr></table>	Date	Time	Tue 1/10	1h 48m 24s	Fri 1/11	1h 35m 50s	Sun 1/12	1h 23m 53s	Wed 1/1	1h 2m 37s	Sat 1/2	0h 47m 7s	Sat 1/3	0h 36m 22s	Tue 1/4	0h 52m 36s	Thu 1/5	0h 45m 30s	Sun 1/6	0h 31m 53s	Tue 1/7	0h 37m 34s	Fri 1/8	1h 0m 26s	Mon 1/9	0h 33m 15s	Wed 1/10	0h 33m 15s
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Actions to complete next month - Following Improvement and Innovation support, post ECIST, 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 and Improvement - Timely Handover process (THP) @45 - Close monitoring via weekly face-to-face meetings with action-based focus are in place across all above programmes of work. - Winter planning is underway which also supports operational escalation throughout the year.	Risks/issues - Financial balance of locums versus substantive staffing, and short notice escalation cover. - Insufficient bed capacity during escalation with the Same Day Emergency Care (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. - Sustainable changes of THP@45 24/7 on the wider organisation: demand v capacity and responsive flow.																																																																																		

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

Performance			Operational update
	Oct 2024	Oct 2025	4hr Performance for the month stands at 68.01% and 2.2% below trajectory. The ICO had 10,681 attendances, up 160 from September. The Emergency Department recorded 7,261 attendances (6th consecutive month in excess of 7000), and up 200 attendances from the previous month. Patient experience, safety, and risk metrics - improvement in ED 12-hour Length of Stay from 655 in September to 568 in October, and of those 297 were greater than 75 years of age, from a previous 363.
MIU/UTC attendances	3403	3420	
MIU/UTC performance	99.6%	99.3%	
ED (type 1) attendances	6605	7258	
ED (type 1) performance	52.3%	53.2%	
ICO attendances	10008	10678	
ICO performance	68.7%	68.0%	
 Opel score October 2025  October 2024 			
Actions to complete next month			Risks/issues
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. 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 Face-to-face meetings with action-based focus are in place re all above programmes of work. - Winter and Business Planning is underway, which also supports operational escalation throughout the year.			- Financial position of the Care Group and organisation and the impact on temporary versus substantive staffing, plus escalation. - Winter pressures from increased respiratory illness impacting on bedded capacity and length of stay. - 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: September vs October 2025 Across all discharge pathways (Acute and Community), performance declined in October 2025 when compared with September 2025 for both Pre-Noon and Pre-5pm discharges. Pre Noon and Pre 5PM Discharges- Adult only <table><caption>Approximate data from 'Pre Noon and Pre 5PM Discharges- Adult only' chart</caption><tr><th>Month</th><th>Acute Pre Noon</th><th>Community Pre Noon</th><th>ICG Pre Noon</th><th>Pre Noon Target</th><th>Acute Pre 5PM</th><th>Community Pre 5PM</th><th>ICG Pre 5PM</th><th>Pre 5PM Target</th></tr><tr><td>May 2024</td><td>25%</td><td>55%</td><td>30%</td><td>33%</td><td>75%</td><td>95%</td><td>70%</td><td>33%</td></tr><tr><td>June 2024</td><td>22%</td><td>50%</td><td>28%</td><td>33%</td><td>72%</td><td>92%</td><td>68%</td><td>33%</td></tr><tr><td>July 2024</td><td>20%</td><td>58%</td><td>25%</td><td>33%</td><td>70%</td><td>90%</td><td>65%</td><td>33%</td></tr><tr><td>August 2024</td><td>22%</td><td>55%</td><td>28%</td><td>33%</td><td>72%</td><td>92%</td><td>68%</td><td>33%</td></tr><tr><td>September 2024</td><td>25%</td><td>50%</td><td>30%</td><td>33%</td><td>75%</td><td>95%</td><td>70%</td><td>33%</td></tr><tr><td>October 2024</td><td>28%</td><td>55%</td><td>32%</td><td>33%</td><td>78%</td><td>98%</td><td>72%</td><td>33%</td></tr><tr><td>November 2024</td><td>25%</td><td>52%</td><td>28%</td><td>33%</td><td>75%</td><td>95%</td><td>70%</td><td>33%</td></tr><tr><td>December 2024</td><td>22%</td><td>50%</td><td>25%</td><td>33%</td><td>72%</td><td>92%</td><td>68%</td><td>33%</td></tr><tr><td>January 2025</td><td>20%</td><td>55%</td><td>28%</td><td>33%</td><td>70%</td><td>90%</td><td>65%</td><td>33%</td></tr><tr><td>February 2025</td><td>22%</td><td>52%</td><td>25%</td><td>33%</td><td>72%</td><td>92%</td><td>68%</td><td>33%</td></tr><tr><td>March 2025</td><td>25%</td><td>50%</td><td>28%</td><td>33%</td><td>75%</td><td>95%</td><td>70%</td><td>33%</td></tr><tr><td>April 2025</td><td>22%</td><td>48%</td><td>25%</td><td>33%</td><td>72%</td><td>92%</td><td>68%</td><td>33%</td></tr><tr><td>May 2025</td><td>20%</td><td>45%</td><td>22%</td><td>33%</td><td>70%</td><td>90%</td><td>65%</td><td>33%</td></tr><tr><td>June 2025</td><td>22%</td><td>48%</td><td>25%</td><td>33%</td><td>72%</td><td>92%</td><td>68%</td><td>33%</td></tr><tr><td>July 2025</td><td>25%</td><td>50%</td><td>28%</td><td>33%</td><td>75%</td><td>95%</td><td>70%</td><td>33%</td></tr><tr><td>August 2025</td><td>28%</td><td>55%</td><td>32%</td><td>33%</td><td>78%</td><td>98%</td><td>72%</td><td>33%</td></tr><tr><td>September 2025</td><td>25%</td><td>50%</td><td>28%</td><td>33%</td><td>75%</td><td>95%</td><td>70%</td><td>33%</td></tr><tr><td>October 2025</td><td>22%</td><td>45%</td><td>25%</td><td>33%</td><td>72%</td><td>92%</td><td>68%</td><td>33%</td></tr></table>	Month	Acute Pre Noon	Community Pre Noon	ICG Pre Noon	Pre Noon Target	Acute Pre 5PM	Community Pre 5PM	ICG Pre 5PM	Pre 5PM Target	May 2024	25%	55%	30%	33%	75%	95%	70%	33%	June 2024	22%	50%	28%	33%	72%	92%	68%	33%	July 2024	20%	58%	25%	33%	70%	90%	65%	33%	August 2024	22%	55%	28%	33%	72%	92%	68%	33%	September 2024	25%	50%	30%	33%	75%	95%	70%	33%	October 2024	28%	55%	32%	33%	78%	98%	72%	33%	November 2024	25%	52%	28%	33%	75%	95%	70%	33%	December 2024	22%	50%	25%	33%	72%	92%	68%	33%	January 2025	20%	55%	28%	33%	70%	90%	65%	33%	February 2025	22%	52%	25%	33%	72%	92%	68%	33%	March 2025	25%	50%	28%	33%	75%	95%	70%	33%	April 2025	22%	48%	25%	33%	72%	92%	68%	33%	May 2025	20%	45%	22%	33%	70%	90%	65%	33%	June 2025	22%	48%	25%	33%	72%	92%	68%	33%	July 2025	25%	50%	28%	33%	75%	95%	70%	33%	August 2025	28%	55%	32%	33%	78%	98%	72%	33%	September 2025	25%	50%	28%	33%	75%	95%	70%	33%	October 2025	22%	45%	25%	33%	72%	92%	68%	33%	Throughout October, the Discharge Lounge was routinely utilised for overnight escalation, supporting inpatient flow and to manage peaks in demand. This operational model has enabled up to 12 patients to be transferred into the lounge for discharge the following day. While this approach improves overall hospital flow and supports safer, more timely inpatient movement, it has impacted negatively the ward-based pre-noon and pre-5pm discharge performance, as these patients are no longer being transferred in the mornings. It is therefore important this is recognised. A review on how we report discharges needs to be considered with BI teams. In addition, the lounge has reopened at weekends to further support timely flow and ambulance handovers. During October, the Discharge Lounge supported 902 patients — the highest recorded by the service, demonstrating significant operational contribution and enhanced utilisation to support system flow. Our Length of Stay (LOS) review programme continues twice weekly. The Acute LOS data shows that the majority of patients with extended stays were clinically appropriate to remain in hospital, reflecting ongoing acute treatment needs. A smaller but consistent cohort were medically optimised and awaiting final discharge steps, such as allocation to social care teams. Community Hospital LOS data demonstrates that the primary driver of extended stay relates to therapy-led discharge dependencies, including assessments and equipment provision. A consistent cohort of patients were clinically optimised and anticipated to be discharged within 48 hours.
Month	Acute Pre Noon	Community Pre Noon	ICG Pre Noon	Pre Noon Target	Acute Pre 5PM	Community Pre 5PM	ICG Pre 5PM	Pre 5PM Target																																																																																																																																																																				
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July 2024	20%	58%	25%	33%	70%	90%	65%	33%																																																																																																																																																																				
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September 2024	25%	50%	30%	33%	75%	95%	70%	33%																																																																																																																																																																				
October 2024	28%	55%	32%	33%	78%	98%	72%	33%																																																																																																																																																																				
November 2024	25%	52%	28%	33%	75%	95%	70%	33%																																																																																																																																																																				
December 2024	22%	50%	25%	33%	72%	92%	68%	33%																																																																																																																																																																				
January 2025	20%	55%	28%	33%	70%	90%	65%	33%																																																																																																																																																																				
February 2025	22%	52%	25%	33%	72%	92%	68%	33%																																																																																																																																																																				
March 2025	25%	50%	28%	33%	75%	95%	70%	33%																																																																																																																																																																				
April 2025	22%	48%	25%	33%	72%	92%	68%	33%																																																																																																																																																																				
May 2025	20%	45%	22%	33%	70%	90%	65%	33%																																																																																																																																																																				
June 2025	22%	48%	25%	33%	72%	92%	68%	33%																																																																																																																																																																				
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October 2025	22%	45%	25%	33%	72%	92%	68%	33%																																																																																																																																																																				
Actions to complete next month Review with BI how we capture pre-noon and pre-5PM discharges from wards.	Risks/issues - Implications of routine escalation space being used that impacts performance discharge targets. - Medical workforce to increase weekend discharges. - We continue to not meet the 33% pre-noon target for acute wards.																																																																																																																																																																											

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

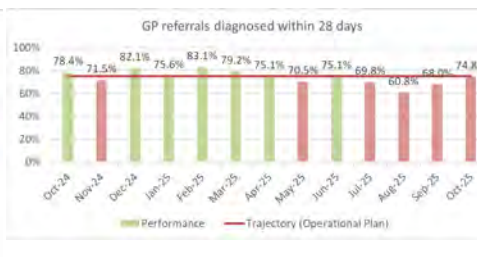
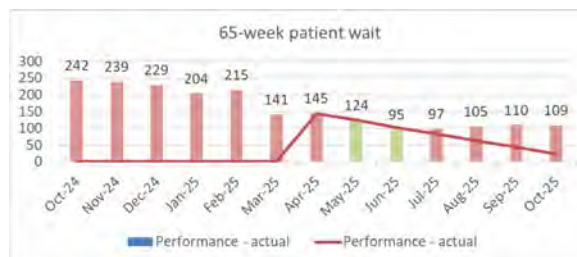
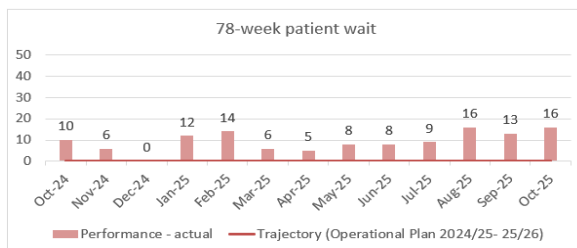
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Operational Plan trajectory Oct 2025
Oversight Framework																
Elective recovery																
RTT 78 week wait incomplete pathway	0		10	6	0	12	14	7	4	8	8	9	16	13	16	0
RTT 65 week wait incomplete pathway	0		242	239	229	204	215	141	145	126	95	97	105	110	109	23
RTT 52 week wait incomplete pathway	268		1451	1276	1265	1238	1209	931	914	805	740	615	618	615	647	586
RTT % Incomplete pathways <18 wks	66.8%		62.2%	61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	64.7%
RTT Wait for first appointment <18 weeks	70.3%		65.6%	65.3%	64.6%	63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	68.2%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		78.4%	71.5%	82.1%	75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	74.8%	75.0%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		77.3%	81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	74.9%
Cancer: No of patients waiting >62 days to start treatment	138		78	77	110	95	94	111	133	225	223	220	257	176	132	138
Cancer: % of patients > 62 days to start treatment	tbc		4.4%	5.0%	7.0%	6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	7.9%	tbc

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 7 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 Trauma and Orthopaedic (T&O) consultants. Further hip and knee surgeons required to meet demand. Tactical booking and sprint being developed.
- Increasing capacity in Dermatology for Faster Diagnosis Standard (FDS). Review change of basal cell carcinoma inclusion. Admin risk to be mitigated ahead of December.
- 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 Referral To Treatment (RTT) pathway validation sprint.

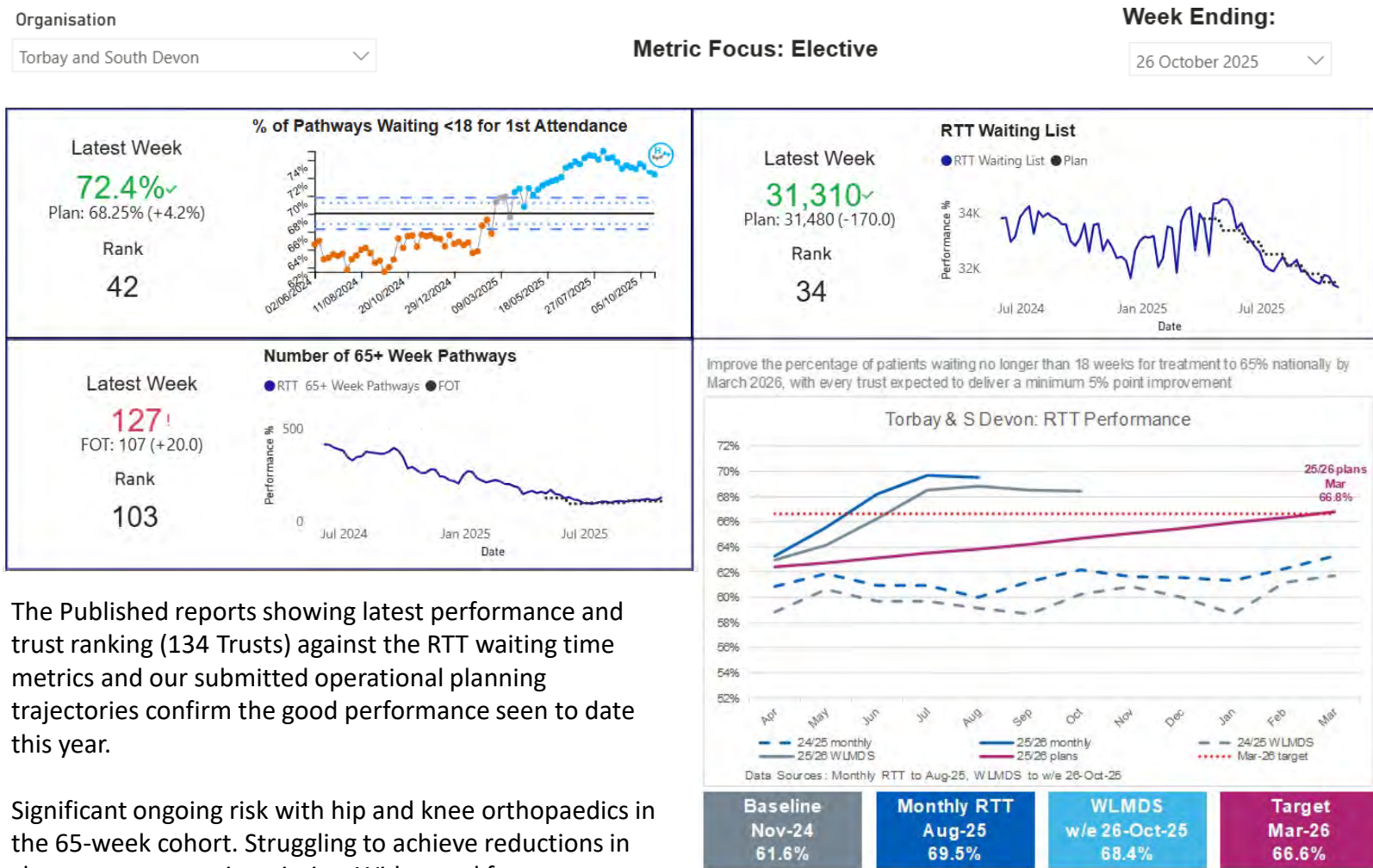
Risks and Barriers

- Workforce – enough surgeons and anaesthetists to meet demand (hip and knee). 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. Particularly for 65-week waits.

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.

Data source: NHSE SW Weekly Performance Dashboard



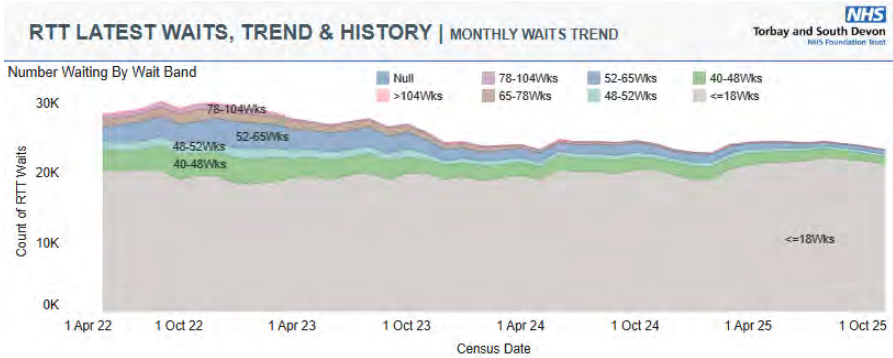
Exception report: 78-Week and 65-Week Clearance: NOF 4 Exit Criteria – Elective Recovery

Performance

Operational update

Good progress has been made over the last 12 months to reduce the number of RTT long wait patients.

	October 2024	October 2025
78 weeks	10	16
65 weeks	243	109
52 weeks	1451	647



78 week: At the end of October (provisional figures) there are 12 orthopaedic patients who have been waiting over 78-weeks against the target of zero. The primary issues are specialty capacity for hip and knee surgery.

65 week: In October (provisional figures) there were 104 breaches - Cardiology (1), Colorectal (1), Gynaecology (5), Ophthalmology (3), Oral Surgery (1), Orthodontics (3), Pain Management (2), T&O (86), UPGI (2) and Urology (1). Most of which will be cleared in November, outside of T&O.

Trauma and Orthopaedic huddle exploring patient by patient actions including reviews into new trauma consultant, job planning, outsourcing and insourcing. The clearance of all 65-week waits by 21st December will not be achieved.

Actions to complete next month

Risks/issues

- 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.

- 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.
- Financial pressures with reduce ERF budget to support position in Planned Care. This will leave other cohorts at risk for H2. Weekly assessments of long waits and cancer pathways will take place to ensure compliance with standards.

Exception report: Stages of treatment – Elective Recovery

TSDF

INFORMATION SERVICES

Filter

Module

Local Treat. Functn.

Clinic or List

WLMDS Pathway

NAVIGATE

Cover Page

All New Waits

Follow Up Pending

IPDC

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 02/11/2025 (based on current wait)

Treatment Function	00-18 weeks	>18-26 weeks	>26-52 weeks	>52-65 weeks	>65-78 weeks	>78 weeks	Grand Total
120 - ENT	1,503	575	811	26	18	18	2,951
130 - OPHTHALMOLOGY	1,437	293	305	25	6	6	2,072
140 - ORAL SURGERY	924	246	585	15	2	1	1,773
110 - TRAUMA & ORTHOPAEDICS	1,003	222	294	33	13	40	1,605
302 - ENDOCRINOLOGY	647	144	422	208	120	5	1,546
330 - DERMATOLOGY	1,182	195	150	1			1,528
340 - RESPIRATORY MEDICINE	831	84	220	71	63	151	1,420
650 - PHYSIOTHERAPY	967	79	171	10	4	1	1,232
101 - UROLOGY	873	181	77	1			1,132
400 - NEUROLOGY	573	157	170	27	14		941
320 - CARDIOLOGY	773	53	54	7	9	20	916
104 - COLORECTAL SURGERY	616	147	139	6		2	910
410 - RHEUMATOLOGY	609	92	158	47	3		909
420 - PAEDIATRICS	589	123	99	4	2	2	819
301 - GASTROENTEROLOGY	673	75	47	1			796
840 - AUDIOLOGY	690	25	33	1	1	1	751
191 - PAIN MANAGEMENT	499	79	153	11	5	1	748
502 - GYNAECOLOGY	648	72	17		2	2	741
106 - UPPER GASTROINTESTINAL SURGERY	306	13	12	6	1	1	339
655 - ORTHOPTICS	262	32	33	3			330
430 - GERIATRIC MEDICINE	171	34	84	2	1		292
103 - BREAST SURGERY	209				1		210
401 - CLINICAL NEUROPHYSIOLOGY	192	1	1				194
143 - ORTHODONTICS	62	9	54	20	1	1	147

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 this year is to 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 October position is 68.0% against trajectory of 64.7%.

The Outpatient Improvement Group will maintain productivity oversight and drive forward improvements to ensure capacity is optimised and Getting it Right First Time (GIRFT) benchmarks are used to inform plans.

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

Period	Percentage
Baseline Nov-24	65.3%
WLMDS w/e 26-Oct-25	72.4%
Target Mar-26	70.3%

Data Source: WLMDS to w/e 26-Oct-25

Torbay & S Devon: Wait to first by specialty				% point change	
Specialty	0-18 weeks	First activity	Wait to first	Baseline	Target
Oral Surgery	878	1,688	52.0%	-13.3%	-18.3%
ENT	1,183	2,241	52.8%	-12.5%	-17.5%
Elderly Medicine	184	296	62.2%	-3.1%	-8.1%
Neurology	510	789	64.6%	-0.6%	-5.6%
Trauma & Orthopaedics	858	1,237	69.4%	4.1%	-0.9%
Other - Medical Services	1,068	1,466	72.9%	7.6%	2.6%
Ophthalmology	1,943	2,566	75.7%	10.5%	5.5%
Plastic Surgery	17	22	77.3%	12.0%	7.0%
Urology	909	1,165	78.0%	12.8%	7.8%
Other - Surgical Services	1,103	1,413	78.1%	12.8%	7.8%
Other - Other Services	38	48	79.2%	13.9%	8.9%
Rheumatology	479	605	79.2%	13.9%	8.9%
Dermatology	1,153	1,453	79.4%	14.1%	9.1%
Cardiology	1,055	1,243	84.9%	19.6%	14.6%
Gynaecology	683	791	86.3%	21.1%	16.1%
General Medicine	22	25	88.0%	22.7%	17.7%
Gastroenterology	665	733	90.7%	25.5%	20.5%
Respiratory Medicine	540	576	93.8%	28.5%	23.5%
Cardiothoracic Surgery	3	3	100.0%	34.7%	29.7%
General Surgery	1	1	100.0%	34.7%	29.7%
Other	12	12	100.0%	34.7%	29.7%
Total pathways	13,304	18,373	72.4%	7.1%	2.1%

Data Source: WLMDS for w/e 26-Oct-25
Baseline is the WLMDS w/e 01-Dec-24

The Trust achieving 72.2% against the end of year target 70.3% for percentage of patients being seen at first outpatient appointment in under 18 weeks from referral. This headroom will be required as a drop in capacity is expected in the run up to EPIC go live with some clinical sessions being used to facilitate training on the new Patient Administration System.

172 of 300

TSDFT Public Board of Directors-26/11/25

11

Exception report: Cancer Waiting Time Standards

Performance						Actions to complete next month	
	June 2025	July 2025	August 2025	September 2025	October 2025		
28-day FDS	75.8%	69.7%	62.1%	67.3%	74.8%*	Dermatology - Performance has further improved to 84% in October with November's performance predicted to reach 93% for the FDS. - Continued insourcing and locum activity to maintain and improve performance. Availability of additional work during December remains a risk – with performance currently forecast to be 80%, however the service are continuing to secure additional sessions. Breast - Waiting times for Breast first appointments remain a priority to improve. For FDS there is 84% compliance against a 90%+ target. - They are currently reviewing the options to put on additional capacity. Lower GI - Additional nurse led capacity has been timetabled in for November to create additional USC slots, however struggling with admin resource to support this. - Secure additional administrative support to fully realise the benefits of increased nurse-led capacity (now out to advert). Urology - Additional HCA posts have been approved to recruit, which will allow a planned increase in outpatient capacity at Paignton.	
31-day treatment	94.1%	93.4%	87.1%	91.8%	91.1%*		
62-day cancer RTT	64.3%	58.2%	65.7%	63.3%	72.4%*		
62-day backlog	223 (7.9%)	220 (7.8%)	257 (9.2%)	170 (7.1%)	152 (6.8%)		
*October 2025 provisional data							
Faster Diagnosis Standard (FDS): The Trust is currently reporting 74.8% against the 75% FDS target. This position is undergoing validation ahead of submission at month end. Skin pathway performance has recovered to 84%, but challenges persist in Colorectal and Urology.							
62-day Cancer Referral to Treatment: October's provisional performance is 72.4%, meeting the 70% interim target. Improvements in Urology and Colorectal have contributed to this recovery.							
Cancer PTL: The backlog is a more predictive, real-time measure and used to forecast and hold specialties to account. The backlog peaked at 9.2% in August. As of 03/11/2025, the backlog is 6.8%, with notable improvement in urology due to shorter biopsy waiting times.							
Risks/issues							
- Cancer Referrals: During this financial year, cancer referrals have risen notably, reaching 13,026 (April to September). Projecting these numbers through the year suggests an 11.5% increase in referrals, averaging 200 additional referrals per month. - Staffing remains the main challenge in radiotherapy, with four agency radiographers covering vacancies and a senior medical physicist currently off work, however, a new Band 8 physicist is due to start in January.							

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) (PSII) (<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 6	↑
Stroke patients spending 90% of time on a stroke ward (>80%) - one month in arrears								Month 6	↔
Mixed sex accommodation breaches (0)									
Follow-ups 6 weeks past to be seen									↑

Quality and Patient Safety Summary

Areas of deterioration and risk

Stroke care

There has been an improvement in the percentage of patients admitted to the stroke unit with 4 hours from 46.4% to 50%, above the national average of 49.4%, the first time the Trust has done this since April 2020. Along with this an improvement in patients scanned within 20 minutes was seen by 10%. A new target that we are now monitoring is swallow assessment within 24 hours. Only 5.7% of patients (against a national average of 55%) received a formal swallow assessment within 24 hours, this is under review.

Fractured neck of femur

No update on data this month.

Areas of stable or improving performance

Patient safety incidents

There were a total of 2 incidents reported as 'severe' in October, and no incidents reported as 'death'. This is a reduction from the previous month. All are being investigated and trends monitored. No never events reported in October.

Maternity

In October there were no stillbirths or neonatal deaths. October saw an increase in 3rd/4th degree tears, other maternity metrics were fairly stable.

Follow-ups past 6 weeks to be seen date

There is a marked improvement for a second month in patients awaiting follow up past 6 weeks.

Safer Staffing

September data is within the NHSE suggested tolerance of 80-120% and also within the TSDFT tolerance of 90-110% fill rates. Registered Nurse numbers are at the lower end for the days at 91.2% but for the nights 95.1%. Care staff fill rates on day shifts are 94.4% and nights are at 103.1%. Fill rates have been better through the month of September.

Complaints

There has been an improvement in acknowledging complaints, but the team remains pressured. It is currently difficult to establish trends in the total number of complaints and concerns per month due to delays registering data.

VTE (Venous Thromboembolism) Assessment

Removed from IQPR and reviewed at SQAG

Mortality: HSMR, HSMR+ and SHMI are all statistically as expected in the latest report presented in Oct 25

Research: we will start reporting the number of open research trials within the Trust for monitoring moving forwards.

CQC Update

CQC 2023 Well Led Inspection May – September 2023

The current position for the Well Led Must Do and Should Do action completion is 86.27%, of which there are only two open remaining Must Do actions.

The outstanding Must Do actions related to the 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. Waiting lists are also part of the Better Care Plan. The remaining CQC Must Do actions are likely to be superseded in favour of the Better Care Plan once sufficient assurance is received that progress can be evidence.

CQC Compliance Actions Status					14th October 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	1	5	2	1
Urgent and Emergency	2	6	2	5	2	2
Medical Care	3	6	3	5	3	3
OPD	1	10		5	1	0
Diagnostics Imaging	7	7	7	7	7	7
TOTAL	15	36	13	31	15	13
Total MDSD Actions	51				% Closed	86.67%
Total MDSD Actions Closed	44					
Percentage MDSD Actions Closed	86.27%	14/10/2025				



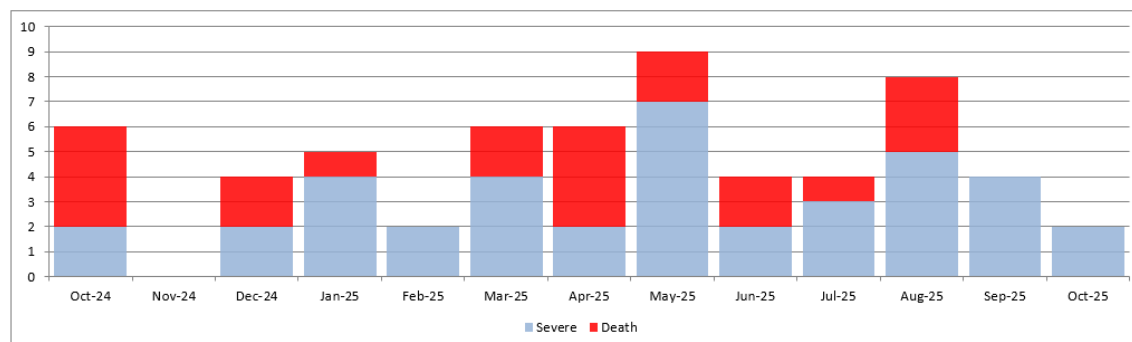
Paediatric Inspection August 2024

The Paediatric action plan (Louisa Cary) is currently reporting as 84.2% completed. 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.

Quality and Safety exception reports – Reported incidents

Reported Incidents - Severe and Death

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Severe	2	0	2	4	2	4	2	7	2	3	5	4	2
Death	4	0	2	1	0	2	4	2	2	1	3	0	0



Incidents reported as severe harm or death

In October 2025 there were no incidents of death reported, and 2 severe harm incidents reported:
 [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 11 patient safety incident investigations (PSIIs) underway:

7 National Priority

- 1x Child death – draft report nearing conclusion
- 1 x Never Event – misplaced NG tube
- 2 x Patient death meeting national criteria
- 1 x raised following family concerns – external investigation commissioned
- 1 x Obstetrics/Gynaecology incident – relating to the mother
- 1 x thematic relating to safeguarding [ligature incidents]

4 Local Priority

- 2x delays across our urgent and emergency care pathway – one report with family, and one with staff for factual accuracy
- 1 x delayed access to elective/planned care
- 1 x diagnostic thematic review relating to blood incidents

1 PSII has been completed in October:

- Child death

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 and 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 on data in October 2025. Previous report read:

A Telstra Health report was presented to Mortality Surveillance Group on 9th October 2025. There is a high volume of R69 (uncoded) data for June 25 discharges. Therefore, the report is based on the data extract for discharges from June 24 to May 25

HSMR+: Regional Peers (Acute non-specialist) - The Trust is 1 of 3 trusts that are within the expected range (out of 13).



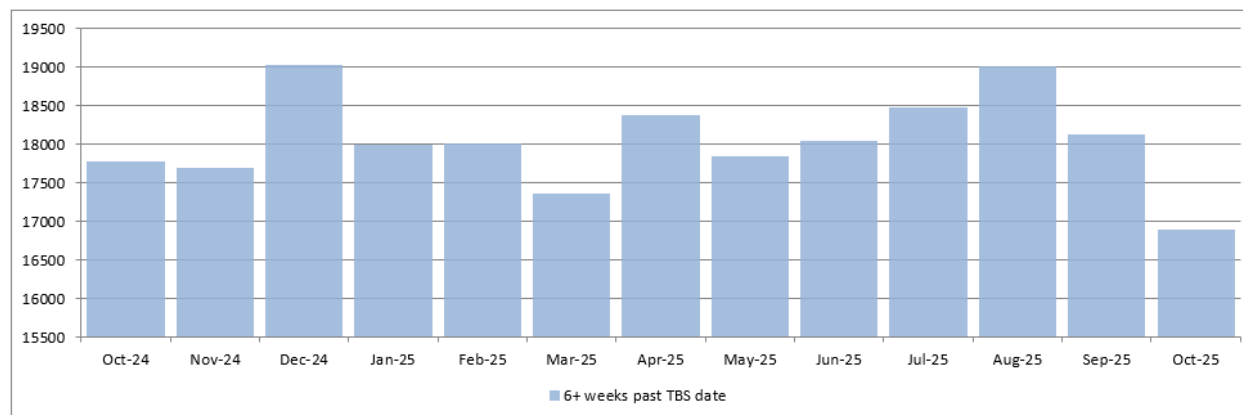
- The latest HSMR for June 24 to May 25 is **103.7** (97.3 – 110.5), this is statistically within the expected range.
- The HSMR+ for non-elective admissions for the current 12-month period is **103.4** and within the expected range. The crude mortality rate for the current 12-month period is 5.6% (National = 6.0%, Region = 6.0%). Overall, 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 **126.3** and remains within the expected range. The rolling 12-month trend shows a general upward trajectory from the August 23 to July 24 data point, but this has levelled over the last five periods.
- Both emergency weekday and weekends HSMR+ remain within the expected range.
- There are seven CUSUM alerts but there are no new alerts for this period that were not apparent in the last report.
- The proportion of patients coded as palliative care and dying in hospital has increased notably over financial years and is higher than National and Regional peers*. The Trust End of Life group will consider if provision of community palliative care services is impacting this.
- The new published SHMI value is 95.11 and statistically 'as expected'
- There are four groups that have a SHMI that is statistically higher than expected (using 95% confidence intervals) and are also statistically higher than expected for Relative Risk using the THUK methodology:
 - o Occlusion or stenosis of precerebral arteries
 - o Respiratory failure, insufficiency, arrest (adult)
 - o Gastrointestinal haemorrhage –
 - o Acute and unspecified renal failure

Alerts will be monitored by the Mortality Surveillance Group.

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

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
6+ weeks past TBS date	17782	17689	19036	17997	18005	17361	18380	17843	18040	18486	19016	18135	16900

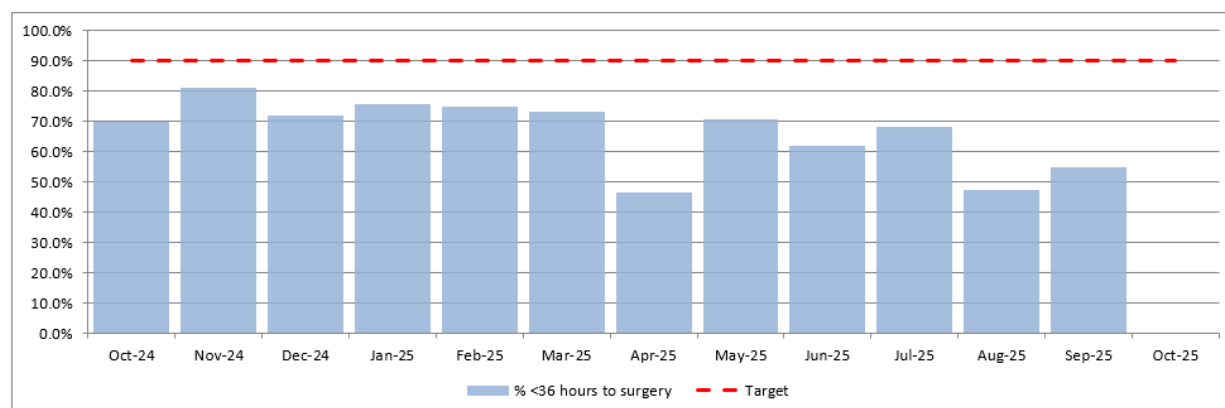


Follow-ups past 6 weeks to be seen

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

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
% <36 hours to surgery	70.0%	81.1%	71.9%	75.6%	75.0%	73.2%	46.5%	70.7%	61.8%	68.1%	47.4%	55.0%	N/A
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Fractured Neck of Femur (one month in arrears – Month 7 data not yet available on National Hip Fracture Database).

October data is 39 hip fractures plus 5 other femoral fractures. This will include the complex periprosthetic fractures. Average time to theatre for the hip fractures was 28 hours.

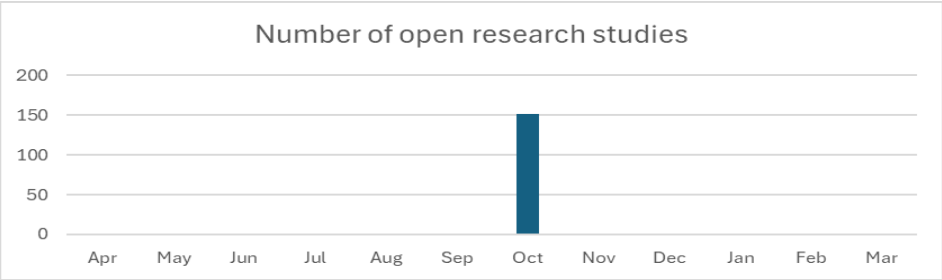
The "other" femoral fractures waited an average of 84 hours with the longest wait at 141 hours.

These cases require specialist kit and hip surgeon availability

Quality and Safety exception report – Research involvement / Mixed Sex Accommodation

Month Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Number of open research studies 151

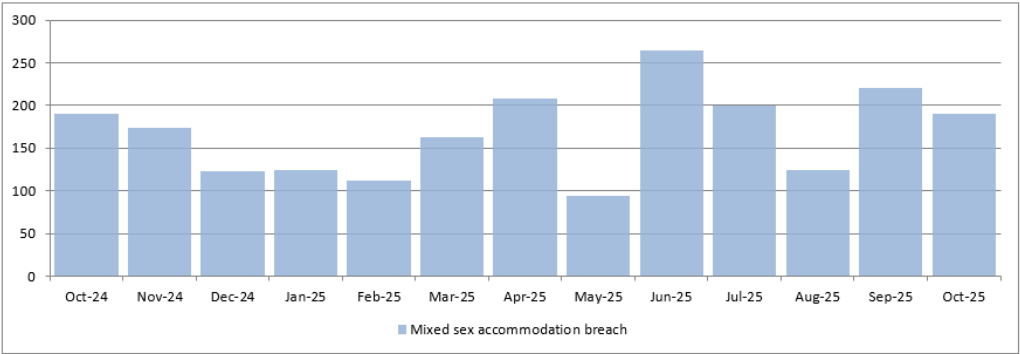


Research involvement

We are adding a new metric on the number of research studies open within the Trust to demonstrate our involvement in this area. Trends will be monitored over time.

Mixed sex accommodation breach

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Breaches - actual	190	174	123	125	112	163	208	94	265	200	124	220	190
Target	0	0	0	0	0	0	0	0	0	0	0	0	0



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.

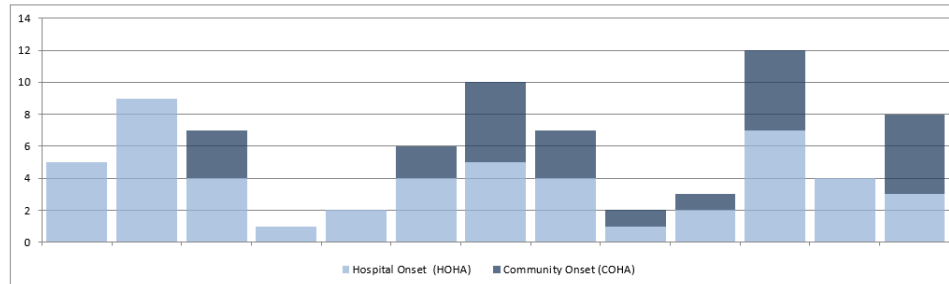
In October we recorded 190 breaches, 30 breaches less then September.

From November 2025, MSA breaches will be monitored at SQAG and no longer be reported on the IPQR.

Quality and Safety exception report - Infection control

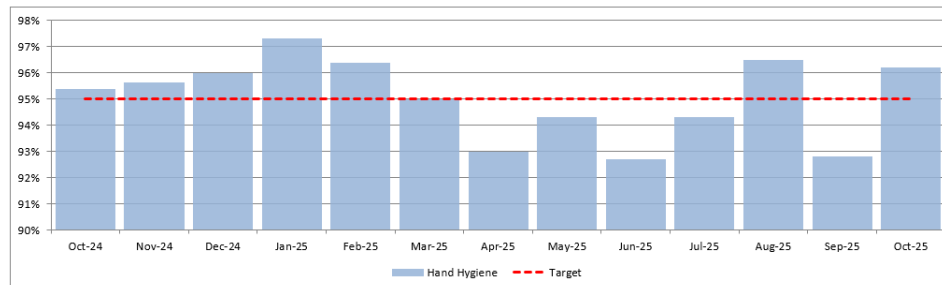
Number of Clostridium Difficile cases

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Hospital Onset (HOHA)	5	9	4	1	2	4	5	4	1	2	7	4	3
Community Onset (COHA)	0	0	3	0	0	2	5	3	1	1	5	0	5



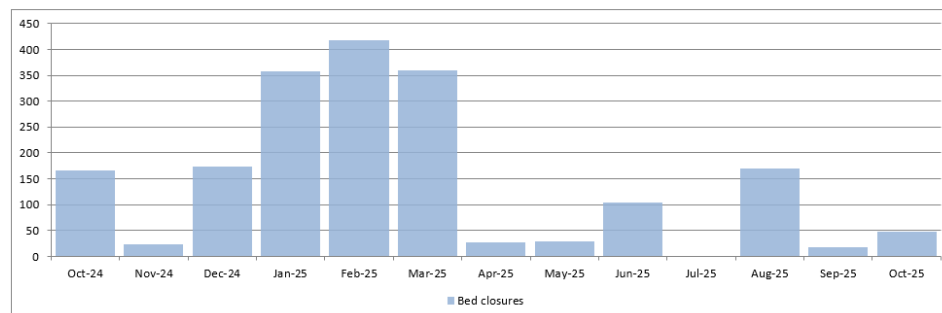
Hand Hygiene

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Hand Hygiene	95%	96%	96%	97%	96%	95%	93%	94%	93%	94%	97%	93%	96%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Infection control - Bed days lost (Acute)

	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Bed closures	166	24	174	358	418	360	28	29	105	0	170	18	47



HOHA – Hospital Onset Hospital Associated (HOHA)

During October there were 3 CDiff HOHA's reported across 3 different in-patient areas; George Earle, CCU and Dawlish. This relates to patients being within the hospital setting for greater than 48 hours. The Infection and Prevention Control (IPC) team will review all data with relevant wards to identify any commonalities and learning opportunities.

COHA – Community Onset Hospital Associated

During October there were 5 CDiff COHA's reported. These related to in-patient stays on Allerton, EAU4, AMU, Simpson and Warrington. These too will be reviewed to identify any trends or learning.

There has been an increase in compliance with October data evidencing 96.2% (target 95%) in hand hygiene compliance up from 92.9% in September 25. Eight in-patient areas did not complete the audit with seven areas scoring below 90%.

Plan:

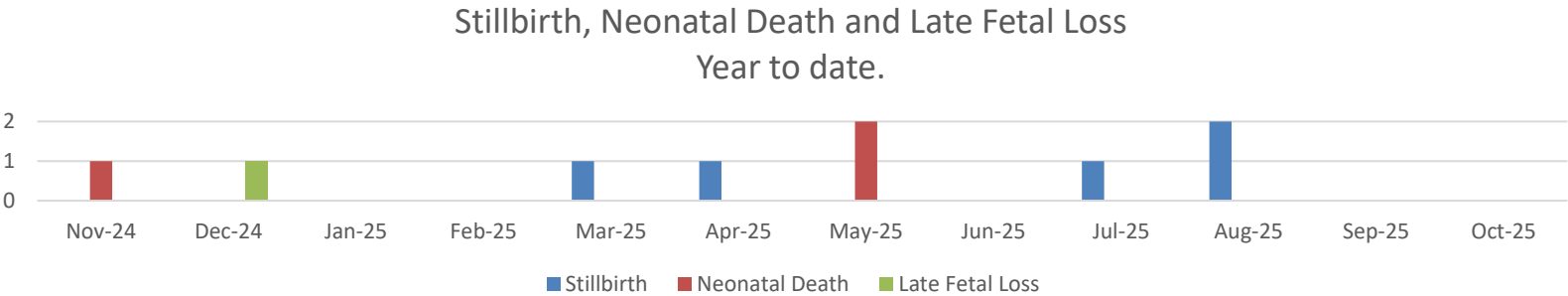
- ADNPP to share data with Care Group senior leader to offer support from an IPC perspective
- Turbo/blue box training to be provided across all non-compliant areas.
- IPC support for ward champions.
- ADNPP to add target score of 95% to November IPC Governance Group agenda as neighbouring trusts target scores are set at 90%

There were 15 bed days lost in October 25 due to IPC related issues. These were across: Brixham, Templar and Simpson due to Covid and Turner due to Rhinovirus for immunocompromised patients. Side room usage continues to be reviewed daily across all in-patient areas working with the site team and wards to ensure appropriate usage.

A new Isolation policy has been ratified to support a standardised approach to bed closures on a trust wide basis with a SOP to be produced to support winter pressures.

**Quality and Safety exception report –
Perinatal Clinical Quality Surveillance November (October 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.

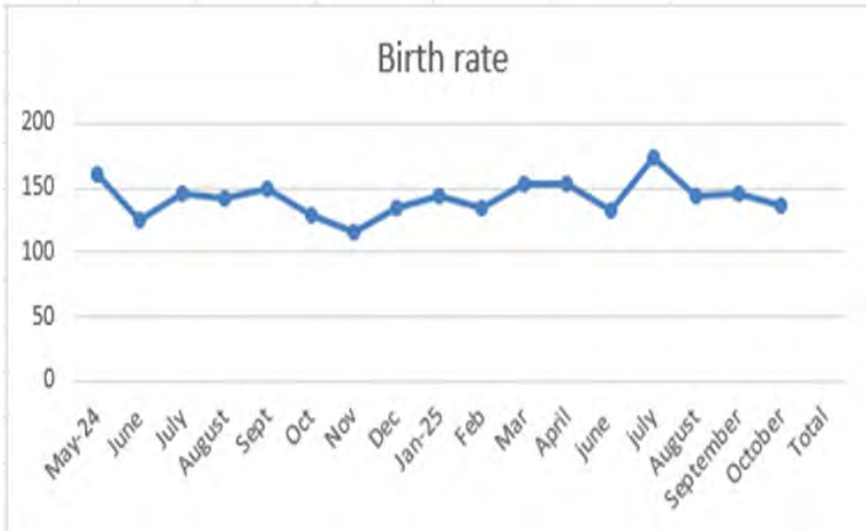
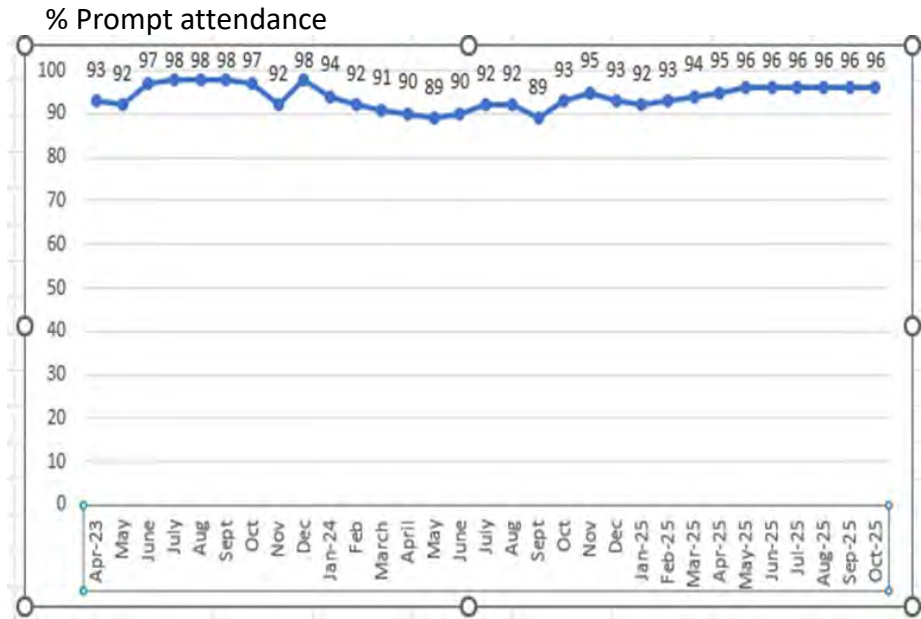
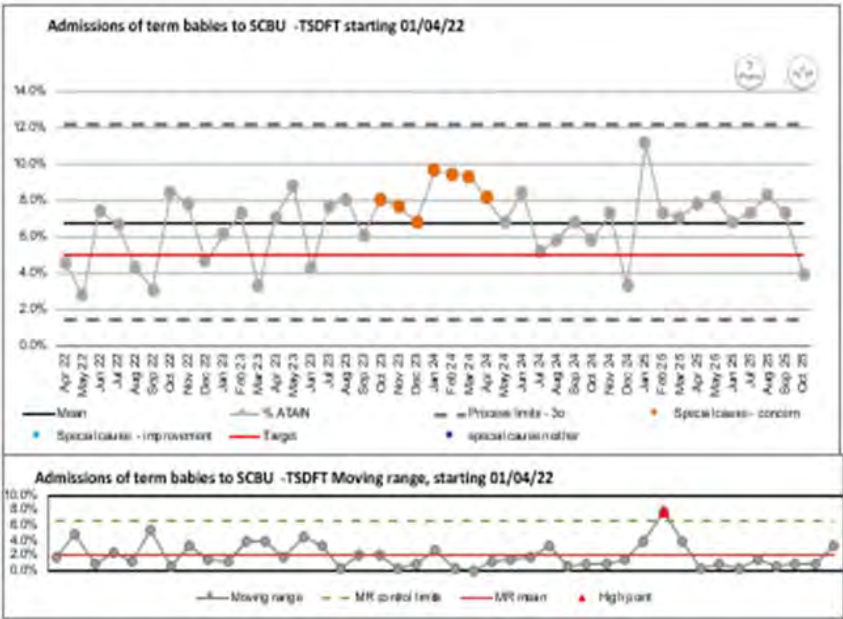
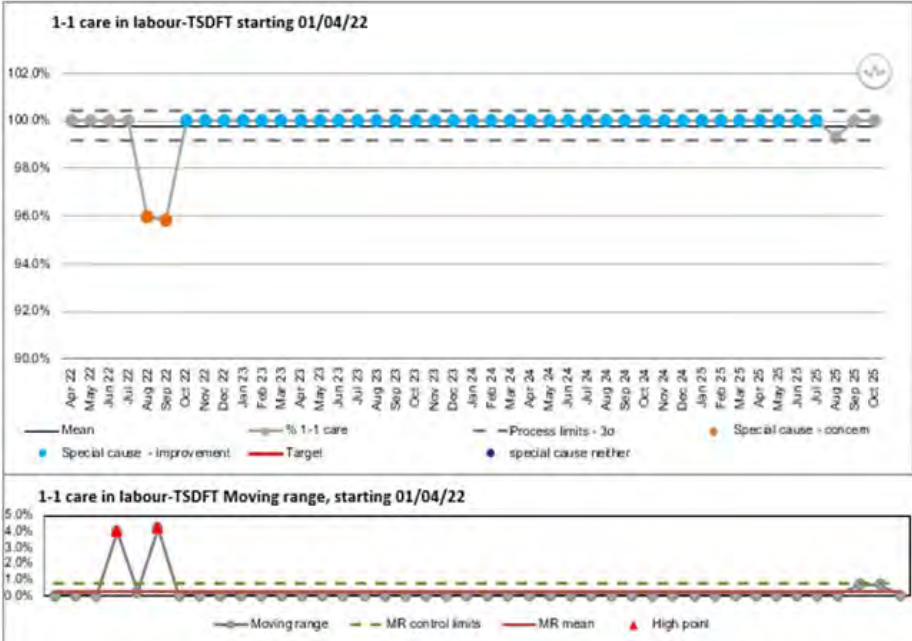
Incidents moderate and above = 0

MNSI – None

CQC – None

Coroner referral – Schedule 5 letter received.

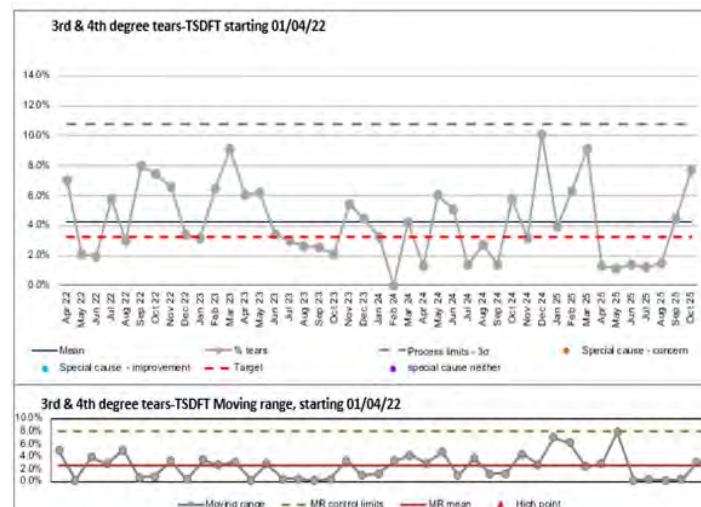
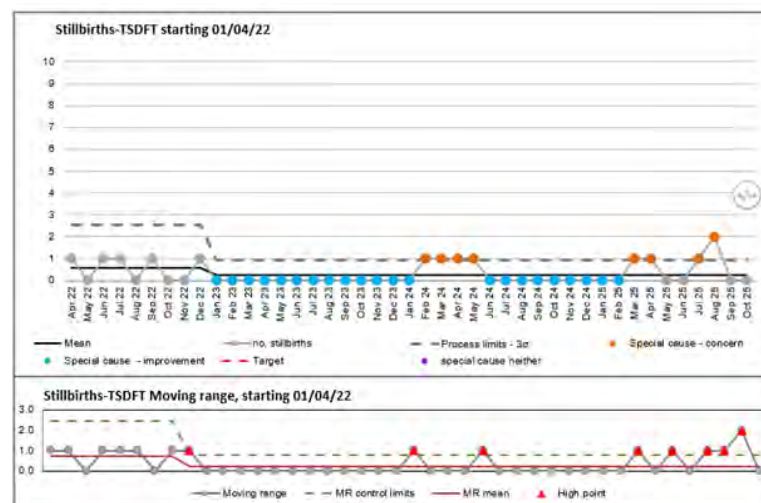
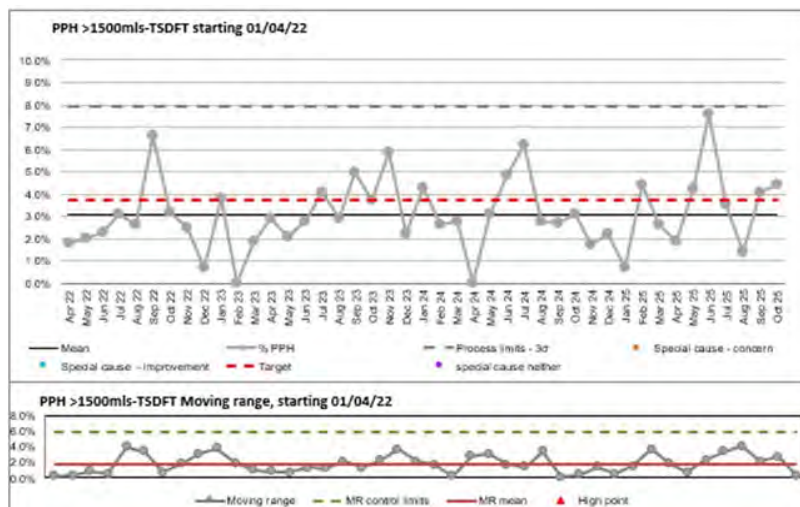
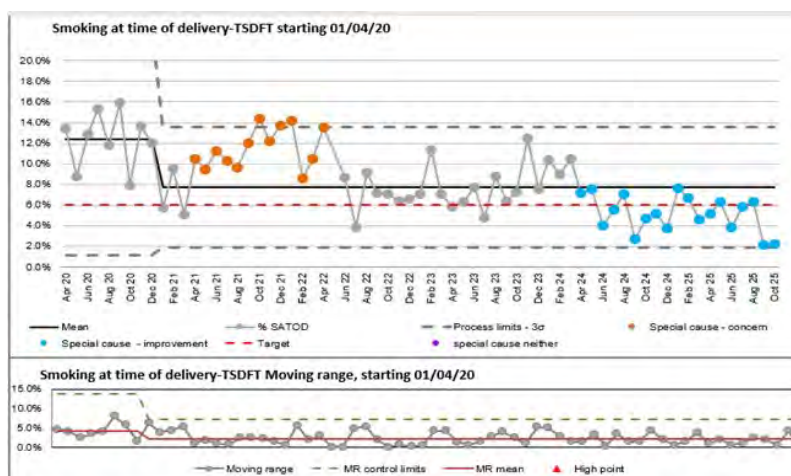
**Quality and Safety exception report –
Metrics relating to the provision of quality maternity care**



Quality and Safety exception report – Metrics relating to the provision of quality maternity care

Births in October: 136

- Sustained reduction for the month of October in smoking at delivery 2.2% well below the national average of 6%
- Zero Stillbirths in the month of October
- Zero Neonatal deaths & no HIE cases
- Increase in the number of 3rd/4th degree tears to 7.7% in October. Quarterly average 5.1% % NMPA target average is 3.2%
- PPH>1500mls @4.4% for October, quarterly average @3.03 which remains below the National target of 3.7%
- A further decrease in term baby admissions to SCBU to 4%. NMPA target is 5% QI work in place to reduce rate- Screen and Treat at bedside



Quality and Safety exception report – Stroke care

Data for September below; data for previous month only available from 15th of current month.

Time critical Stroke Standards	Natl. average Apr-Jun 2025												
		Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Number of patients (N)		42	50	46	50	46	56	55	62	54	50	58	53
% Scanned within 20 minutes updated target	30.9%	11.9%	10.0%	15.20%	24.0%	14.9%	23.2%	16.4%	29.0%	43.1%	24.5%	29.3%	39.6%
% Admitted to Stroke Unit within 4 hours	49.4%	31.70%	36.70%	25.00%	34.00%	24.40%	50%	37%	37%	47.30%	28%	46.40%	50%
Median time to reach the stroke unit (hours:mins)	03:52	10:37	07:32	10:08	07:53	09:23	03:45	06:00	05:31	04:16	06:17	04:18	03:40
% of patients spending 90% of their time on the Stroke Unit	82.7% (Team)	69.40%	71%	59%	71.40%	70.20%	83.60%	69.10%	77.40%	75.90%	78.90%	81%	81%
% Patients given formal swallow assessment within 24 hours	55.2%	36.4%	10.0%	15.2%	8.0%	4.3%	19.0%	7.3%	8.1%	8.5%	7.5%	5.2%	5.70%
% (No.) Patients that received Thrombolysis	14.0%	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)	8.6% (5)	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	01:17	01:27

In September there were some improvements:

- An increase in the proportion of patients scanned within 20 minutes; above the national average.
- An increase in the proportion of patients admitted to the stroke within 4 hours – just above the national average and highest score at the Trust since April 2020.
- The median time to get to the stroke unit improved; approx. 7 minutes faster than the national average.
- Thrombolysis rate improved with seven patients receiving this treatment in September.

However:

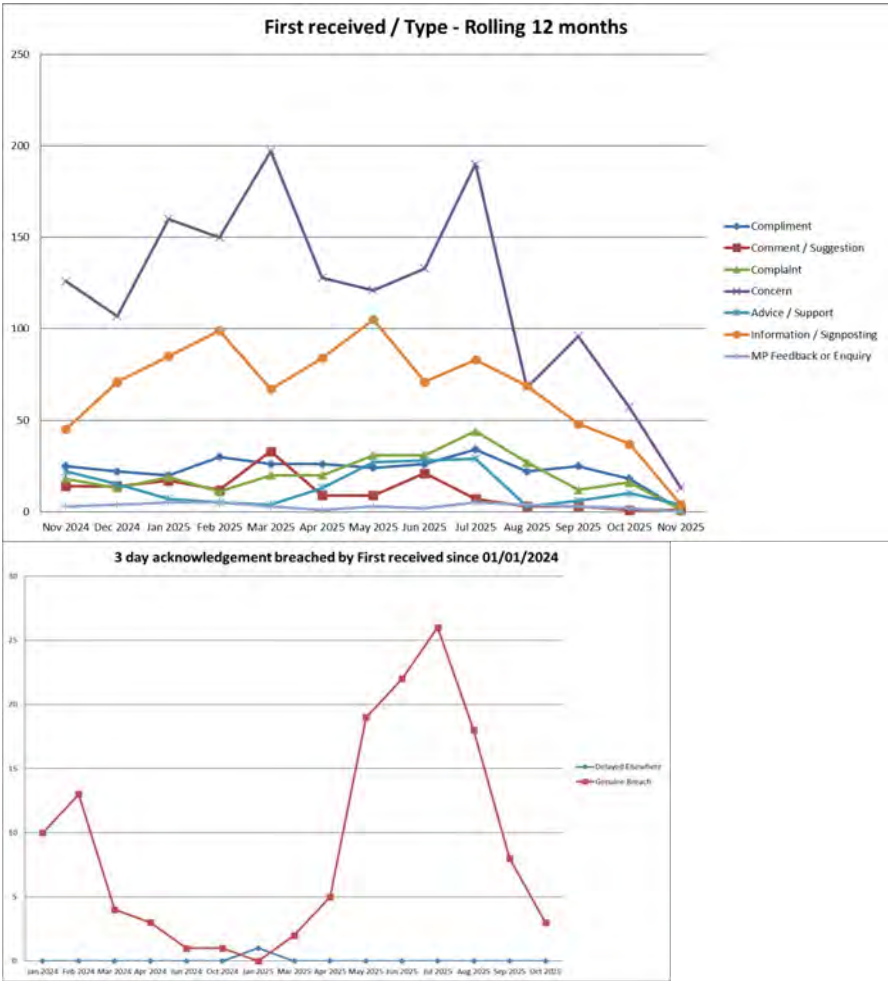
- A new target that we are now monitoring is swallow assessment within 24 hours. Only 5.7% of patients (against a national average of 55%) received a formal swallow assessment within 24 hours. Workforce challenges remain across SALT.

Following a letter from the national clinical lead for Stroke, Dr David Hargroves, outlining the 9 key points that he would wish to see us target for improvement in, the Stroke Action Plan has been built, and actions are under way. A pathway mapping event has been scheduled for 21st November.

Quality and Safety exception report – Feedback and engagement

October 2025 acknowledgement compliance:

- To date in 2025/26, 101 complaints have not been acknowledged within 3 working days of receipt. This figure represents only those that have been added to DCIQ for processing and not those unprocessed within the mailbox.
- A recovery plan is being produced to manage the existing backlog. This will see new metrics being added here for oversight once approved, alongside the previously regulatory and quality standard targets.



The Trust’s Patient Experience Team have processed 141** contacts from October, of which there were:

- Compliment – 18
- Complaint – 16
- Comment/Suggestion - 1
- Concern – 57
- Advice/Support - 10
- Information/Signposting - 37
- MP Feedback – 2

These figures are likely to increase due to the lag between receiving and processing contacts, due to capacity issues.

Top 3 complaint themes	Top 3 compliment themes:
Clinical treatment	Clinical treatment
Care	Appointment
Assessment	*Blank – only two categories this month*

Escalation: Risk 4286

Team

- The Patient Experience team continues to be significantly impacted by vacancies
- Staffing levels continue to impact capacity, and the team are unable to adequately manage the continuous workflow.

Data

- ✓ The team are behind with case management and data capture

**Data collected 12.11.2025 – all data subject to change due to recategorisation & delayed processing

Quality and Safety – Safer Staffing – Dashboard September 2025

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.45	4.15	0.02	3.28	7.50	4.07	0.04	3.39

CHPPD- Satisfactory Assurance

The Trust overall actual CHPPD for RN/Midwives in September 2025 is 4.07. This is slightly under the overall planned of 4.15. The overall Trust actual CHPPD for HCSW is 3.39. This is slightly higher than planned at 3.28 this is due to the service demands of the Enhanced Therapeutic Observations of Care that is required at night. Work has been completed within the service to ensure that there is a robust governance process surrounding the allocation of staff, shifts requests and cross charging of DPT for patients who do not require acute bed-based care. The rigour in this process has improved the service efficiency and the use of agency mental health HCSW ceased from 29th Sept 2025.

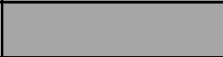
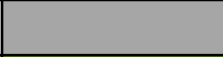
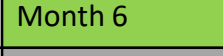
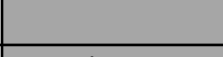
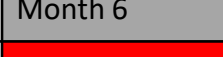
September's data is within the NHSE suggested tolerance of 80-120% and also within the TSDFT tolerance of 90-110% fill rates. RN numbers are at the lower end for the days at 91.2% but for the nights 95.1%. Care staff fill rates on day shifts are 94.4% and nights are at 103.1%. Fill rates have been better through the month of September.

The last 4 months has seen a stabilisation of the CHPPD leading to the Trust falling in line with the planned CHPPD. The CHPPD does remain red in some clinical areas where the sickness and vacancy rate is elevated. The CHPPD remains red in these areas, as the demand and supply to backfill sickness and Vacancies are not being filled by temporary workforce requests.

The use of Temporary workforce remains amber. Demonstrating that we are using a proportion of temporary workforce to backfill the FTE establishments. Work is in progress by recruitment to focus on their KPI's to improve the timeline for the recruitment onboarding process. The use of band 2-3 agency has now ceased as Mental Health HCSW are now being absorbed within the Trusts safer Staffing levels.

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	Month 6 	↑
Domiciliary Care hours per week – total demand		
Domiciliary Care hours per week – % outstanding	Month 6 	↓
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		↑
Cancer – 28-day faster diagnosis standard		↑
Cancer - 31-day wait from decision to treat to treatment - national reporting		↓
Cancer - 62-day wait for treatment - national reporting		↑
Cancer - Patient waiting longer than 104 days from 2 week wait		↑
Referral to treatment - % Incomplete pathways less than 18 weeks		↓
RTT 52-week wait incomplete pathway		↓
RTT 65-week wait incomplete pathway		↑
RTT 78-week wait incomplete pathway		↓
RTT 104-week wait incomplete pathway		↔
On the day cancellations for elective operations		↔
Cancelled patients not treated within 28 days of cancellation		↓
Theatre utilisation		↑
Virtual Outpatient (Non-face-to-face) appointments		↓
Bed Occupancy (Acute)		↑
No Criteria to Reside – percentage - (acute)		↓
Percentage of patient discharges pre-noon		↓
Percentage of patient discharges pre-5pm		↑
Number of patients >7 days length of stay (daily average)		↑
Number of extended stay patients >21 days (daily average)		↑
Ambulance handover delays > 30 minutes		↑
Ambulance handover delays > 60 minutes		↑
UEC - patients seen within 4 hours		↓
ED patients with >12-hour visit time pathway		↑
Time to Initial Assessment within 15 mins – Emergency Department		↑
Clinically Ready to Proceed delay over 1 hour - Emergency Department		↑
Non-admitted minutes mean time in Emergency Department		↓
Admitted minutes mean time in Emergency Department		↑
Diagnostic tests longer than the 6-week standard		↑
Dementia Find		
Care Planning Summaries % completed within 24 hours of discharge – Weekday		↓
Care Planning Summaries % completed within 24 hours of discharge – Weekend		↑
Clinic letters timeliness - % specialties within 4 working days		↓

Trust Board

Month 7 Finance Report

Date of meeting	Date report produced
26 th November 2025	13 th November 2025

Author(s)		Report approved by	
Name and title:	Nichola Rees Finance Partner	Name and title:	James Corrigan Interim CFO
Phone:		Date:	13 th November 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 the end of month 7 (31st October 2025) and forecast out turn (FOT) for the year ending 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 6).

As at month 7 the Trust is reporting a net YTD deficit of **£13.8m** against a planned deficit of **£11.3m**. The **£2.6m** variance relates to phasing of the month 7 deficit support funding. The net forecast deficit for the year end is as planned at **£8.0m** (slide 3) as the Trust has been advised by the ICB to assume this full deficit support will be earned back in Q4.

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 6 forecast, the gross risk was assessed as £18.9m to delivering the £8m planned deficit.

The gross risk has reduced from £18.9m to £17.8m in month 7. Actions are in place to reduce run rates further and in total these actions give the ability for the Trust to deliver the forecast plan for 2025/26. Currently, there are robust plans to deliver £10.7m (M6 £10.3m) of the further savings required; with a further £3.6m (M6 £4.8m) of high-risk actions identified, leaving a gap of £3.8m. The current net risk to delivering the forecast outturn is therefore £7.4m (M6 £8.6m).

The Trust is reporting £18.8m YTD CIP achievement, £1.2m ahead of plan (slide 6) although recurrent delivery is lower than plan (£12.4m v £10.1m). The annual forecast is to achieve the £41.5m plan, (split recurring £24.9m and non-recurring £16.6m) as assessment of recurrent savings will increase significantly over future months.

The planned exit underlying position for 25/26 (before national/system support) has been reassessed as part of the month 6 forecast process and the deficit has increased from £81.8m to £99.5m. The Trust is working to finalise the recurrent impact of movements in the forecast outturn. This is an iterative process throughout 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 (slide 4).

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

Appendices

N/A

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

Executive Committee - Review

Key recommendations and actions requested

The Finance & Performance Committee 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 is off plan by £2.6m YTD due to deficit support funding (DSF).
- FOT to 31st October 2025 is on plan as full DSF receipt as the Trust has been advised by the ICB to assume this full deficit support will be earned back in Q4.

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
Population Health and Wellbeing	
Quality of services provided	
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
Quality, Safety and Patient Experience	
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	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

Terms of authorisation, NHS England licence and regulations

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.



Monthly Financial Performance Report

Month 7

Executive Summary

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the financial position year to date (YTD) as at October 2025 and forecast out turn (FOT) for the year ended 31st March 2026.

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 5). As at month 7 the Trust is reporting a net YTD deficit of **£13.8m** against a planned deficit of **£11.3m**. The **£2.6m** variance relates to phasing of the month 7 deficit report funding. The net forecast deficit for the year end is as planned at **£8.0m** (slide 3) as the Trust has been advised by the ICB to assume this is earned back in Q4.

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 6 forecast, the gross risk was assessed as £18.9m to delivering the £8m planned deficit. The gross risk has reduced from £18.9m to £17.8m in month 7. Actions are in place to reduce run rates further and in total these actions give the ability for the Trust to deliver the forecast plan for 2025/26. Currently, there are robust plans to deliver £10.7m (M6 £10.3m) of the further savings required; with a further £3.6m (M6 £4.8m) of high-risk actions identified, leaving a gap of £3.8m. The current net risk to delivering the forecast outturn is therefore £7.4m (M6 £8.6m).

The Trust is reporting £18.8m YTD CIP achievement, £1.2m ahead of plan (slide 6) although recurrent delivery is lower than plan (£12.4m v £10.1m). The annual forecast is to achieve the £41.5m plan, (split recurring £24.9m and non-recurring £16.6m) as assessment of recurrent savings will increase significantly over future months.

The planned exit underlying position for 25/26 (before national/system support) has been reassessed as part of the month 6 forecast process and the deficit has increased from £81.8m to £99.5m. The Trust is working to finalise the recurrent impact of movements in the forecast outturn. This is an iterative process throughout 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 (slide 4).

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 7

	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	62.5	62.5	(.0)	267.5	437.0	439.0	2.1	729.3	749.5	758.6	9.2
Operating Expenditure - Pay	(29.3)	(30.6)	(31.6)	(1.0)	(147.0)	(222.6)	(224.1)	(1.5)	(389.0)	(375.6)	(380.8)	(5.2)
Operating Expenditure Non-Pay and Financing Cost	(30.2)	(32.2)	(33.8)	(1.6)	(150.4)	(225.6)	(228.7)	(3.1)	(373.5)	(381.9)	(385.9)	(4.0)
Surplus / (Deficit) Sub Total	(4.9)	(0.3)	(2.9)	(2.6)	(29.9)	(11.3)	(13.8)	(2.5)	(33.2)	(8.0)	(8.0)	(0.0)
<i>Excluding Non Recurrent Deficit Funding</i>		(2.6)	0.0	2.6	0.0	(18.0)	(15.4)	2.6	0.0	(30.8)	(30.8)	0.0
Surplus / (Deficit) Total	(4.9)	(2.9)	(2.9)	(0.0)	(29.9)	(29.3)	(29.2)	0.0	(33.2)	(38.8)	(38.8)	(0.0)

The Trust's financial position at the end of October shows a year-to-date deficit of **£13.8m**, against a planned deficit of **£11.3m**. The **£2.6m** variances relates to a delay in phasing of the month 7 deficit report funding. This position excluding the deficit support funding of **£15.4m** would be a year-to-date deficit of **£29.2m**

Year to date - Income **£2.1m** higher than plan (Pass Through Drugs & Devices £2.3m, other income £0.4m, offset lower than plan CIP delivery £0.5m), Pay costs are higher than plan **£1.5m**, Non pay costs **£3.1m** higher than plan (slide 12).

The Trust is reporting a year end forecast of an **£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 on slide 5. The position excluding support funding is **£38.8m deficit**.

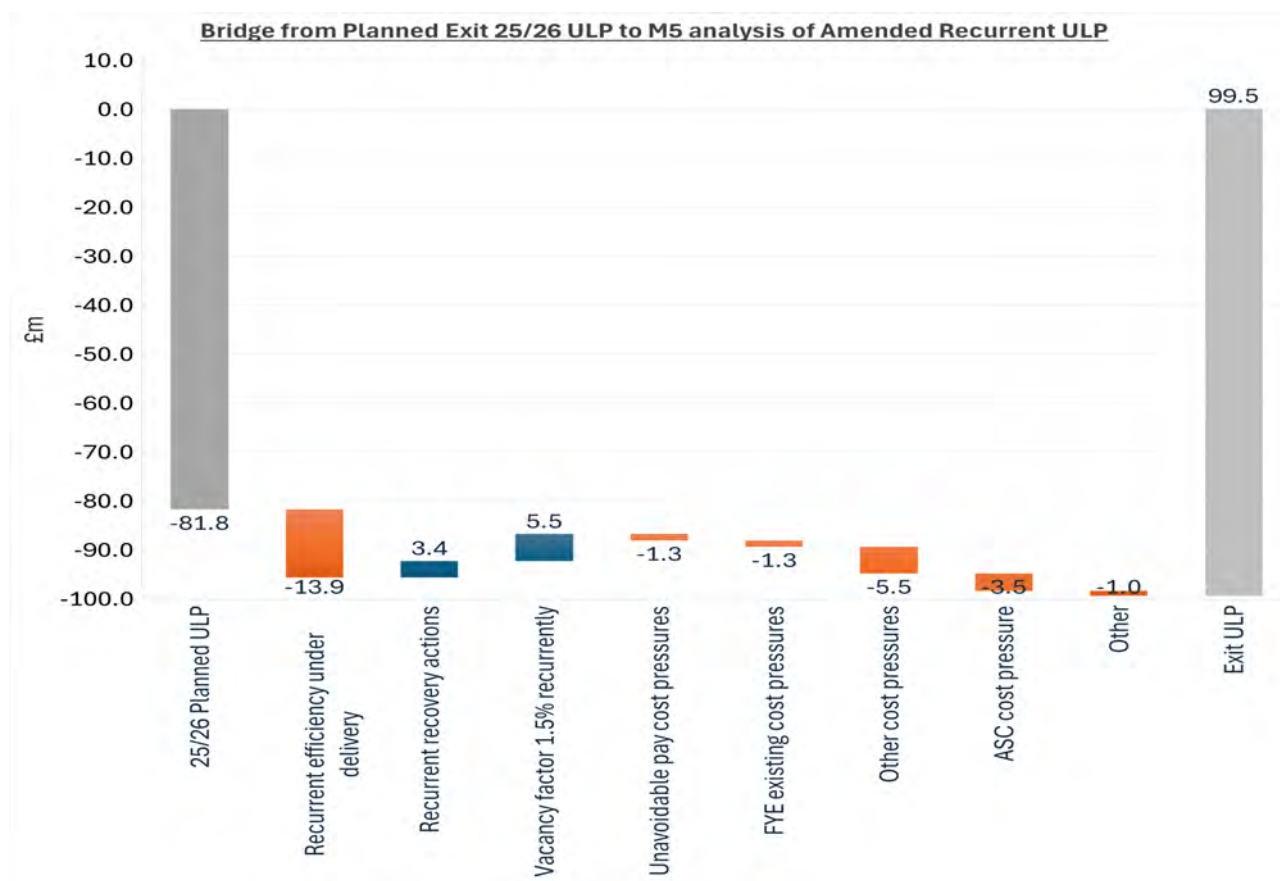
Forecast - Income **£9.2m** higher than plan (Pass Through Drugs & Devices £3.9m, Council grant income £0.7m, R&D & Education £1.9m, other income £5m, offset lower than plan CIP delivery £2.3m), Pay costs higher than plan **£5.2m** mainly temporary staffing costs, Non pay costs **£4m** higher than plan (slide 12)

The Committee can take **satisfactory assurance** that the plan to date is delivering.

Bridge from Planned Exit 25/26 ULP to Updated Recurrent ULP



Torbay and South Devon
NHS Foundation Trust

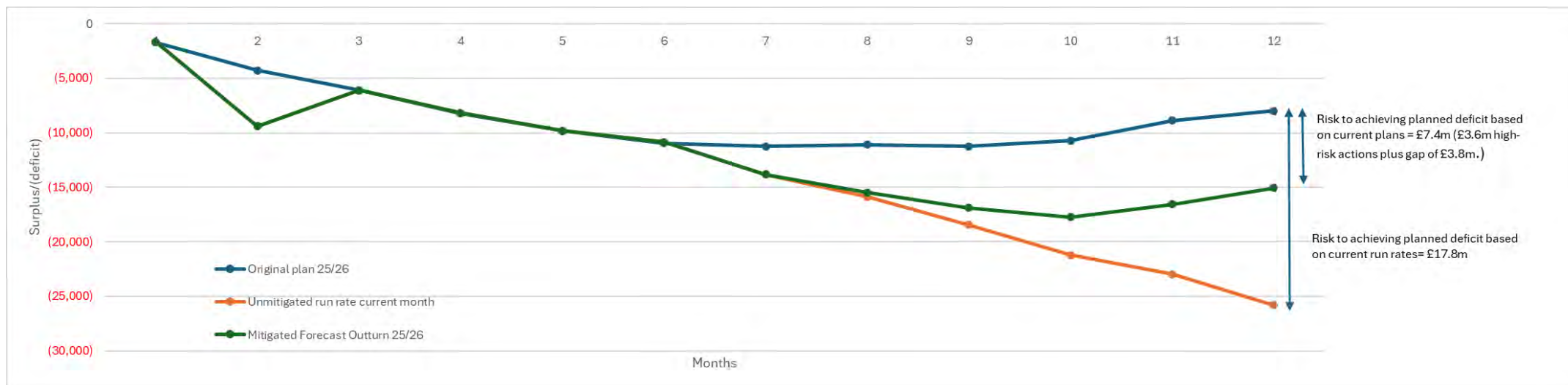


	£'m
25/26 Planned ULP	-81.8
Recurrent efficiency under delivery	-13.9
Recurrent recovery actions	3.4
Vacancy factor 1.5% recurrently	5.5
Unavoidable pay cost pressures	-1.3
FYE existing cost pressures	-1.3
Other cost pressures	-5.5
ASC cost pressure	-3.5
Other	-1.0
Exit ULP	99.5

Assumes:

- high risk CIP is delivered non recurrently in 2025/26
- Includes pay award and risk share pressures
- IS funding is removed
- CHC funding still to be agreed

Risk to 25/26 Planned Forecast



- Following a review of the month 6 forecast, the gross risk was assessed as £18.9m to delivering the £8m planned deficit. The gross risk has reduced from £18.9m to £17.8m in month 7 due to recovery actions.
- Actions are in place to reduce run rates further and in total these actions give the ability for the Trust to deliver the forecast plan for 2025/26.
- If the current run rate trends continue with no mitigating actions, the deficit will be £25.8m, against the planned deficit of £8m; presenting a £17.8m (M6 £18.9m) deficit to plan.
- There are robust plans to deliver £10.7m of the further savings; with a further £3.6m of high-risk actions identified, leaving a gap of £3.8m.

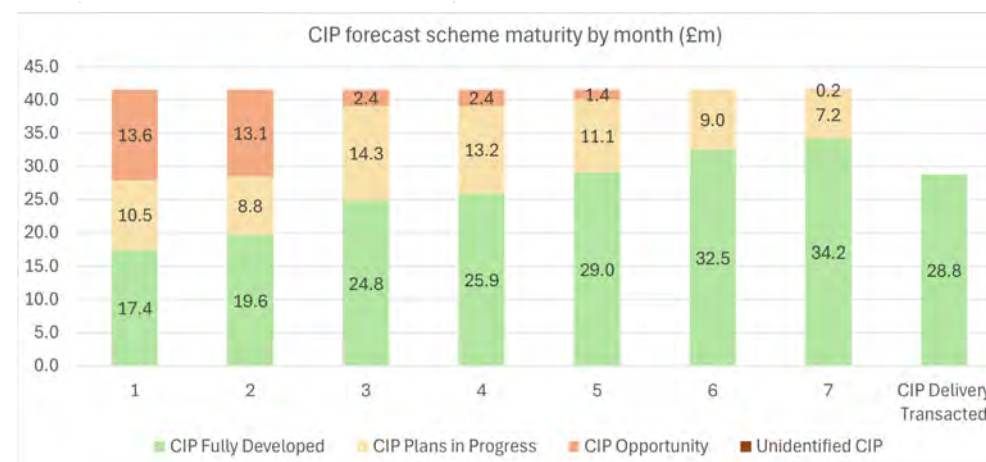
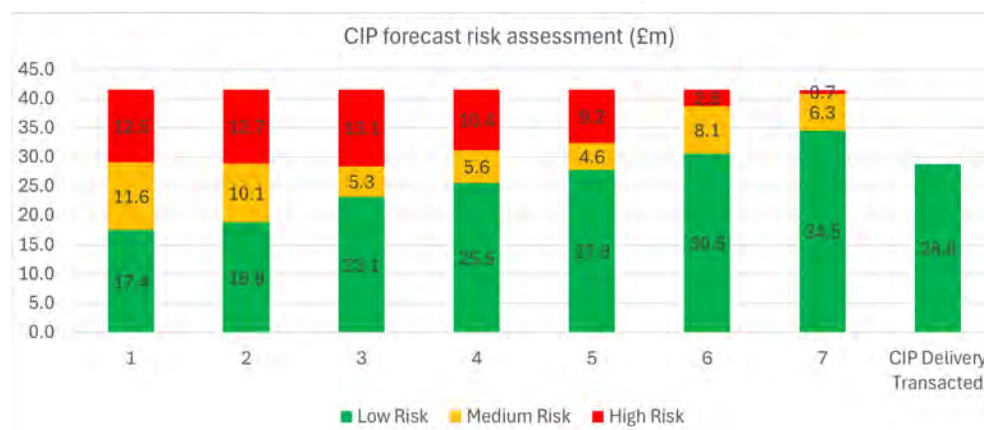
Efficiencies/CIP – maturity & risk

	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	12.4	10.1	(2.3)	32.8	24.9	(7.9)
Non-recurrent efficiencies	5.2	8.7	3.5	8.7	16.6	7.9
Total	17.7	18.8	1.2	41.5	41.5	0.0
Recurrent %	70%	54%		79%	60%	
Non-recurrent %	30%	46%		21%	40%	

Profile of plan across quarters

Q1 – 14%
 Q2 – 19%
 Q3 – 31%
 Q4 – 37%

Care Group	High Risk Forecast CIP Delivery £m
Medicine and Urgent Care	0.1
Planned Care and Surgery	0.1
Shared Corporate Services	0.5
Grand Total	0.7



The Trust is reporting £18.8m YTD CIP achievement, £1.2m ahead of plan. The annual forecast is to still achieve the £41.5m plan although at M7 forecast the recurring figure is £24.9m (£7.9m less than plan) and non-recurring £16.6m (£7.9m 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.

Efficiencies/CIP - by Care Group

Total CIP Delivery	Delivered YTD			Forecast Outturn		
Care Group	Plan £m	Delivery £m	Var +/-	Plan £m	Delivery £m	Var +/-
Families & Communities	3.1	3.7	0.6	6.4	6.9	0.5
Medicine and Urgent Care	2.2	2.4	0.2	4.6	4.6	(0.1)
Planned Care and Surgery	4.1	4.4	0.3	8.4	8.6	0.2
Shared Corporate Services	3.4	3.4	(0.0)	13.0	12.4	(0.5)
Children and Family Health Devon	0.6	0.6	0.0	0.7	0.8	0.1
Adult Social Care – Torbay	4.2	4.2	0.0	8.4	8.3	(0.1)
Total	17.7	18.8	1.2	41.5	41.5	0.0
Total Recurrent CIP Delivery	Delivered YTD			Forecast Outturn		
Care Group	Recurrent Plan £m	Recurrent Delivery £m	Var +/-	Recurrent Plan £m	Recurrent Delivery £m	Var +/-
Families & Communities	1.4	2.4	1.0	3.8	4.9	1.1
Medicine and Urgent Care	2.0	1.1	(0.8)	4.0	2.4	(1.5)
Planned Care and Surgery	2.7	1.7	(0.9)	5.6	4.5	(1.1)
Shared Corporate Services	2.4	0.9	(1.5)	11.3	5.1	(6.1)
Children and Family Health Devon	0.0	0.0	(0.0)	0.1	0.0	(0.1)
Adult Social Care – Torbay	4.0	3.9	(0.1)	8.1	7.9	(0.1)
Total	12.4	10.1	(2.3)	32.8	24.9	(7.9)
Recurrent as a % of Total	70%	54%		79%	60%	

CIP forecast currently assumes will be achieved in line with plan total (£41.5m) although with a lower than planned level of recurrent efficiency. There are £0.7m of high risk rated schemes within this as noted on slide 6.

Care Group Summary

Care Groups	M7				YTD M7 25/26				Financial Year			
	PY 24/25	CY 25/26			PY 24/25	CY 25/26			PY 24/25	Forecast Outturn 25/26		
	Actual £m	Plan £m	Actual £m	Var +/- £m	Actual £m	Plan £m	Actual £m	Var +/- £m	Forecast Outturn £m	Annual Plan £m	Forecast Outturn £m	Var +/- £m
Children and Family Health Devon (CFHD)	0.1	(0.0)	0.1	0.1	1.1	0.2	1.0	0.8	1.9	0.0	1.0	0.9
Families & Communities	(11.8)	(11.5)	(11.6)	(0.1)	(75.0)	(81.7)	(81.2)	0.5	(127.2)	(138.6)	(138.9)	(0.4)
Medicine and Urgent Care	(9.1)	(7.9)	(8.1)	(0.2)	(55.3)	(56.0)	(56.1)	(0.2)	(93.2)	(95.3)	(96.5)	(1.1)
Planned Care and Surgery	(14.8)	(13.2)	(13.5)	(0.3)	(89.3)	(93.1)	(94.6)	(1.5)	(153.0)	(158.7)	(160.3)	(1.6)
Corporate	(5.3)	(4.5)	(4.0)	0.6	(29.2)	(31.3)	(30.5)	0.7	(50.1)	(51.8)	(52.6)	(0.9)
Workplace (Estates)	(2.8)	(2.5)	(2.6)	(0.1)	(18.3)	(18.4)	(17.8)	0.6	(30.8)	(31.0)	(30.8)	0.1
Reserves & Other Income (Inc Fin Costs)	50.3	47.6	45.1	(2.5)	309.8	327.1	324.5	(2.6)	513.5	565.2	571.5	6.3
Adult Social Care – Torbay	(7.7)	(8.3)	(8.4)	(0.2)	(54.6)	(58.1)	(59.0)	(0.9)	(94.3)	(97.9)	(101.3)	(3.4)
Surplus / (Deficit) Total	(1.1)	(0.3)	(2.9)	(2.6)	(10.7)	(11.3)	(13.8)	(2.5)	(33.2)	(8.0)	(8.0)	0.0

CFHD: YTD £0.8m lower than plan due to vacancies and non pay underspend. Underspend position to continue to year end reducing as vacancies are filled and reinvestment in pressured services; forecast underspend £0.9m.

Families and Communities: YTD £0.5m lower than plan due to over delivery of CIP (non-recurrent). Forecast £0.4m higher than plan due to CHC growth pressures, partially offset by forecast over delivery of CIP.

Adult Social Care (Torbay): YTD £0.9m higher than plan due to growth in client numbers in Residential & Nursing based settings and increases in Dom care 'client complexity', offset by an accrual benefit (£0.6m). Full year effect of cost pressures above is forecast to be £3.4m higher than plan.

Medicine & Urgent Care: YTD £0.2m higher than plan due to ED Medical staffing £0.3m and Cardiology consumables £0.3m partially offset by over delivery of CIP (non recurrent) . Forecast higher than plan £1.1m due to ED Medical staffing costs £0.6m and increased volume levels of Cardiology consumables £0.5m , escalation costs £0.4m partially offset by underspend in Older People wards.

Planned Care: YTD £1.5m higher than plan due to medical pay £0.9m, drugs £0.4m, theatre and lab consumables £0.2m and Elective Recovery Fund spend earlier than plan £0.2m, offset by additional pay savings used to over deliver CIP. Forecast £1.6m higher than plan due to continuing high cost of consumables £0.9m, medical pay £0.6m and non-medical pay costs £0.1m.

Workplace: YTD £0.6m lower than plan driven by £0.5m estates vacancies, estates maintenance and utilities costs (budget phasing) and £0.1m income for 24/25 for retail sales. Forecast £0.1m lower than plan, due to a £0.5m under-delivery of CIP offset with estates vacancies and utilities costs.

Corporate: YTD £0.7m lower than plan - R&D surplus income exceeding costs offset in reserves. Forecast £0.9m higher than plan, due to £1.0m under-delivery of CIP, £0.9m cost pressures for insurance, procurement transformation, people digital and NHP (partially mitigated YTD by vacancies and overachieved income). R&D surplus £0.7m offset in reserves

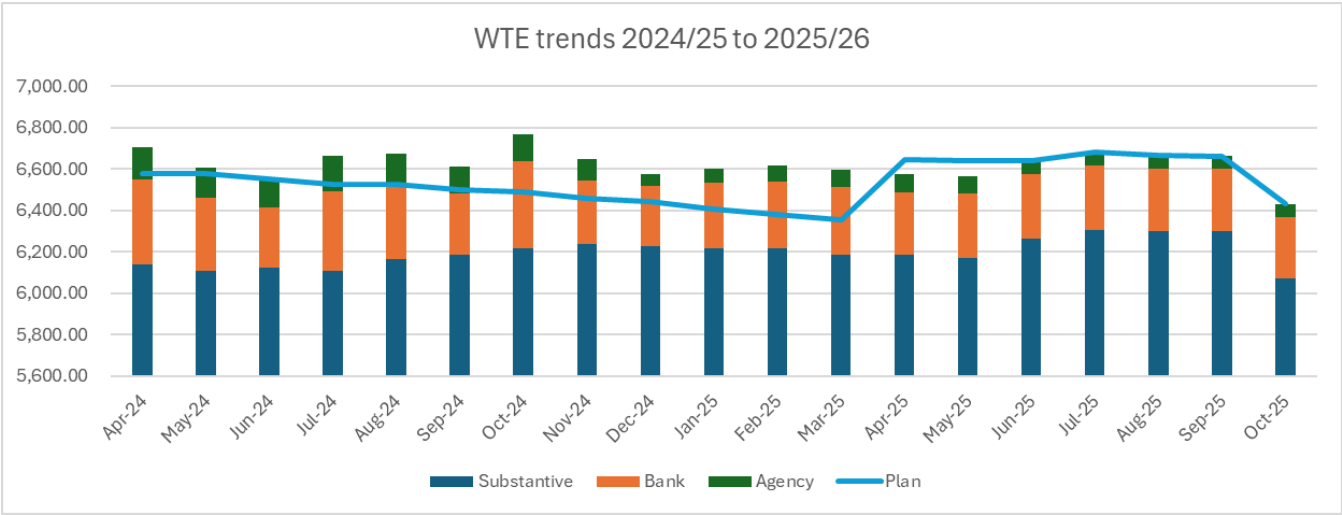
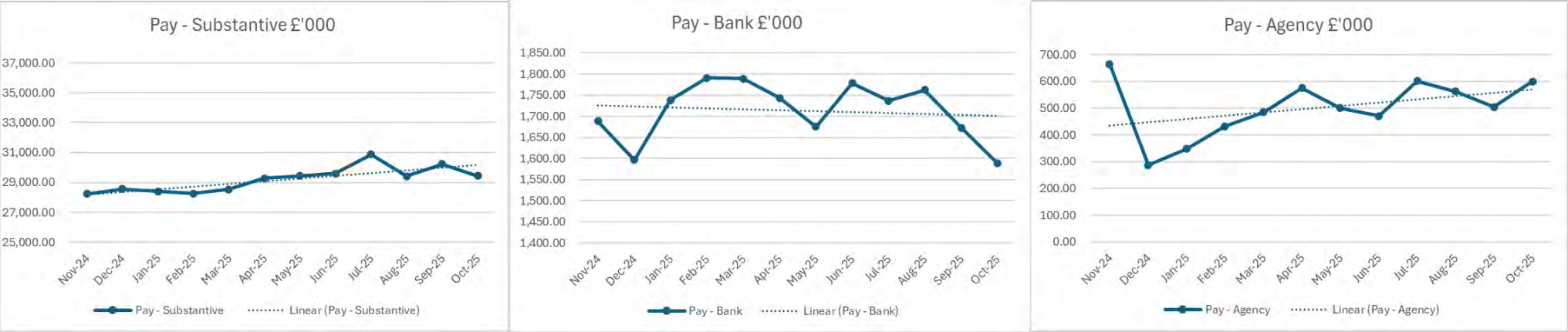
Reserves & Other Income (inc Finance costs) : YTD is £2.5m higher than plan due to the trust not received the deficit support funding in October. Forecast £6.3m lower than plan being reserves £8.2m (including delivery of further mitigating run rate improvements from recovery plan), finance costs £1.0m, offset with lower than plan income £2.9m

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	(207.1)	(208.3)	(1.2)	(349.2)	(355.9)	(6.7)	6,069	6,264	(194)
Pay - bank	(11.4)	(12.0)	(0.6)	(19.3)	(18.7)	0.6	298	307	(9)
Pay - agency	(4.2)	(3.8)	0.4	(7.1)	(6.1)	1.0	63	96	(33)
Grand Total	(222.6)	(224.1)	(1.5)	(375.6)	(380.8)	(5.2)	6,430	6,666	(235)

- As at end October there are 235WTE higher than plan. This is due to the phasing of an additional 230 WTE reduction expectation in the CIP plan at M7. The plan has however been updated with a revised delivery target of c107WTE through workforce controls, and with further additional efficiencies expected in non pay and income as part of the recovery action plan.
- The YTD financial position £1.5m higher than plan for overall pay costs, mainly with substantive posts higher than plan £1.2m due to efficiency programme phasing and medical staffing pressures.
- Forecasted year end over expenditure of £5.2m is due to efficiency programme phasing and continuing medical staffing pressures.

Month 7 – Rolling Worked WTE and Pay Run Rate Trends



Non-Pay Summary

Description	M7				YTD M7 25/26				Financial Year			
	PY 24/25	CY 25/26			PY 24/25	CY 25/26			PY 24/25	Forecast Outturn 25/26		
	Actual £m	Plan £m	Actual £m	Var +/- £m	Actual £m	Plan £m	Actual £m	Var +/- £m	Forecast Outturn £m	Annual Plan £m	Forecast Outturn £m	Var +/- £m
CNST	(0.8)	(0.8)	(0.8)	0.0	(5.4)	(5.8)	(5.7)	0.1	(9.1)	(9.9)	(9.8)	0.2
Drugs costs	(4.1)	(4.0)	(5.1)	(1.1)	(28.3)	(28.4)	(31.2)	(2.8)	(50.0)	(48.0)	(52.9)	(4.8)
Non-executive directors	(0.0)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	(0.1)	0.0	(0.2)	(0.2)	(0.2)	0.0
Other non-pay operating costs	(5.4)	(6.2)	(6.4)	(0.1)	(38.2)	(43.6)	(42.2)	1.5	(70.6)	(73.4)	(69.6)	3.8
Procurement	(11.6)	(11.3)	(11.5)	(0.2)	(75.4)	(79.3)	(80.9)	(1.6)	(132.8)	(134.7)	(135.8)	(1.1)
Purchase of social care	(9.8)	(9.6)	(9.9)	(0.3)	(64.0)	(67.2)	(68.0)	(0.7)	(110.6)	(113.4)	(116.3)	(2.9)
Financing Costs	(0.1)	(0.2)	(0.1)	0.1	(0.2)	(1.1)	(0.7)	0.4	(0.1)	(2.1)	(1.3)	0.8
Operating Expenditure Non-Pay and Financing Costs	(31.7)	(32.2)	(33.8)	(1.6)	(211.7)	(225.6)	(228.7)	(3.1)	(373.5)	(381.9)	(385.9)	(4.0)

Non-pay YTD **£3.1m** higher than plan:

- Pass through drug costs **£2.0m** offset with income, other drugs **£0.8m** (rheumatology, general surgery, outpatients, labs)
- Procurement and Other Non-Pay Operating costs **£0.1m** higher plan comprising EPR **£1.2m** (offset with income), pass through devices **£0.4m** (offset with income), other Corporate costs **£0.7m** (insurance, procurement transformation, people digital and NHP), offset with lower than plan ERF **£1.1m** (costs are in pay), workplace utilities **£0.3m**, Care Group other non pay **£0.4m**, CFHD **£0.4m**,
- Purchase of social care **£0.7m** higher than plan due to an accrual benefit (**£0.8m**), offset by growth in client numbers and complexity **£1.5m**. Finance costs **£0.4m** lower than plan

Non pay forecast is **£4.0m** higher than plan after expected run rate improvements from the recovery plan **£4.6m**. The underlying position of **£8.6m** higher than plan relates to:-

- Pass through drug costs **£3.0m** (offset with income), other drugs **£1.8m** (rheumatology, general surgery, outpatients, labs)
- Procurement and Other Non-Pay Operating costs **£1.9m net** higher than plan excluding **£4.6m** recovery plan run rate improvements:-
 - EPR costs **£1.9m** and Pass through devices **£0.7m** higher than plan (both offset with income)
 - Corporate - under delivery CIP **£1.8m**, non pay costs **£1.3m** higher than plan (insurance, procurement transformation, people digital and NHP). Care Group other non pay costs higher than plan **£0.6m** (supplies, services, consumables)
 - Planned Care lower than plan **£3.6m** being over delivery non pay CIP **£1.4m** (offset with under delivery income), ERF **£1.9m** (offset with ERF pay costs), other miscellaneous non pay **£0.3m**
 - CFHD & risk share **£0.9m** lower than plan
- Purchase of Social Care **£2.9m** higher than plan due to growth in client numbers and complexity.
- Finance costs lower than plan **£0.8m**, CNST **£0.2m**

ERF Income Position against 19/20 Baseline

Care Group	M7 Income 19/20 £m	M7 Income 25/26 £m	M7 Income Variance £m	M7 Income Variance %
Planned Care and Surgery	32.4	35.6	3.3	110%
Medicine and Urgent Care	6.4	9.4	3.0	148%
Families and Communities	4.0	4.9	0.9	123%
Grand Total	42.8	50.0	7.2	117%

- The table shows the M7 position against the 24/25 version of the 19/20 ERF baseline adjusted for number of working days and the 25/26 tariff uplift. The 19/20 numbers will be updated once the 25/26 version of the 19/20 baseline is released.
- If income per working day remains at current levels (with the exception of December when historically working day income is lower) the year end forecast will be 114% against the 19/20 baseline. Improvements in outpatient procedure coding are contributing to this position.
- The Trust is recurrently funded to deliver 110% of 19/20 baseline elective activity. To meet the national requirement of 5% improvement in RTT performance, the Trust must deliver 114% for which it has received a further £2.8m in variable funding.

Productivity Metrics (national data) – M4 25/26 vs M4 24/25

M4	vs M4 24/25	Movement from M3
Inflation adj. expenditure growth	2.27%	0.47%
Cost weighted activity growth	1.95%	-0.35%
Implied productivity growth	-0.32%	-0.82%

- National productivity data is produced every month in 3 monthly arrears. Implied productivity is tracked against prior year figures to demonstrate improvements in productivity once accounting for increases in funding.
- As at month 4, implied productivity is worse than 24/25 by 0.3% (M3 0.5% better).

Implied productivity metric indicates significant opportunity and a challenge to return to pre-covid levels of productivity. Work to understand this in more detail and to replicate the calculation at specialty level is underway along with collaboration and learning with colleagues at NHSE region and Trusts across the region.

As part of the Trust approach to planning for 2026/27, work has begun on drafting productivity data packs at specialty level. These will be linked to the work on Service Line Reporting and can be used in that work to inform and support development of a pipeline of financial improvement projects and CIP schemes which can underpin operational planning. It will be necessary to consider the impact of the new EPR on counting and coding of activity as the productivity work progresses.

Cash Position – Month 7

	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	(7.3)	(10.1)	(2.9)	(1.7)
Capital Non-Cash movements (depr&amort)	13.1	13.1	(0.0)	23.6
Working Capital Movement	16.3	(9.1)	(25.3)	(21.9)
Net cash generated from / (used in) operations	25.4	20.6	(4.8)	26.7
Net Capital Expenditure (Purchase/Disposals)	(38.3)	(10.3)	28.0	(59.3)
Interest Received	0.6	1.0	0.3	1.5
Net cash generated from/(used in) investing activities	(37.7)	(9.3)	28.4	(57.8)
PDC paid/received	20.4	0.3	(20.1)	42.9
Loans paid/received	(1.0)	(1.0)	0.0	(2.0)
Capital on finance leases and PFI	(3.0)	(2.6)	0.4	(5.1)
Interest element on loans, finance lease and PFI	(1.4)	(1.2)	0.1	(2.2)
Net cash generated from/(used in) financing activities	15.1	(4.5)	(19.6)	33.7
Closing cash balance	2.8	6.8	3.9	2.6

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(10.1)
Finance income	1.0
Finance expense	(2.2)
PDC dividend expense	(3.3)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(14.6)
Capital donations/grants/peppercorn lease I&E impact	0.4
PFI revenue costs on an IFRS 16 basis	2.3
PFI revenue costs on a UK GAAP basis	(1.9)
TOTAL Provider Surplus/(Deficit) - System performance	(13.8)

The closing cash balance for M7 is £3.9m 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 operations is £4.8m below plan, mainly due to a larger than expected reduction in trade payables driven by payment timing (5 BACS payment runs in October).
- Investing activities show a £28.4m variance, reflecting re-phasing of the capital plan.
- Financing activities show £20.1m variance primarily due to little PDC drawn to this date - changes to the split of EPR payments amongst the Devon Trusts has delayed the timing of when PDC can be claimed.

Cash Risks:

- Non-recurrent deficit support funding for Q3 has been withdrawn (£7.7m). It is anticipated that this will be received in Q4, however this is still to be confirmed.
- There is also a risk of non-delivery of CIP impacting on cash.
- Potential industrial action will impact on a cash balance later in the year.

Cashflow Forecast – Month 7

Start Date 01.11.2025	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
	£000	£000	£000	£000	£000
Cash Balance B/F	7,591	11,946	6,184	9,843	10,448
TOTAL RECEIPTS	69,925	68,118	76,764	68,419	71,462
TOTAL PAYMENTS	(65,570)	(73,880)	(73,105)	(67,813)	(79,298)
NET Movement	4,355	(5,762)	3,659	606	(7,836)
Cash Balance C/F	11,946	6,184	9,843	10,448	2,613

The Month 7 cashflow forecast has been prepared based on the following basis:

- Withheld Q3 Deficit Support Funding of £7.7m will be received in Q4, but this has yet to be confirmed.
- The application for £8m PDC Revenue Cash Support has been successful and will be received on 17th November.
- The capital plan and associated funding sources remain as per the M7 capital plan including £3.4m 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 7

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	294.6	264.4	(30.3)
Other Non-Current Assets (Receivables)	4.0	4.1	0.0
Cash & Cash Equivalents	2.8	6.8	3.9
Working Capital (excl cash)	(25.1)	(46.9)	(21.8)
Non-Current Liabilities (Loans/Leases/Other)	(54.6)	(51.7)	2.9
Total Assets Employed (Assets + Liabilities)	221.8	176.6	(45.2)
Public Dividend Capital	302.5	280.6	(21.9)
Revaluation	61.0	60.7	(0.3)
Surplus / (Deficit) Sub Total	(12.7)	(14.6)	(1.9)
I&E reserves	(129.0)	(150.0)	(21.0)
Reserves Total	221.8	176.6	(45.2)

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(10.1)
Finance income	1.0
Finance expense	(2.2)
PDC dividend expense	(3.3)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(14.6)
Capital donations/grants/peppercorn lease I&E impact	0.4
PFI revenue costs on an IFRS 16 basis	2.3
PFI revenue costs on a UK GAAP basis	(1.9)
TOTAL Provider Surplus/(Deficit) - System performance	(13.8)

- Fixed Assets are lower than plan **£30.3m** due to re-phasing of the Capital Plan. However, it is expected that the year-end position is still expected to align closely 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 **£3.9m** higher than plan, explained in detail in cashflow report.
- Working Capital (excl cash) variance of **£21.8m** is mainly explained by a £12m variance in deferred income, related to timing differences, and £8.1m reduction in debtors outstanding due to lower debtors' days and DSF.
- Loans and Leases liabilities are **£2.9m** lower than plan, due to a reduction of leasing in favour of outright purchase.
- PDC capital drawdown to the end of M7 is **£2.23m**, £17m behind the plan due to schemes' dependencies on other Trusts and re-profiling between organisations and delayed approvals.
- Year-to-date capital expenditure stands at **£11.5m**, (plan £23.5m, delay due to National Schemes spend).

One Devon– ICS position (reported 1 month in arrears)

As at month 6 the Devon ICS is reporting a year to date £20.8m deficit, £11.1m higher than plan. The forecast for the year end is to breakeven at system level.

Description Organisation	Month 6			Forecast Outturn		
	Plan £m	Actual £m	Var +/- £m	Plan £m	Forecast £m	Var +/- £m
Devon ICB	4.0	10.6	6.6	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	(0.5)	(18.2)	(17.7)	0.0	0.0	0.0
Torbay and South Devon NHS FT	(11.0)	(10.9)	0.1	(8.0)	(8.0)	0.0
University Hospitals Plymouth NHS FT	(2.5)	(2.5)	0.0	0.0	0.0	0.0
Total	(9.8)	(20.8)	(11.1)	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 6 is as follows:

Section	Assurance	Trend from previous month
Overall assurance	Limited	No change
Financial performance	Limited	Deterioration
Savings and efficiencies	Limited	No change
Financial risks	Limited	No change
Workforce	Limited	No change

Devon Financial Escalation Framework – TSDFT Assessment

Dimension	Measure	RAG thresholds	Month 5	Month 6	Month 7
Revenue Plan Delivery	Year to date revenue variance to plan	Red rating where more than 0.5% adverse of plan operating expenditure Green rating where on, or favourable to plan	0.0%	0.0%	-0.6%
	Year to date revenue variance to plan, excluding the impact of loss of DSF	Red rating where more than 0.5% adverse of plan operating expenditure Green rating where on or favourable to plan	0%	0%	0%
	Forecast revenue variance to plan	Red rating where more than 0.5% adverse of plan operating expenditure Green rating where on or favourable to plan	0.0%	0.0%	0.0%
	Forecast revenue variance to plan, excluding the impact of loss of DSF	Red rating where more than 0.5% adverse of plan operating expenditure Green rating where on or favourable to plan	0%	0%	0%
Efficiency Programme	Percentage of efficiency scheme value unidentified	Expectation of £nil from M04	0.0%	0.0%	0.0%
	Percentage of efficiency schemes assessed as high risk	Red rating where more than 20% of scheme value high risk. Green rating where less than 10% is high risk	22%	7%	2%
	Percentage efficiency delivery against plan year to date	Red rating where less than 95% Green rating where plan value achieved or exceeded	116%	116%	107%
	Percentage forecast recurrent efficiency delivery against plan	Red rating where less than 95% Green rating where plan value achieved or exceeded	93%	75%	76%
Cash Management	Forecast cash support required from the System	Green rating where none Red rating where required	Permanent	Permanent	Permanent
Capital	Year to date charge against CDEL as a percentage of forecast CDEL expenditure	Green rating where YTD expenditure is within 15% of straight-line profile. Red rating where YTD expenditure is more than 30% variance from straight-line profile	26%	32%	33%
	Forecast capital spend as a percentage of allocated system capital	Red rating where spend is either 10% or 10% less than allocation Green rating where allocation fully utilised	0%	0%	0%

Revenue plan delivery

- YTD position adverse to plan by the value of the withheld DSF funding for month 7.
- Net unmitigated risk is indicated in the PFR at £3.8m
- Assumes full receipt of DSF in forecast.

Efficiency programme

- Improvement in proportion of schemes assessed as high risk.
- The forecast achievement of recurrent savings has deteriorated to 76% of plan.

Capital plan

- Revised indicators highlight the delays to confirmation of funding and of progress of the intended scale of the capital programme in the financial year.
- TSD figures indicate significant back-ending of the capital programme - influenced by implementation of the EPR and regional business case sign-off delays.

Board of Directors

Our Plan for Better Care

Date of meeting	Date report produced
26 th November 2025	20 th November 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 (OPFBC) 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 of evidence for this report.

Through the OPFBC Oversight Group, each workstream has received an overarching Executive Assurance rating aligning to the Board Assurance RAGs to ensure consistent application and understanding of the status of each workstream.

While the overarching objective of the programme is to create the conditions for sustainable improvement and not just deliver financial savings in 2025/26, there is a requirement for the combined outcomes from a number of the workstreams to support delivery of £36.9m of the £41.5m savings required to deliver the annual plan. This report shares the latest position.

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 November 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 progress made during the reporting period with the Board of Directors invited to **Discuss**.
- **Acknowledge** the risks to delivery and ongoing work required to improve our risk position 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, Safety and Patient Experience	Ensuring quality and safety through the improvement plan will be a golden thread.
Leadership and Governance	Leadership and governance programme of improvement will address this objective.
Performance	Performance programme of improvement will address this objective.
People and Culture	People programme of improvement will address specifically our workforce and consistent and transparent communication, and engagement will be established.
Strategy and Business Intelligence	Strategy programme of improvement will address this objective.
Finance	Finance programme of improvement will address this objective but also working collaboratively across all programmes in a triumvirate approach.

Risk: Risk ID (as appropriate)	
Risk	Risk ID
An IIP risk register has been formally stood up in M7. Specific risk IDs are assigned and mitigation assessed to ensure appropriate action.	

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 (OPFBC) 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 November 2025. Further detail is shared in Annex 1.

2. Delivery Update

- 2.1 As part of the cycle of business, workstream leads produce highlight reports against a set of pre-determined key deliverables. These reports are reviewed with Senior Responsible Owners (SROs) to reinforce accountability for progress and performance. Following which they are presented to the OPFBC Oversight Group for scrutiny and constructive challenge.
- 2.2 The Oversight Group continues to foster a culture of constructive peer challenge to ensure assumptions are tested, ambition is appropriately stretched, and opportunities to accelerate delivery are maximised. This approach is reflected in the Group's strengthened requirements for approving requests to extend deliverable timelines, with a focus on identifying root causes, assessing impact, and confirming the actions needed to restore or increase delivery momentum.

- 2.3 An Executive Assurance rating is applied per workstream aligned to the Board Assurance RAGs . Table 1 summarises the status position of November vs October.

Table 1:

Programme / Workstream	Oct 25	Nov 25
Leadership Programme		
1.1 Governance & Assurance		
1.2 Well-Led	Complete	Complete
1.3 Board & Executive Development		
Strategy Programme		
2.1 3-5 Year Strategy		
2.2 EPIC		
2.3 Peninsula Acute Sustainability Programme		
2.4 Adult Social Care		
2.5 Continuing Health Care		
2.6 Child & Family Health Devon		
Performance Programme		
3.1a Elective Care		
3.1b Diagnostics		
3.1c Outpatients Transformation		
3.1d Cancer Services		
3.2 UEC Flow		
3.3a Community Services Redesign (Frailty)		
3.3b Elective Centre of Excellence	Workstream under review	
3.4 Maternity and Neonatal Safety Improvement Programme		
3.5 Managing Our Estate		Under review
Finance		
4.1a Sustainable Financial Improvement Programme Process		
4.1b Sustainable Financial Improvement Programme Delivery		
4.2 Financial Capability & Capacity		
4.3 Managed Services & Subsidiary Company Arrangements		On Hold
4.4a One Devon Shared Services – Finance		
4.4b One Devon Shared Services - Procurement		
People		
5.1 Workforce Plan & Transformation		
5.2 People & Education Capability & Capacity		
5.3 Culture, Organisational Development & Learning		

- 2.4 Following the OPFBC Executive challenge process, several extraordinary Executive meetings were held in November to agree next steps for the PASP and Managed Services & Subsidiary Company Arrangement workstreams. The agreed direction for PASP will be progressed in the next reporting period. The Managed Services & Subsidiary workstream has been formally paused pending national guidance. Work continues to refine the One Devon Shared Services Procurement workstream plan to ensure that the proposed deliverables reflect the required level of ambition. The Managing Our Estates workstream is currently under review.

- 2.5 Informing the overall assurance RAG is the deliverable progress. Of the 149 deliverables that are fully open in the plan to be transacted, 21.8% are categorised as off track and of the 93 deliverables due for completion by the end of October 2025, 61.3% are actually complete. Coaching and support for workstream leads continues to strengthen reporting, with a focus on clearly articulating the root cause of issues, the impact of any delays, the corrective actions being implemented, and the expected timeline for returning to plan.
- 2.6 Risk remains a significant driver of the overall assurance RAG. During the reporting period, 100 risks were recorded on the IIP risk register and shared with the Oversight Group. A further nine new risks were presented and approved by the Oversight Group for formal inclusion in the December reporting cycle. With the exception of Adult Social Care and CFHD, in-month changes to risk scores have been minimal, reflecting the ongoing need for the 'confirm and challenge' approach adopted by SROs and the Oversight Group. The highest-rated risks to delivery are detailed in Annex 1.

3 CIP Delivery Assessment

- 3.1 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.
- 3.2 The Trust has a challenging £41.5m CIP target to achieve in 2025/26, of which *Our Plan for Better Care* contributes £36.9m (Original Plan). Year-to-date (M1–M7) delivery stands at £15.9m.
- 3.3 Table 2 summarises the CIP position by workstream identifying delivery year to date (M1-M7) 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 £6.2m. There remains a further £4.7m 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-M7)	Full Year Delivery	Forecast – Potential and Delivered	Forecast - High delivery risk	Forecast - Medium delivery risk	Forecast - Low delivery risk	Forecast (Including delivered)	Variance between original and forecast
2.4a Adult Social Care/Continuing Health Care	£ 8,062,000	£ - 3,920,932	£ 7,111,175	£ 7,895,703	£ -	£ 784,528	£ 7,111,175	£ 7,895,703	£ 186,297
2.4b Continuing Health Care	£ 2,127,000	£ 1,456,748	£ 2,928,991	£ 3,087,190	£ -	£ -	£ 3,087,190	£ 3,087,190	£ 960,190
3.1a Planned Care – Elective Care	£ 2,000,000	£ 750,000	£ 1,500,000	£ 1,500,000	£ -	£ -	£ 1,500,000	£ 1,500,000	£ 500,000
3.1b Planned Care – Diagnostics DM01	£ 580,000	£ 294,000	£ 504,000	£ 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	£ 1,822,000	£ 984,162	£ 1,252,416	£ 1,391,165	£ 125,000	£ 13,749	£ 1,252,416	£ 1,391,165	£ 230,835
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 1,500,000
4.4a One Devon Shared Services Finance	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
4.4b One Devon Shared Services Procurement	£ 338,000	£ 35,505	£ 87,348	£ 587,348	£ -	£ 500,000	£ 87,348	£ 587,348	£ 249,348
5.1 Workforce Plan & Transformation**	£ 19,387,192	£ 8,512,700	£ 11,449,604	£ 15,646,041	£ 100,000	£ 2,049,043	£ 13,496,998	£ 13,638,744	£ 3,741,151
Total	£ 36,886,192	£ 15,954,095	£ 24,833,264	£ 30,611,447	£ 225,000	£ 3,347,320	£ 27,039,127	£ 28,604,150	£ 6,274,745
*The original plan value for this workstream has increased following the transfer of the LD Hub/SPACE Contract Reduction scheme, which was previously assigned to the Families and Communities Care Group. The scheme has now been incorporated within the 2.4a workstream under Adult Social Care to ensure accurate reporting and programme alignment.									
** Excluding schemes already covered in the workstreams above to avoid double counting.									

4 Conclusion

- 4.1 Considerable effort continues to be applied to enable *Our Plan for Better Care* to be a robust mechanism of monitoring the organisations key priorities. Furthermore, PMO continue to ensure it is a fully embedded programme of excellence supporting with highlight reports, coaching, upskilling and identifying resource needed in key areas. Progress continues to be made reflecting the organisation's shared commitment to addressing its challenges effectively.

5 Recommendations

- 5.1 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 to delivery and ongoing work required to improve our risk position in the core domains.
 - **Take assurance** that the improvement programme is executively owned and is evidencing impact to the organisation's key priorities.

5. Assurance

- 5.1 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



Our Plan for Better Care

Torbay and South Devon NHS Foundation Trust
Novmeber 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. It summarises; a) programme overviews, b) workstream monthly assurance position, c) CIP delivery against applicable workstreams and d) declares the highest risks to delivery highlighting current mitigations in place which have been 'confirmed and challenged' in month. Furthermore, following our monthly highlight reporting, each detailed workstream position can be found in the appendices.



Delivery of the IIP is overseen by the Our Plan for Better Care Oversight Group which is chaired by the Chief Executive. which includes 5 core domains - Leadership, Strategy, Performance, Finance and People (recognising Quality runs as a golden thread through all). 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 improvements necessary 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. Our Plan for Better Care Executive Assurance RAG aligns to the Board Assurance RAGs already in place to ensure consistent application and understanding of the status of each workstream.



RAG definitions are;

Significant Assurance

Satisfactory Assurance

Limited Assurance

No Assurance





High-Level Programme Summary



Leadership Programme

- **Governance & Assurance (Limited Assurance):** Well-Led actions mapping completed, with wording aligned to deliverables for consistency and triangulation. While some targets remain outstanding due to delays in receiving the Well-Led report, adherence to the plan ensures prioritisation of actions at pace to drive necessary improvements. Finance metrics for the refreshed IQPR will be finalised by end of November, supported and signed off by the CFO for inclusion in the final version. Risk framework review completed; updates, training, toolkit, and DCIQ transition remain on track with external support. Governance framework implementation planned for January 2026 to stabilise the position.
- **Executive & Board Development (Satisfactory Assurance):** Board development proposals are progressing well however, agreement on the Leadership Behavioural Framework compact with the Board is required promptly.

Strategy Programme

- **3-5 Year Strategy (Satisfactory Assurance):** The draft organisational strategy is nearing completion, with minor refinements to follow the forthcoming Board workshop. An extension has been requested to January to enable final approval by the Board.
- **EPIC (Satisfactory Assurance):** Overall progress across the EPIC workstream provides satisfactory assurance, with benefits realisation scheduled for refreshment and alignment. The Estates workstream has escalated to serious status following identification of critical power distribution and fire safety issues. A third-party contractor has been engaged to address compliance, with the SRO leading determination of the critical path.
- **PASP (No Assurance):** An executive meeting is scheduled for 17 November to review the Trust's position. OPFBC has agreed that a robust communication strategy is essential to address speculation surrounding paused service redesign projects.
- **Children & Family Health Devon (Limited Assurance):** Transition to a single provider is confirmed, with ICB decision expected by end of November. Staff consultation scheduled for December; transfer planned by April 2026. Key risks include contracting resource gaps, financial assurance on stranded costs, and clarity on budget impacts. Contracting support is being actively explored to mitigate these risks at pace.
- **Continuing Health Care (Limited Assurance):** Improved governance structures under development following publication of the Model ICB; additional workforce recruited to support delivery of service. Forecast overspend of £1M driven by high-cost placements, despite step delivery over-performing in CIP. Financial risk transfer from April poses significant uncertainty due to potential unsustainable financial burden with unclear hosting model post-April. Immediate priority is to expedite discussions with ICB to agree a future sustainable SLA.
- **Adult Social Care (Limited Assurance):** Transformation plans and KPIs remain under review, with significant capability and capacity challenges. While the CMS project is progressing well, other workstreams are lagging, underscoring the scale of the challenge. The SRO will work closely with the Workstream Lead in month to accelerate critical actions and address gaps.



High-Level Programme Summary (2)



Performance Programme

- **Elective Care (Limited Assurance):** Tactical actions are in progress to reduce the longest waits through focused scheduling and prioritisation. Strategic initiatives progress including MSK physiotherapy redesign, theatre utilization improvements, and striving towards high-volume surgical lists to accelerate throughput. Extensions requested for PTL review and ophthalmology diagnostics due to capacity, but OPFBC challenged timelines for faster delivery.
- **Diagnostics (Limited Assurance):** CDC utilisation improving as are imaging waits currently at six weeks. DMO1 performance rose from 29.4% to 36% attributed to the resolution of previous data-related issues, facilitating better tracking and assessment. CDC contract delays flagged as high risk and escalated for urgent intervention from Director of Corporate Governance.
- **Outpatient Transformation (Limited Assurance):** Progress on the Bookwise system build is ongoing; a manual room utilisation process is currently in place. Centralising outpatient functions has been identified as a critical enabler and a governance paper is being developed to scope suggested structures. This links to EPIC benefits realisation and the digital outpatient strategy.
- **Cancer Services (Limited Assurance):** Rework of deliverables to emphasize transformational improvements has been drafted (including teledermatology, cancer pathways, and MRI/biopsy turnaround times). OPFBC agreed in principle although requested clearer timelines and milestones to bring pace to improvements required.
- **Urgent & Emergency Care Flow (Limited Assurance):** Recent efforts have led to a significant improvement in ambulance handover times, successfully reduced to an average of 33 minutes. This enhancement allows for a strategic shift in focus towards achieving the 4-hour target for patient treatment. The ward optimisation programme has been reinstated, with a baseline assessment currently in progress to facilitate a rapid rollout of improvements. Challenges remain, particularly regarding the risks associated with winter pressures and the management of frailty pathways. Addressing these issues will be crucial to maintaining progress and ensuring the continued quality of care provided to patients.
- **Community Services Redesign - Frailty (Limited Assurance):** The launch of the new service has been delayed due to issues encountered with NHS Professionals. An extension for resolution has been granted, allowing for one additional week to address the outstanding issues. This situation has been escalated to senior leadership for urgent intervention. Associated financial risks have been successfully mitigated and recruitment efforts have yielded successful outcomes, reflecting progress in building the necessary team for the service.
- **Elective Centre of Excellence (Limited Assurance):** Key initiatives refreshed and will focus on theatre accreditation and capital planning to optimise resource allocation for sustainable development. This cohesive approach will drive performance and improve community engagement, enabling the organisation to effectively address emerging challenges and opportunities. There has been success in securing a NED sponsor who will now be aligned fully to the workstream.
- **Maternity & Neonatal Improvement (Satisfactory Assurance):** The first Perinatal Improvement Board meeting was held, and a governance framework has been drafted. Significant progress towards meeting the 10/10 CNST safety standards by March is being achieved; however, Safety Action 8 (focused on education) is at risk due to low attendance in anaesthetist training. This has been escalated for additional support. A workforce uplift of 1.8% to 3.8% is currently under review by the board, and safety improvements in the theatre are planned for January. A request to shift to bi-monthly reporting to OPFBC was denied ensuring the organisation maintains monthly oversight internally for continued assurance and continued bi-monthly assurance to our external stakeholders.
- **Managing our Estate (Limited Assurance):** Workstream under review in M7.

High-Level Programme Summary (3)

Finance Programme

- **Sustainable Financial Improvement Programme Process (Satisfactory Assurance):** Most deliverables are complete or on track, and CIP governance oversight arrangements are confirmed and functioning. Work on Service Line Reporting (SLR) has commenced; however, progress is slower than anticipated due to constraints arising from the planned finance restructure, limited engagement from clinical operational teams, and overall capacity challenges. The rollout is currently prioritised for higher-risk specialties. Delays in clinical team responses have been noted, with actions underway to accelerate engagement and drive momentum. Efforts are also focused on embedding SLR within financial management processes and ensuring full involvement of Finance Business Managers (FBMs).
- **Sustainable Financial Improvement Programme Delivery (Limited Assurance):** The workstream remains broadly on track, with delivery progressing well. However, a few high-value items such as capitalisation initiatives and the transfer of debt to adult social care are still outstanding. These actions are time-sensitive and must be finalised promptly to mitigate risk escalation. Enhanced assurance processes are now in place through joint reviews with Finance and PMO, supported by strengthened governance and tracking mechanisms. A review of future deliverables will be incorporated into the planning cycle for 2026/27, with the first executive session scheduled for 24 November.
- **Finance Capability & Capacity (Limited Assurance):** Consultation for senior staff appointments has been delayed due to panel and matching issues. The final job was matched 15th November, and documentation is now being finalised. Consultation is expected to begin w/c 24th November followed by the appointment of senior roles to increase capacity. Work on Level 1 accreditation will commence in the coming month. PDRs should continue despite capacity challenges; FBMs have completed their tasks, but follow-up is required to ensure full compliance.
- **Managed Services & Subsidiary Company Arrangements:** On hold pending national direction; likely deferred to 2026–27.
- **One Devon Shared Services Finance (Satisfactory Assurance):** Overall, the workstream remains on track and is progressing well. The focus continues to be on detailed activities such as charts of accounts and related implementation tasks, aligned with the programme's gateway and go/no-go process. A post end-state hosting risk has been identified as missing from the current risk register and will be added to ensure appropriate oversight.
- **One Devon Shared Services Procurement (Limited Assurance):** Progress remains limited. Shared service delays are hindering planning for next year's programme, and current delivery figures understate actual performance due to unaccounted capita benefits, which will be reviewed. Engagement with care groups and clinical teams is weak; the performance SRO will support escalation. Recruitment gaps within the procurement team are creating resource shortages, and this issue will be escalated to clarify financial implications.

People Programme

- **Workforce Plan & Transformation (Limited Assurance):** WTE stands at 6,671 against a baseline of 6,815. Further data validation is required, alongside a clear evaluation of opportunities to reduce WTE for the remainder of the year. Governance arrangements to monitor staffing controls include weekly nursing meetings and monthly medical meetings. A monthly summary report is now planned for further SRO oversight. Resource constraints within the People Digital and EVA teams have been noted; OPFBC has requested further exploration within these teams to identify next steps. Legislative changes are impacting e-rostering procurement, with escalation to the Finance SRO initiated for additional support.
- **People & Education Capability & Capacity (Limited Assurance):** KPIs have been updated to strengthen governance and refine metrics. Two key deliverables, a revised work plan for People Directorate and policy framework have been rescheduled from November to December to align with strategic workshops planned for 1st and 3rd December. ER long-term sickness has risen from 266 to 339 and formal ER cases have grown from 7 to 10; increased ER capacity through additional team hours has helped improve case closure rates between September and October but this element of the workstream remains high priority. Progress on education policies remains stalled. To address this, an additional Partnership Forum meeting is planned for December to accelerate policy ratification.
- **Culture, OD & Learning (Limited Assurance):** The workstream is on a positive trajectory compared to the initial plan, despite ongoing operational pressures such as winter demand and case backlogs. Cultural insights work has commenced to align workforce experience data with incident reporting, and OPFBC has requested that a formal paper be submitted to the Executive Committee to provide further clarity on this area.

Workstream Progress Summary November

Programme / Workstream	Aug 25	Sept 25	Oct 25	Nov 25
Leadership Programme				
1.1 Governance & Assurance				
1.2 Well-Led			Complete	Complete
1.3 Board & Executive Development				
Strategy Programme				
2.1 3-5 Year Strategy				
2.2 EPIC				
2.3 Peninsula Acute Sustainability Programme				
2.4 Adult Social Care				
2.5 Continuing Health Care				
2.6 Child & Family Health Devon				
Performance Programme				
3.1a Elective Care				
3.1b Diagnostics				
3.1c Outpatients Transformation				
3.1d Cancer Services				
3.2 UEC Flow				
3.3a Community Services Redesign (Frailty)				
3.3b Elective Centre of Excellence			Workstream under review	
3.4 Maternity and Neonatal Safety Improvement Programme				
3.5 Managing Our Estate				Under review
Finance				
4.1a Sustainable Financial Improvement Programme Process				
4.1b Sustainable Financial Improvement Programme Delivery				
4.2 Financial Capability & Capacity				
4.3 Managed Services & Subsidiary Company Arrangements				On Hold
4.4a One Devon Shared Services – Finance				
4.4b One Devon Shared Services - Procurement	New workstream in M6			
People				
5.1 Workforce Plan & Transformation				
5.2 People & Education Capability & Capacity				
5.3 Culture, Organisational Development & Learning				

Workstream Status RAG	
Significant	- Delivery of the 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 achievement of the deliverables and core objective of the workstream.
Satisfactory	- Delivery of the 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 deliverables and the core objective of the workstream.
Limited	- Delayed-delivery of the metrics with some falling below the acceptable standard. - The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. - Delivery cannot be fully evidenced, with some deliverables off track. - 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 deliverables and the core objective of the workstream.
No	- Non-delivery of the metrics with the majority falling below acceptable thresholds. - The organisation is exposed to significant risk (due to non-compliance). - Delivery cannot be evidenced or is behind plan, with majority of deliverables off track. - 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 deliverables and the core objective of the workstream.

Key Updates in Month:

- Both the Managed Services & Subsidiary Company Workstream and PASP workstream convened extraordinary Executive meetings in November to determine next steps. The outputs will be taken forward in the next cycle of business.
- Managing Our Estates workstream is currently under review.
- Work continues to develop the One Devon Shared Services-Procurement workstream plan to ensure the deliverables reflect the required level of ambition

The Improvement Programmes Impact to CIP (M7)

Our Plan for Better Care - Dashboard									
Programme	Original Plan	Year to Date Delivery (M1-M6)	Full Year Delivery	Forecast – Potential and Delivered	Forecast – High delivery risk	Forecast – Medium delivery risk	Forecast – Low delivery risk	Forecast (including delivered)	Variance between original and forecast
Strategy programme	£ 10,209,000	£ 5,377,678	£10,039,838	£ 10,982,893	£ -	£ 784,528	£ 10,198,365	£10,982,893	£ 773,893
Performance programme	£ 5,452,000	£ 2,028,152	£ 3,256,416	£ 3,395,165	£ 125,000	£ 13,749	£ 3,258,416	£ 3,395,165	£ 2,056,835
Finance programme	£ 1,838,000	£ 35,505	£ 87,348	£ 1,174,696	£ -	£ 500,000	£ 87,348	£ 587,348	£ 1,250,652
People programme	£ 19,387,192	£ 8,512,760	£11,449,684	£ 15,646,041	£ 100,000	£ 2,049,043	£ 13,496,998	£13,638,744	£ 3,741,151
Total	£ 36,886,192	£ 15,954,095	£ 24,833,264	£ 30,611,447	£ 225,000	£ 3,347,320	£ 27,039,127	£ 28,604,150	£ 6,274,745

CIP Workstream Summary Dashboard									
Workstream name	Original Plan	Year to Date Delivery (M1-M7)	Full Year Delivery	Forecast – Potential and Delivered	Forecast – High delivery risk	Forecast – Medium delivery risk	Forecast – Low delivery risk	Forecast (including delivered)	Variance between original and forecast
2.4a Adult Social Care/Continuing Health Care	£ 8,082,000	£ 3,920,932	£ 7,111,175	£ 7,895,703	£ -	£ 784,528	£ 7,111,175	£ 7,895,703	£ 186,297
2.4b Continuing Health Care	£ 2,127,000	£ 1,458,746	£ 2,928,661	£ 3,087,190	£ -	£ -	£ 3,087,190	£ 3,087,190	£ 960,190
3.1a Planned Care – Elective Care	£ 2,000,000	£ 750,000	£ 1,500,000	£ 1,500,000	£ -	£ -	£ 1,500,000	£ 1,500,000	£ 500,000
3.1b Planned Care – Diagnostics DM01	£ 580,000	£ 294,000	£ 504,000	£ 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	£ 984,152	£ 1,252,416	£ 1,391,165	£ 125,000	£ 13,749	£ 1,252,416	£ 1,391,165	£ 230,935
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 1,500,000
4.4a One Devon Shared Services Finance	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
4.4b One Devon Shared Services Procurement	£ 338,000	£ 35,505	£ 87,348	£ 587,348	£ -	£ 500,000	£ 87,348	£ 587,348	£ 249,348
5.1 Workforce Plan & Transformation**	£ 19,387,192	£ 8,512,760	£11,449,684	£ 15,646,041	£ 100,000	£ 2,049,043	£ 13,496,998	£13,638,744	£ 3,741,151
Total	£ 36,886,192	£ 15,954,095	£ 24,833,264	£ 30,611,447	£ 225,000	£ 3,347,320	£ 27,039,127	£ 28,604,150	£ 6,274,745

*The original plan value for this workstream has increased following the transfer of the LD Hub/SPACE Contract Reduction scheme, which was previously assigned to the Families and Communities Care Group. The scheme has now been incorporated within the 2.4a workstream under Adult Social Care to ensure accurate reporting and programme alignment.

** Excluding schemes already covered in the workstreams above to avoid double counting.

The Trust has a challenging **£41.5m** CIP target to achieve in 2025/26, of which *Our Plan for Better Care* contributes **£36.9m** (original plan). Year-to-date (M1–M7) delivery stands at **£15.9m**, with full year delivery of **£24.8m** and a forecast of **£30.6m**.

The dashboard opposite summarises the CIP position by programme and further by workstream highlighting a remaining variance of **£6.2m**. There remains a further **£4.7m** CIP outside the IIP being monitored through other governance.

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 full financial review meetings (incorporating CIP), chaired by the CFO.



Highest Risks to Delivery

Definitions

Movement in month – Key:

★	New Risk	↓	A decrease in risk score
↔	The score remains the same	↑	A rise in risk score

Highest risks to delivery in this reporting period:

Workstream & Risk Reference	Risk Description	Initial Risk Score	Mitigations	Current Risk Score	Risk Trend
3.5-02 Managing Our Estate	Risk: Critical Infrastructure failure. Cause: Inadequate capital investment available to deliver estates strategy and improvements required. Consequence: Significant harm to patients and workforce.	25	1) Implementation of Estates improvement programme to increase reactive and proactive maintenance capacity, including working through workflow via daily SITREP to prioritise technical resource where most needed. 2) Working closely with Care Group Clinical Governance Leads to understand estates incidents including impact to patients and workforce to enable team to prioritise resource where needed. 3) Ensuring Trust Capital programme recognises estate need in priority order. 4) Commission of 6 facet condition survey to support management of estate risks undertaken. 5) Ensuring maintaining estate within HTM regulations / guidelines and seeking to improve maintenance aligned to industry standards. 6) Recruiting competent estates workforce who can deliver to industry standards. 7) Access to Authorised Engineers (AEs) to provide independent compliance oversight.	25	↔
2.3-01 PASP	Risk: There is a risk that the PASP will fail to achieve intended outcomes or deliver measurable impact for the TSDFT and its partners. Cause: The PASP has a wide scope and significant ambition, but delivery resources, supporting infrastructure, and organisational alignment are insufficient. Consequence: This could lead to wasted investment, loss of partner confidence, reputational damage, and missed opportunities to drive system improvement.	20	1) Encourage PAPC and system partners to prioritise developments, clarify aims and ensure resources align with ambitions. 2) Refocusing PASP on TSDFT Strategic Priorities.	20	↔
2.4a-03 Adult Social Care	Risk: The departure of Channel 3 consultants at the end of September will leave insufficient resource to deliver planned change. Cause: Reliance on external consultancy support, with limited internal capacity or handover arrangements in place. Consequence: This could lead to stalled delivery, slippage against key milestones, loss of momentum, reduced stakeholder confidence, and failure to realise intended benefits.	25	1) Handover plan agreed with senior management; checklist to be produced. 2) Develop a transition plan with Channel 3 to ensure knowledge transfer, identify and secure internal resource to take on delivery responsibilities, explore interim or alternative external support if required, prioritise critical deliverables to maintain progress.	20	↔
2.4a-07 Adult Social Care	Risk: Delivery of the Front Door may be delayed due to project lead resourcing conflicts. Cause: The Project Lead is engaged across multiple major projects, limiting available capacity for the Front Door Project until a detailed delivery plan is confirmed. Consequence: Potential slippage in delivery milestones, reduced focus on key outputs, and slower decision-making or coordination across workstreams."	25	1) Additional project support to be provided post Channel 3 exit 2) Reprioritisation of workstreams to ensure the Front Door receives adequate delivery focus 3) Confirm detailed delivery plan and resourcing requirements to inform longer-term allocation 4) Monitor resourcing pressures via weekly SRO briefings and delivery group oversight	20	↔



Highest Risks to Delivery

Definitions

Movement in month – Key:

	New Risk		A decrease in risk score
	The score remains the same		A rise in risk score

Highest risks to delivery in this reporting period (continued):

Workstream & Risk Reference	Risk Description	Initial Risk Score	Mitigations	Current Risk Score	Risk Trend
3.4-04 Maternity	Risk: Inability to meet CQC Must Do and increase obstetric theatre workforce due to alternative demand needs of the care group responsible for this workforce. This is required to establish a second obstetric theatre team on site to respond to patient need. Cause: Due to the nature of obstetrics, urgent access to an emergency theatre is needed 24 hours a day. Where treatment has been delayed due to lack of availability of access to an emergency theatre. There is a dedicated obstetric theatre in hours but this used four elective sessions leaving six sessions available for emergencies. During the four elective sessions if an additional theatre is required for an emergency, the theatre coordinator will identify the next immediately available theatre. Out of hours there is one emergency theatre available that is fully staffed with a second on call team available to staff an additional theatre if the staffed theatre is already in use. a second on call team would take 20-30 minutes to be onsite and the theatre operational. Consequence: Inability to provide care within nationally recommended timescales, eg Category 1 LSCS within 30 mins and Category 2 within 75 minutes. Any delay may result in life threatening harm to mother or baby."	25	1) Daily morning safety huddle involving obstetrics, anaesthetics and theatre, to include which theatres are available, which theatre could be utilised 2) Review of clinical risk as identified by the delivery suite coordinator and on call obstetrician at each handover 3) Early identification and communication with the MDT of potential requirement of need to access theatre 4) Theatre 10 (Griffin Suite) available Monday all day, Tuesday-Friday pm for emergency obstetric use. 5) In the event of needing a theatre outside of these hours ceasing the elective list if no alternative theatre free. 6) SOPS in place to support obstetric MDT in activating the emergency theatre team, theatre and enabling access to theatre in and out of hours. 7) Weekly audit of Cat 1 and 2 decision to delivery times. 8) Matron for in patient services and Matron for Theatres meeting monthly to review Cat 1 and 2 and communication. 9) Significant work has been put in place to mitigate this risk inc. training and recruitment plans for theatre operating practitioners to be increased. Regular meetings between Theatres & Maternity to agree next steps in ongoing. 10) Progress being overseen by MNIP programme and reported to region.	20	
5.1-06 Workforce Plan & Transformation	On-call Review- Will increase cost expenditure with pay arrears circa £300k plus ongoing cost pressure	20	1) Full review of on-call to ensure appropriateness of those depts participating in on-call arrangements	20	

- During this reporting period 100 risks were recorded on the IIP risk register & shared with OPFBC.
- 6 of these risks are currently scoring 20 or above.
- All Adult Social Care risks reviewed as per request for OPFBC with 2 still remaining at scoring 20.
- 1 risk was closed in month for the Sustainable Financial Improvement Programme Delivery workstream as per approval in the last reporting period and 2x risks reduced residual scores for Child & Family Health Devon.
- 9 new risks was identified and presented to OPFBC in month (1x 3-5 year strategy, 1x Adult Social Care, 4x Community Services (Frailty), 1x Elective Centre of Excellence & 2x Workforce Plan & Transformation). These new risks will be formalised for December reporting.
- Please see Appendix B for the full detailed IIP Risk Register.



Appendices

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.

Building a
Brighter
Future

Governance & Assurance

NHS

Torbay and South Devon

NHS Foundation Trust

Delivered
✓ The Board development session to progress implementation of the streamlined governance model was held on 29 October 2025 with the Board agreeing a number of actions for implementation. Work has commenced to implement these and to work with key stakeholders. ✓ All TSDFT current and relevant committee documentation, including ToRs, are collated and available via the Trust's Website. Structures can also be found on ICON. Governance Summit held on 07.10.2025 and future Governance Delivery Group meetings are in place. ✓ Drafting of the onward delegation framework is underway, delayed slightly due to competing priorities from the Insightful Board Review, but now being prioritised to support implementation of the new governance model. ✓ The mid-year review of the Risk Management Framework was completed and development of refreshed risk management framework, training, including a risk toolkit and proposed transition to DCIQ, remain on track and supported by external resource ✓ Data feeds for the Balanced Scorecard in some areas became automated, agreement was made on fixing the scope of automation to enable a lock down by end of November with an acceptance that some manual intervention will remain. The process to move toward balanced scorecard use and away from paper report has included briefing the COO and is aligned with ExCo's review and agreement of proposal. ✓ Wider review of governance arrangements identified misalignment between meeting schedules and reporting timelines. Recommendations have been made to strengthen governance continuity and assurance, with further discussion required with the Director of Corporate Governance.

Next Steps
Following the October 2025 Board Development session will be critical to transition from framework development to implementation: • embedding of the revised governance, risk, and reporting structures both practically and in core governance documentation; and • producing a Board development programme

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 (Board Assurance Framework) 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). Follow up on 24/10	↔
% Risk Management Training undertaken	0	>90% Q3 26/27	Training data not available yet meeting Education team 06/08 to progress. Not due for delivery yet	↔
Refreshed IPQR, aligned to best practice with robust governance applied	Existing	Refreshed version ratified	Off-track -recoverable	↔

Risk	Mitigation
No new risks have been added to the current workstream.	

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	Limited



Board & Executive Development



Torbay and South Devon
NHS Foundation Trust

Delivered

✓

The Workstream is progressing well, with the completion of Deliverable 4: Define and implement Board development sessions for 25/26.

✓

The whole day development sessions for Board scheduled for 24 and 29 October 2025 completed and well-led recommendations embedded into milestones with development topics defined. A Paper was developed for consideration at Board Development on 29/10/2025 and signed off.

✓

CSPO substantive recruitment process has completed, and the CFO and CPO planned end date is March 2026 with interims in post

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 (Board Assurance Framework) 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). Follow up on 24/10	↔
% Risk Management Training undertaken	0	>90% Q3 26/27	Training data not available yet meeting Education team 06/08 to progress. Not due for delivery yet	↔
Refreshed IPQR, aligned to best practice with robust governance applied	Existing	Refreshed version ratified	Off-track -recoverable	↔

Next Steps

➤

Develop the Leadership Behavioural Framework following agreement of the compact with the Board: Communicate behaviours compact to senior leadership team for cascade to teams; Include behaviours compact in all Board and Executive development sessions; Identify gaps in behaviours and develop learning session to address the gaps; Include leadership framework and behaviours compact in 360 feedback and yearly appraisals

Risk	Mitigation
No new risks have been added to the current workstream.	

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	Satisfactory

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 workstream overall status is satisfactory as there is a minor delay in one deliverable which can be mitigated as indicated in the newly added risk ✓ The Trusts draft strategy was shared with the Board in w/c 20th October, and a Board Development Workshop focussed on the strategy was facilitated on 24th October. ✓ A set of amendments and actions have been taken away from the Board workshop, and it was agreed that further time would be required to complete the strategy. Now aiming for completion in Jan 2026. ✓ New risk, supported by OPFBC Oversight Group, has been identified regarding extending the strategy development process and will be formally added to the risk register for the next cycle of reporting.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Ratification of final strategy by Board	N/A	Oct 2025	Expect completion by Jan 2026	↓
Commence strategy communications with organisation and relevant information available online and through other relevant channels	N/A	Nov 2025	Expect to commence communications about draft strategy in Nov	↔

Next Steps
➤ Further updates to the strategy document following board development workshop ➤ Focus on financial elements of the strategy and relationship with other financial/transformation plans – forming explicit links as appropriate ➤ Involvement of governors, and revisiting and progressing the strategy engagement plan

Risk	Mitigation
Cause: Board may decide to extend the strategy development process. Impact: Will delay development process and adoption of strategy	Close communication with Board alongside response to actions agreed at Board workshop on 24/10/25.

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	Satisfactory



EPIC



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The Epic programme remains at an overall status of good, with steady progress made across major workstreams and clear next steps identified for key risks. The current program status score of 8/10 compares favourably with the average Epic site score of 6.8/10 for this stage of the program. ✓ The first critical process of the Manager Pack activities (Manager Validation Process) has gone extremely well. This process typically takes up to 4 months to complete and is currently reporting 96% compliance after less than 5 weeks of excellent engagement from our Care Group teams. Alongside this process c.800 members of staff have been enrolled as Super – Users and registration for Super-User training has begun. Of note; c.30% of our Nurse managers have enrolled as Super Users, this is a very positive development that will create strong organisational foundations before, during and after go-live. ✓ Excellent progress has been made with full-scale data validation which commenced on 8th September moving from “Good” to “Excellent”. Round 1 was completed ahead of schedule on 21st October. ✓ Critical appointments to the Beacon team means the capacity to deliver and validate the 780 treatment protocols has now been secured. There will continue to be close monitoring of activities against Beacon build and validation to ensure progress is maintained at the required pace. ✓ Estates continue to investigate the electrical load and fire safety risks associated with EPR Implementation. 3rd party contractors have been engaged to support this work. COO is maintaining Exec oversight of progress. ✓ The oversight group received the escalation regarding the admin review and outpatients review and heard that the implications are to be fully scoped and a plan agreed to maintain planned progress against each deliverable.

Next Steps
➤ The ‘User and System Readiness’ phase continues up to Jan 23rd 2026. In the next month our priorities will include the completion of: Activity planning over Go-live; Registration for Super – User training; Plans for our 120 Day GLRA (9th December) and FD Stage 4 review (12th November); Plans to support RNOH Go-Live; Completion of our assessment of fire safety risks and HRB approach; Continuation of progress in round 2 of our Full - Scale data validation

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	Benefits remains “Good” Work on developing Benefits profiles continues, along with identification of emergent benefits. Re-baselining activity has been undertaken, and benefits dashboards will be reported to ISG for the first time in October. A paper on how Admin and OP benefits from the FBC will be blended with our admin and managements reviews has had air-time at ExCo and meetings are planned in week beginning 27 th Oct to plan the program of work.	↔
Quality & Safety indicators	To be confirmed a month before go-live	TBC prior to rollout	Quality and safety is embedded in Epic as a product, and within our Programme by CxIO overview.	↔
Patient & staff experience	Latest patient staff experience report	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	Will be informed by go-live activity plans	TBC prior to rollout	Discussions on elective activities and how the Easter weekend will be handled from a UEC perspective have begun and will be concluded in October	↔
Training for Trainers	Baseline is 0 to be trained trainers	49 trainers by 30 November 2025	All 49 trainers have been identified, and the schedule of training has been shared with Care Groups and the STS trainers.	↔

Risk	Mitigation
No new risks have been added to the current workstream.	

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	Satisfactory



Peninsula Acute Sustainability Programme



Torbay and South Devon
NHS Foundation Trust

Summary Position
✓ Work to achieve the specific deliverables of this workstream has not progressed, therefore there is no assurance. The outcome of the escalation in which a Board level discussion was recommended to reconsider our Trust position and requirements of PASP, was agreed at Oversight and the escalation held on 17.11.2025. The output will be taken forward in the next reporting cycle. The following high-level updates were received to the Private Board of Directors on 29.10.2025 from a report produced on 30.09.2025: ✓ Stroke: Plans to establish a 24/7 mechanical thrombectomy service at UHP remains on schedule for Q3. Options for on-call rota alongside Somerset are being explored before a Peninsula wide solution can be in place in another eighteen to twenty-four months. Meeting to discuss process for shorter referral forms with community and social care planned for next month. CTP go live date at RCHT confirmed mid-October. ✓ Oral and Maxillofacial Surgery (OMFS) : Following consultant recruitment at Royal Devon University Hospitals NHS Trust, the proposed interim trauma transfer has been stood down. Productivity and demand data are collected which will be used to plan for service reconfiguration options. A workshop is being planned for end of November. ✓ Dermatology: A workshop was held in October to agree priorities for delivery before EPIC implementation. Key areas for improvement including referral and cancer pathways was agreed for improvement over the next six months. Regional workforce planning with HEE and the Cancer Alliance are shaping a sustainable Peninsula-wide model. ✓ Sarcoma: Options appraisal for a Peninsula Oncology Service is underway, assessing twin-centre and consolidated models to ensure clinical quality and resilience. ✓ Urology: A workshop was held in September that agreed outline plans for standardising assessment and diagnostics across acute sites (A&G, pre-investigation, one-stop clinics). Work is focusing on improving access and consistency across emergency and surgical pathways, supported by complete workforce data from three of the four trusts. Further options for service reconfiguration will be explored at the October workshop. ✓ Surgery in Children: Review of out-of-area activity and complex procedures continues, with a triage process for referrals confirmed for implementation by end of October. Work on specialised surgical reconfiguration is paused pending ICB direction. However, data for reconfiguration of elective inpatient activity from the smaller sites is under review.

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.			
Summary Position continued			
✓ Orthopaedics: Activity analysis and best-practice review completed to inform the feasibility of joint replacement centres. Further work is paused while the ICB finalises strategic intentions. ✓ Gynaecology: Trust-level engagement complete and clinical leads established. Demand and capacity analysis has concluded, and a best-practice review is shaping options for consolidating specialist procedures while moving suitable activity into community settings. ✓ PenRAD: Over 32,000 reports completed to June 2025, delivering c.£0.4m savings and reducing outsourcing to 22%. Work continues on a subsidiary delivery model. ✓ Pathology Network: £2.65 m NHSE funding bid approved for histopathology automation; management and commercial cases drafted. Logistics optimisation and benefits mapping progressing. The options for networked model have been narrowed down to two site agnostic options. Next steps are to conclude moderation by the national clinical director of the site retained services and model the saving efficiencies for the options in time for the November boards. ✓ Cancer Alliance: Development of a Peninsula Cancer Strategy underway, with workforce and education planning strengthening delivery capacity.			
Next Steps			
➤ Escalation meeting to be held on 17.11.2025 to reconsider our Trust position and requirements of PASP, was agreed at Oversight and the escalation meeting will be held on 17.11.2025			
Risk		Mitigation	
No new risks			

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	No



Adult Social Care



Torbay and South Devon
NHS Foundation Trust

Delivered	Key Performance Indicators	Baseline	Target	Current Position	Trend
✓ The deliverable relating to the implementation of a new case management (CMS) is broadly on plan. A CMS Configuration document approved by ASC CMS Board and Torbay Council; test strategy developed and approved; test schedule drafted; attendees identified for first phase of CMS administration training. First user acceptance test due to start in Jan 2026. ✓ The review of the integrated operating model of service provision is on track, with an options paper prepared on realignment of functions for the next Section 75 meeting. Concurrently, a discovery phase focused on workforce composition, cost and benchmarking. Externally resourced assignment ended 31.10.2025 but handover to TSDFT is a risk due to insufficient project management resource to continue work at same pace. ✓ Reviewing SLR data progressed with Operational and Finance Teams through October. Finance are unable to complete their analysis until the end of November, consequently, the risk of failing to complete the deliverable by end of November is high and noted in the mitigations. ✓ A detailed plan to deliver the new Practice Model has been developed and initiated in October. The review of practice models has been completed and preferred model has been chosen (3-conversation model) at newly formed Task & Finish group and subsequently approved at ASC Transformation Board on 29.10.25.	Direct Payments: Proportion of adults receiving long-term community support who receive a Direct Payment (%)	KPI Development is part of the development of ASC deliverable plans which are due at the end of November 2025			
	Practice Model: Practitioners trained (%). Share of staff in scope who have completed the practice model training.				
	SLR: Share of total spend with agreed apportionment and mapping. (%)				
	Operating Model: Proportion of roadmap milestones delivered to agreed dates (%)				
	Front Door: Contacts resolved at first point without onward referral (%)				
	Home First: Permanent admissions to residential/nursing care homes per 100,000 of population				
	Forecast out-turn				
Next Steps	Risk	Mitigation			
➤ CMS: continuation of data migration ➤ SLR data analysis by Finance ➤ ASC Practice Model presentation to stakeholders and develop training package for social workers and development of evaluation framework ➤ Detailed plans to be finalised for outstanding deliverables: Timely Interventions; Direct Payments, Front Door and Home First	Risk: TSDFT service desk will not be able to log tickets with System C for resolution. Cause: TSDFT emails cannot be used to log Jira tickets within the System C portal which means that Consequence: It may not be possible to resolve software problems promptly	Work with System C to identify an appropriate way forward, potential options are: Torbay Council manage the Jira tickets Torbay email addresses are provided to TSDFT A generic Torbay Council email address is used by the TSDFT service desk All tickets are logged via phone to System C and emails updates can be routed to TSDFT emails use new email domain (not nhs.net)			

CIP Scheme Name7	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG	Assurance	Rating
Two schemes	£7,981	£7,011	£7,796	(£186)		Executive Sponsor Rating	Limited



Continuing Health Care



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ Progress completing overdue CHC reviews and planning FNC reviews continues with three Band 6 nurses successfully recruited to mitigate this position. NHSE KPI's on 28-day performance (86%) and long waits over 12 weeks (0) all being achieved with TSDFT consistently achieving these mandated KPIs compared with neighbouring organisations. Client numbers are in line with regional conversion rates ✓ Ongoing work to address IT issues across ICB/LA systems and where CHC information to be held and review of CHC model in Torbay linking into case management functions and IT systems ✓ Completion of business planning template work to look at growth across client and finance data and further review of workforce following growth review ✓ Progression of the review of CHC governance and reporting (Deliverable 2) to ensure the Executives and Board are sighted on the CHC service and understand the regulations associated is off-track as indicated in the mitigations. The self-assessment has been completed with the ICB as per the agreed Model, and further work will be required to create a governance structure in the ICB to oversee provider function. Noted also that in the meeting it was agreed that CHC staff to remain employed by TSD which supports the development of the model of provision and structure. ✓ Previous analysis has identified a significant shortfall in income required for the CHC service. Now the operating model has been decided by the ICB, contractual negotiations are needed with ICB to discuss costs and income. The CFO to meet with ICB to negotiate funding. ✓ Market development through operational intelligence progressed regarding enhanced support in care homes (Devon wide) and plans for follow up and a work plan is in place.
Next Steps
➤ Focus on self-assessment with ICB to produce work plan ➤ Strengthen of governance and reporting structure across TSD ICB ➤ Completion of IT project forms

Key Performance Indicators	Baseline	Target	Current Position	Trend
To manage year on year cost growth to be > or equal to 3%	1.4%	356f%	1.4%	↔
No long waiters (over 12 weeks) and 80% of decisions concluded within 28 days	69%	Only those due in month	0	
Reduction in overdue FNC reviews	196	60	230	↔
CIP target reached 25/26	0	£2.2m	£3.2m	★
CHC Forecast (performance against expenditure budget)	£56,085	£56,085	£56,278	New KPI
<u>Expenditure Type</u> CHC Total FNC Interim Funding Adult IIP IPC Pilot	(Original baseline)	(Full Year Budget - After transacted CIP)	Full Year Spend from (Month 7 Financials)	

Risk	Mitigation
No new risks	

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	£2,929	£3,088	£961		Executive Sponsor Rating	Limited



Child & Family Health Devon



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ The primary objective of this workstream is for CFHD Service to be delivered by a single employer safely and in the most cost- effective way. The options appraisal report for a single provider was presented to TSDFT Board and approved. Notice was given to ICB on TSDFT board decision by CPSO on the 29th October 2025. A Programme Director for TSDFT has commenced. ✓ The review of financial implications and provision of assurance report to Finance Performance Committee is delayed but negotiations have commenced. Oversight requested that a CFO assurance statement was agreed. ✓ Engagement with CFHD staff continues and planned decision sharing event planned for 13th November 2025. Staff side are engaged in the CFHD engagement events in preparation for decisions being made and next steps. ✓ IM&T transfer workstream has commenced and completion of transfer is the 31st October 2025. ✓ A consultation plan is in final draft form for discussion with staff side, for consultation to commence on 1st December for a period of 62 days.

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	Baseline not yet confirmed due to awaiting decision about single service provider	30 September 2025	Approved on 29 th October 2025	★
Identify financial risks	Baseline not yet confirmed due to awaiting decision about single service provider	September 25	Delayed negotiations in progress.	↓
Reduce / remove interoperability challenges within CFHD	Baseline not yet confirmed due to awaiting decision about single service provider	3 months post-transfer completion	On track	↔
Agree TUPE transfer of staff to new provider	Baseline not yet confirmed due to awaiting decision about single service provider	March 26	On track	↔

Next Steps

- ICB ratification of single provider decision on 26th November 2025
- Escalation meeting with the COO, CNO, CPO and CSPO be held on 4th November 2025.
- Identify and recruit TSDFT staff member to support contracting decisions
- Complete and understand financial risks and implications
- Staff-side and Stakeholder engagement to commence now TSDFT have agreed decision. Consultation paper to be agreed. Staff engagement to continue post TSDFT decision.
- Dedicated leads from each Trust identified (Stacey Constable for DPT and Sarah Davies for TSDFT). TSDFT programme meetings to be set up led by Sarah Davies from mid-November. Source additional HR/employee relations support

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance £000's
No CIP aligned to workstream				

Risk	Mitigation
No new risks	

Assurance	Rating
Executive Sponsor Rating	Limited

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

- ✓ A more focussed approach to long waiters within T&O has commenced, with patient level detail reviewed on a weekly basis. This has identified some challenges within the service and has allowed planning to get further ahead.
- ✓ Ahead of the launch of 8-6-4-2 in December a number of specialities are now publishing their timetables out at 8-12 weeks. This is enabling the team to get ahead of scheduling in these areas for elective theatres and reduce cancellations due to patients not being ready.
- ✓ The first robotic list and first hernia high throughput list ran during October. Reviews of both are underway to embed learning in future planned lists with the view to improving activity.
- ✓ A review of theatre need for each speciality has been completed. Work will now commence on amending the current theatre timetable to meet this demand.
- ✓ Work on the updated demand and capacity plans is progressing, with strategic workshops underway to review the current position and test key assumptions. This will support a clearer forecast for long-wait clearance through core capacity. A refreshed business case has also been developed to outline the requirements for additional Anaesthetic and Trauma and Orthopaedics consultant capacity to optimise theatre utilisation. This will be presented to the Executive Operational Group in November.
- ✓ In line with Executive direction, Elective Care Workstream has been working to refocus and prioritise transformational change over business-as-usual activity, draft deliverables are in progress.

Next Steps

- Review and refine delivery plans to ensure alignment with the refreshed transformational priorities.
- Develop detailed milestones, dependencies, and decision points for each deliverable.
- Present the updated Plan on a Page (POP) for formal review and sign-off through the SRO and Our Plan for Better Care governance.
- Finalise business case for change for Tairu for MSK physiotherapy relocation.
- Recruit perio-operative coordinators to support preassessment.
- Fix texting service to help support automatic offers to go to alternative providers for T&O, particularly Hip and Knee
- Business case via EOG regarding closing the theatres gap for surgeons and reduce fallow theatres

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 from activity schedule to achieve 114%	£2m	£1.2m	2m	0	

Key Performance Indicators	Baseline	Target	Current Position	Trend
RTT 18 week wait by March 2026	58.56	66.6%	69.0%	★
RTT 52 week wait y March 2026	3.74%	<1% of waiting list	2.1%	↑
Theatre utilisation rates	80%	85%	77.8%	↓
Theatre fallow sessions	81%	85%	83%	↑
Reduce all long waiters over 78 week and 65 weeks	9	0	18	↓
Wait to 1 st activity by March 2026	63%	70.3%	72.2%	★
Validation in the last 12 weeks	38%	90%	90.8%	★
Achieve activity volumes as per Targeted Investment Fund (TIF) business case	18 / 40	25 / 60	This metric is already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	
Achieve Activity vs 24/25 ytd Elective Ordinary	1,640 (last year ytd)	1,907 (plan ytd)	This metric is already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	
Achieve Activity vs 24/25 ytd - Elective Day Case	15,760	15,838	This metric is already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	
Achieve Activity vs 24/25 ytd Outpatient New	44,490	45,381	This metric is already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	
Achieve Activity vs Plan Outpatient Follow Up	121,087	127,929	This metric is already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	
Reduce LCAD in Ophthalmology for Medical Retina and Glaucoma	18%	>5%	This metric is already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	
Activity against plan 19/20 baseline	Activity v 19/20 levels by POD Planned Care	114% of 19/20 baseline	This metric is already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	

Risk	Mitigation
No new risks have been added to the current workstream.	

Assurance	Rating
Executive Sponsor Rating	Limited

Brighter
Future

Diagnostics DM01

NHS

Torbay and South Devon
NHS Foundation Trust

Delivered
✓ ERF backlog planning and C&D analysis are complete, with monitoring now embedded in BAU governance. The milestone remains off track pending financial confirmation for the CDC reporting proposal. ✓ Recruitment of endoscopists needed to exit insourcing remains slow, although tactical options are in place to reduce nursing insourcing as we move into next year. Delivery remains broadly on track, but the financial benefit is now expected to materialise in next year’s CIP. ✓ Significant progress has been achieved, with agreement secured to widen CDC imaging criteria to include more complex cases, particularly MRI. Early data shows improved utilisation of CDC capacity, helping to ease pressure on acute services. All operational actions are now complete, with delivery on track through year end while the team awaits final contract sign-off. ✓ In line with Executive direction, Diagnostics Workstream has been working to refocus and prioritise transformational change over business-as-usual activity, draft deliverables are in progress.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Achieve <5% for 6 weeks diagnostics	35%	5%	36% (Oct 2025)	↔
CT Urgent 2ww - Reporting turnaround time - in days	15	3	12 (Oct 2025)	↑
CT Urgent - Reporting turnaround time - in days	19	5	14 (Oct 2025)	↑
CT Routine - Reporting turnaround time - in days	21	10	17 (Oct 2025)	↑
MRI Urgent 2ww - Reporting turnaround time - in days	8	3	8 (Oct 2025)	↔
MRI Urgent - Reporting turnaround time - in days	19	5	15 (Oct 2025)	↑
MRI Routine - Reporting turnaround time - in days	20	10	15 (Oct 2025)	↑
X-ray Urgent 2ww - Reporting turnaround time - in days	1	3	1 (Oct 2025)	★
X-ray Urgent - Reporting turnaround time - in days	1	5	1 (Oct 2025)	★
X-ray Routine - Reporting turnaround time - in days	2	10	2 (Oct 2025)	★

Next Steps
➤ Progress final sign off of InHealth contract

Risk	Mitigation
Issue: The contract between TSD and InHealth remains awaiting final sign-off.	The litigation team has been engaged to support progress, but completion remains contingent on InHealth issuing the final contract.

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
Endoscopy Workforce Transformation	£80k				Financial benefit 2026/27	Executive Sponsor Rating	Limited
Mobile scanning unit	£500k	£504k	£504k	£4k			

BUILDING A
Brighter
Future

Outpatients Transformation

NHS

Torbay and South Devon
NHS Foundation Trust

Delivered

✓

The outstanding strategic mandate and unresolved governance constraints continue to outweigh progress made on individual deliverables. The mandate for the centralisation of outpatient services is scheduled for submission to EXCO on 10/11/2025. Until this mandate is formally approved and the associated structural issues are addressed through the development of a full business case, the workstream cannot demonstrate full delivery assurance.

✓

New Terms of Reference for centralising the management of outpatients will be developed under the leadership of the Chief Operating Officer, strengthening governance and ensuring a coherent, Trust-wide approach.

✓

The BookWise system is currently in the Build phase, with configuration underway for deployment across key areas including Level 2 Outpatients, Crowthorne, Level 8 Hutchings, H&L, Ophthalmology, and all of Newton Abbot. A total of 125 licences have been allocated, with any remaining licences to be issued to community sites. Go-live is scheduled for February 2026.

✓

Business planning remains on schedule with strong Care Group engagement. Following the workshop on 07 November 2025, the next session is confirmed for 12 November 2025 to continue shaping the approach to strengthening core clinical capacity and reducing reliance on high-cost insourcing.

✓

In line with Executive direction, Outpatients Transformation Workstream has been working to refocus and prioritise transformational change over business-as-usual activity, draft deliverables are in progress

Key Performance Indicators	Baseline	Target	Current Position	Trend
RTT 18 week wait	58.56	66.6%	This metric is already routinely reported through the EOG	
RTT 52 week wait	3.74%	<1% of waiting list	This metric is already routinely reported through the EOG	
PIFU	8%	9%	8.8%	↔
DNA	4.5%	4%	4.9 (Oct 2025)	↓
Cataract market share	62%	75%	62%	↓
% of patients receiving first outpatient appointment in 18wks			This metric is already routinely reported through the EOG	
Advice & Guidance	15.3% (Aug 24)	16%	11%	
Specialties applying GIRFT clinic templates	Still in development.			
Conversion rates			This metric is already routinely reported through the EOG	
New to Follow Up ratios	Still in development.		1:2:4	↓
Coding of outpatients	Still in development			↓
Clinic efficiency (fallow clinics)	Q4		This metric is already routinely reported through the EOG	
Discharged at first appointment	Still in development		28.1%	↑
First Follow Up			This metric is already routinely reported through the EOG	

Next Steps

➤

Finalise and agree detailed milestones for each cancer pathway and infrastructure project within the refreshed POP.

➤

Present the updated POP for SRO and Our Plan for Better Care Oversight Group approval.

Risk	Mitigation
No new risks have been added to the current workstream.	

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
Outpatient transformation	£500k	£0	£0	£-500k	Closed not progressing	Executive Sponsor Rating	Limited

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TSDFT Public Board of Directors-26/11/25



Cancer Services



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ In Dermatology, a new Operational Manager was appointed in October providing additional leadership capacity and supporting progress on pathway changes and delivery oversight. ✓ Improvements in Urology and Lower GI pathways to meet Best Practice Timed Standards including completion of approvals to recruit additional HCA posts in Urology and administrative support in colorectal to increase capacity and recover outpatient waiting times. ✓ Imaging waiting time reductions has improved by utilising additional CDC capacity, an improvement in DM01. ✓ Progress towards replacement and improvement of oncology infrastructure, has been made with the implementation of Mosaiq oncology information system. Together with capital funding approval for a new radiotherapy treatment planning system, which will provide the long-term infrastructure for the continuity of radiotherapy services. However in the short term, a fourth agency radiographer has been secured, improving the treatment capacity in the unit. ✓ Cancer Services is fully engaged with the Care Group Business Planning and participated in all scheduled planning workshops, with the next Business Planning workshop confirmed for 12/11/2025. ✓ In line with Executive direction, Cancer Services Workstream has been working to refocus and prioritise transformational change over business-as-usual activity, draft deliverables are in progress.

Key Performance Indicators	Baseline (June 2025 – submitted figures)	Target	Current Position (October)	Trend
28-day Cancer standard	80.64%	80% (by March 2026)	74.4%	↑
62-day Cancer standard	75.38%	75% (by March 2026)	72.4%	↑
31-day Treatment standard	93.6%	96%	91.1%	↔
62-day backlog	8.9%	< 6%	7.1%	↔

Next Steps
➤ Finalise and agree detailed milestones for each cancer pathway and infrastructure project within the refreshed POP. ➤ Present the updated POP for SRO and Our Plan for Better Care Oversight Group approval.

Risk	Mitigation
No new risks have been added to the current workstream.	

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	Limited

Brighter
Future

UEC Flow

NHS

Torbay and South Devon

NHS Foundation Trust

Delivered
✓ Timely Handover Protocol was fully implemented 24/7 on 6 October 2025 even with growing demand for ED and new peaks of attendance. As a result of the protocol ambulance handovers reduced from 60 minutes in September to 33 minutes in a month that the trust saw a new high in ambulance attendances (2526). ✓ Significant improvement work has been delivered and embedded including testing changes around ambulance handovers, standardisation of roles in ED, utilisation of Fit2Sit, re-direction from triage, Double RAA. The focus of improvement moving forward is the flow on ward and streaming workstreams. Progress has been made in Surgery through a redesign of the Ears Nose and Throat pathway (ENT) and Paediatrics have enhanced a new green pathway. ✓ A key workstream moving into winter period is focused on demand management. The workstream aims to comprehensively review South West Ambulance Service (SWAST), GP admissions, HCP referrals, mental health attendances, and alternative pathways. It will serve as a forum to share and coordinate existing projects, including the X-ray car, fall management, pragmatic head injury protocols, respiratory initiatives, care coordination, and frailty programme.

Key Performance Indicators	Baseline	Target	Current Position	Trend
4 hour performance	70.09	78%	68.01%	↓
Average Ambulance handover time	47 mins	45 mins	33 mins	↑
45 min Max handover per ambulance	659	0	467	↑
No Mental Health patient over 24hrs in ED – Data not available in formal report). Will need to be developed.	8	0	19 (24 hours)	↑
Paeds 4hr Performance 95%	86%	95%	77.9% (Oct)	↑
Max 12 hrs in the ED	8.71% ED	10%	8.1%	↑
No criteria to reside	6.7%	5%	7%	↓
Average pre noon discharges	21.8%	33%	20.1%	↓
Non elective length of stay	To be resolved post deliverable review		5.3 days	
Community Hospital length of stay			14.97 days	↑
ED Conversion rate – Baseline should be 31% for last 6 month			33.2%	↔
Discharges P0, P1 - P3 – Will require formal report				

Next Steps
➤ Embedding THP 24/7 as BAU including review of process and ongoing SOP development ➤ Re-invigorating the ward improvement programme (Care Group meeting already conducted with COO and Deputy COO). ➤ Direct to SRU catheter pathway development ➤ Re-focus on 12 hour long waits in ED ➤ Focus on non admitted pathway, specifically time to clinician in ED. ➤ Focus on post take ward rounds key metrics ➤ Launch internal professional standards as a formal workstream with tangible benefits

Risk	Mitigation
Issue: Delays for mental health patients remain a concern.	Daily escalation in place with DPT and system.

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	Limited

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TSDFT Public Board of Directors-26/11/25



Community Services Redesign (Frailty)



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ The Staff and public engagement process to choose a name for the Newton Abbot Frailty Service attracted 652 responses received. 'The Harbour' has been confirmed as the chosen name.
- ✓ Relocation of midwifery team within Newton Abbot Hospital to Sherbourne House completed 28th October. This enables the relocation of the Frailty Virtual Ward team into this space after the 17th November launch (stage 1 of the programme). Arrangements are pending with couriers and Informatics Technology for the movement and setup of Frailty Virtual Ward equipment at Newton Abbot.
- ✓ Recruitment delayed by 2 weeks with majority of posts now live on TRAC. Bank process remains outstanding. Interview dates booked in preparation and consultation due to end 16th November.
- ✓ Escalation process for Urgent Community Response (UCR) team agreed, Process-mapped, outlining steps, escalation levels, and mitigating actions required to deliver a 0–2 hour response.
- ✓ Three scheduled 'Drop-In Q&A Sessions' for care homes have been completed. Recordings to be uploaded to HIVE. Further sessions planned w/c 3rd November for SWAST, Primary Care, community teams, and acute colleagues.
- ✓ Single IVR routing for telephony access delayed awaiting IT prioritisation. AMU routing decision tree developed to support delay ad BAU transfer to Newton Abbot Community Hospital for appropriate patients.
- ✓ Workforce consultation in progress and due to finish on the 16th November. Staff 1:1's have been booked with the last scheduled on the 13th November.

Next Steps

- Launch Date planned from the 17th November for direct referral (call before convey) activates with Frailty Virtual Ward staff relocated to Newton Abbot Hospital (this requires additional GP resource to enact).
- Implementation of a single IVR telephone solution to support the re-direction of appropriate patients to the frailty clinician on track to receive calls
- Implementing weekly improvement huddles to identify since launch – what has gone well, what has not gone so well and what would be even better if to ensure the service is able to continuously improve its functionality and efficiency.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Reduced ED attendances	4	6	N/A – metric will be reported once dataset becomes available in December/January.	↔
% of CGAs completed	30%	80%	30%	↔
Occupied bed days	140	210	N/A – metric will be reported once dataset becomes available in December/January.	↔
80% of patients seen in the Community Healthy Ageing Hub (CHAH) have a CG	25	80%	N/A – metric will be reported once dataset becomes available in December/January.	↔
Transfer rate from CHAH into the acute setting remains between 10-30% (BGS and Acute Frailty Network standard)	9.03%	10-30%	N/A – metric will be reported once dataset becomes available in December/January.	↔
Reduction in number of care home attendances to ED during CHAH hours of operation that don't require treatment from an acute setting	20	95%	N/A – metric will be reported once dataset becomes available in December/January.	↔
Reduction in number of patients with 3+ acute admissions in their last 90 days of life	TBC	To be established	N/A – metric will be reported once dataset becomes available in December/January.	↔
Readmission rate to acute from beds (and community) – standard 30-day admission rate	TBC	To be established	N/A – metric will be reported once dataset becomes available in December/January.	↔

Risk	Mitigation
Inability to realise financial savings to offset investment to frailty model	Ward closure plan developed for options to close community hospital base or partial close of a ward in TSD
Demand for new frailty model outstrips capacity	Clinical triage process in place and core KPIs established to monitor access and demand
Standard operating procedures delayed beyond service go-live date	SOPS can be used in draft form pending formal sign off
The uptake of bank shifts and the onboarding/local induction of these staff (band 5 nurse, general practitioner, therapist) to the service for the 17 th November.	Request NHSP to complete a target SMS for frailty shifts to promote.

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	Limited



Community Services Redesign (Elective Centre of Excellence)



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ Key enablers such as the establishment of GIRFT accreditation working group are now in place with an identified Non-Executive Director for support ✓ Mitigation planning for theatre downtime arising from the refurbishment is underway, with no risk currently identified to the waiting list, and finalisation of the plan expected by mid December. ✓ Strategic discussions are being taken forward to assess future elective and non elective theatre capacity requirements, including alignment with the capital programme. ✓ A business case has been drafted to deliver additional activity in theatres and will be submitted to EOG for review. It will include options to increase the number of theatres in operation. ✓ A limited number of items remain dependent on external decisions, including national funding confirmation and final service specifications. These dependencies are actively monitored with clear next steps defined. Productivity, job planning information, and evaluation work continue to underpin the development of future business cases

Next Steps

Key Performance Indicators	Baseline	Target	Current Position	Trend
The Ophthalmology proposals would result in the following additional appointments (per yr) Glaucoma MR Cornea	N/A	5,760 4,800 960	Proposals not currently operational	
The OMFS proposals would result in the following additional appointments (per yr) OP appointments Procedure appointments	N/A	10,290 7,392		

Risk	Mitigation
Approval of NHSE capital funding (capital approved for replacement theatres, however OMFS and diagnostic lanes still not approved).	Approvals required

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	Limited



Maternity and Neonatal Safety Improvement Programme


Torbay and South Devon
NHS Foundation Trust

Delivered
First Perinatal Improvement Board (PIB) meeting held successfully; workstream updates provided and a two-month forward plan agreed, additional PIB members identified to strengthen representation and expertise. PIB Terms of Reference and governance framework agreed by PIB members ✓ Overarching workstream goals and golden threads drafted to guide programme delivery; formal approval scheduled for next PIB ✓ Safety standards for Maternity Incentive Scheme (CNST - The Clinical Negligence Scheme for Trusts) - remain on track to meet 10/10 by March 2026. SA8 relating to education is currently not compliant but a plan is in place to achieve compliance which has improved since last month. The main concern is anaesthetist's attendance at PROMPT; however, this is being addressed with the anaesthetic lead consultant for obstetrics; additional mop-up sessions are planned ✓ Birthrate Plus (BR+) Establishment review final report received and decision required from Board regarding uplift percentage, then the current position can then be updated. ✓ Obstetric theatre workforce risk paper has gone to Staffside and is being formally reviewed at the next Partnership meeting on 20 November 2025 and noting on course to roster ODP cover for out-of-hours obstetrics from 26 January 2026. This is not yet the full team, however this is the biggest safety marker in prevention of delay. ✓ Improved Triage model has an agreed start date of 17 November 2025 for estates work and capital funding risk has now been removed from the risk log. ✓ Quality Improvement support delivered to workstreams to clarify priorities, refine activity, and shape project scope for delivery

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	9/10	↑
Birthrate Plus (BR+) Establishment review	100% compliant for most recent report published April 2021	100% compliant by December 2025	See comment below	↔
MSSP Exit Criteria	<20% complete	60% complete by March 2026	<20% complete	↔
A medical workforce to meet service acuity and activity requirements	See September report for update	fully established by end of 25/26	See September report for update	↔
Improved triage model	60% compliant with national standards	100% compliance with national standards by Q3 25/26	60% compliant	↔

Next Steps
➢ Confirm frequency of reporting to OPFBC, following PIB meetings now taking place bi-monthly ➢ Finalise and approve overarching workstream goals and golden threads at the next PIB ➢ Develop KPIs for each workstream, led by Workstream Leads ➢ Develop a meeting planner to support effective oversight of timelines, deliverables, and interdependencies ➢ Workstream Leads to engage with Project Leads to agree project scope, expectations, and next steps

Risk	Mitigation
Issue: Safety standards for Maternity Incentive Scheme (CNST - The Clinical Negligence Scheme for Trusts) SA8 relating to education. The main concern is anaesthetist's attendance at PROMPT	This is being addressed with the anaesthetic lead consultant for obstetrics; additional mop-up sessions are planned

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	Satisfactory

Building a
Brighter
Future

Managing Our Estate

NHS

Torbay and South Devon
NHS Foundation Trust

Delivered
✓ Workstream is currently under review

Key Performance Indicators	Baseline	Target	Current Position	Trend
Enactment of divisional workplan following agreement of next steps set out in assessment report.	Implementation of next steps to start (subject to agreement)	>50% of recommendations that are agreed to be taken forward within timescales agreed with Ex Co	Next steps to agree focus for work.	↔
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	Enacted and underway	↔

Next Steps

Risk	Mitigation
No new risks have been added to the current workstream.	

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
16 Workplace CIP schemes	1,462	1,392	1,586	-185	14	1	1	Executive Sponsor Rating	Limited

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
✓ Further progress has been made in this period and most actions are complete or on track. ✓ Progress is being made on the introduction of SLR and productivity reporting, analysis and support. The draft Productivity Opportunities pack from NHS E has been received and will inform planning workshops and CIP opportunities for 26/27. SLR meetings with Care Groups are scheduled and being held with outcomes from meetings being progressed. SLR reports for quarter 2 in 2025/26 are being developed with Month 6 financial information. ✓ Strengthening finance business partnering support and finance support to SLR/costing/productivity continues to be interdependent with Workstream 4.2 Financial Capability and Capacity workstream. The 30-day staff consultation of the new finance structure has been signed off by Executive Committee but has been delayed due to job matching process. Consultation is now due to commence by end November. ✓ Oversight heard that the governance for CIP oversight has been confirmed following the Board Development session at the end of October. This will be executed through an extended EOG with an updated agenda, implemented as of November and marks the completion of the deliverable pertaining to an updated governance structure for CIP oversight

Key Performance Indicators	Baseline	Target	Current Position	Trend
Introduction of SLR	Reporting unavailable	Reporting available & embedded	Productivity Opportunities pack from NHS E has been received. SLR meetings with Care Groups are scheduled. SLR reports for Q2 in 2025/26 are being developed.	↔

Next Steps
✓ Complete introduction of SLR ✓ Implement finance capacity improvements

Risk	Mitigation
No new risks have been added to the current workstream.	

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	Satisfactory



Sustainable Financial Improvement Programme Delivery


Torbay and South Devon
NHS Foundation Trust

Delivered

✓

PMO has developed a scheme level review process to strengthen CIP assurance and identification of schemes requiring additional support, which has been implemented in November.

✓

Delivery for Month 7 is £3.13m compared to the plan of £4.15m, a variance £1.0m under plan. £18.81m compared to a year-to-date plan of £17.65m, a variance of £1.16m over plan

✓

The forecast outturn (delivered and forecast) is £41.54m against the original plan of £41.54m. A reliance on non-recurrent delivery of CIP will have ongoing consequences in future years and is therefore a key area of focus within the full financial review meetings.

✓

There is evidence of increasing maturity across several workstreams, with some schemes progressing from red to amber and amber to green. Whilst reducing, £0.74m of the forecast outturn remains red RAG rated and will continue to be monitored through PMO and Care Group governance to ensure mitigation.

✓

There are 36 outstanding CIP schemes, 9 unapproved but worked up, with 27 potential opportunities that have been added to Trust-wide schemes. These opportunities are currently being scoped with finance and operational colleagues to develop project outline documents for progression through the CIP governance process.

Key Performance Indicators	Baseline	Target	Current Position (Month 7)	Trend
Total CIP target (£) vs. delivered (£)	£41.5 m	£41.5 m	£28,795,660 transacted full year	↑
% of recurrent vs. non-recurrent savings	79% of plan recurrent	79% delivered recurrent	60.0%	↓
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	Draft received and dissemination for work up	
Total CIP target (£) vs. forecast (£)	N/A	£41.5m	£41.5m	↑

Next Steps

•

List of mitigations for CIP and wider financial risk to be developed further - CIP pods to be drafted and governance progressed as appropriate

•

Approval of outstanding PODS, development of new schemes, converting non recurrent to recurrent all needs further attention

•

Clarify savings estimates from MARS, management review, admin review through the context of 2026/27 planning

Risk	Mitigation
No new risks have been added to the current workstream.	

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
						Executive Sponsor Rating	Limited



Financial Capability & Capacity



Torbay and South Devon
NHS Foundation Trust

Delivered	Key Performance Indicators	Baseline	Target	Current Position	Trend
✓ Oversight heard that the 30-day staff consultation of the new finance structure has been signed off by Executive Committee but has been delayed due to job matching. The final post has now been formally matched and staff consultation is due to commence by end of November. ✓ The achievement of level 1 Finance accreditation and implementation of internal mentoring system are not progressing (still 27 of the 50 completed so far) due to issue of limited capacity of current staff and senior finance staff still to be recruited to posts, relating to the new structure. ✓ Work to build a sense of 'valued Finance Team' continues with the Regents House first floor office refurbishment now completed and monthly finance team briefings ongoing as business as usual so that finance staff are kept informed about issues. ✓ Budget Holder training offering has been drafted and is currently being reviewed by Senior Leadership Team.	% of finance staff with completed PDRs	41% (April 25)	100%	48%	↔
	% of finance roles appointed to future-state senior structure	64%	100%	64%	↔
	Percentage of non-finance staff trained in finance essentials	Not recorded	100%	Not rolled out yet	↔
	Improved forecast and UL assessment	6 monthly	Monthly	M5 process has been refined and M6 assessment in progress as part of budget setting process	↔

Next Steps
➤ Commence staff consultation and expediate filling of empty roles. ➤ Review and trial budget holder training pack ➤ Review of refined ULP process ➤ Focus of resources on MTFP and 26/27 planning

Risk	Mitigation
No new risks have been added to the current workstream.	

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	Limited



Managed Services & Subsidiary Company Arrangements


Torbay and South Devon
NHS Foundation Trust

Summary Position
✓ Following an extraordinary Executive escalation meeting this workstream has been formally paused, pending national direction.

KPIs	Baseline	Target	Current Position	Trend

Next Steps

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
						Executive Sponsor Rating	ON HOLD



One Devon Shared Services (Finance)



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ A Financial accounts working group has now been set up with attendees from SBS and all Trusts. This group will focus on external and mandatory reporting requirements to ensure these are considered in the new system.
- ✓ A Chart of Accounts introduction meeting has been set up for all Trusts and SBS. This is to introduce and provide information on the Chart of Accounts , the structure and what fields of information can be held.
- ✓ A TSD working group has now been set up to review the SBS cost centre mapping, which will be needed for a successful migration to the new system.
- ✓ Fortnightly leadership engagement sessions are taking place for TSD staff. These are informal sessions with the SBS client-side teams to allow queries & concerns to be addressed and followed up. SBS Client side team also provide updates on progress and near future tasks/information requests.
- ✓ HR, Finance & Staff side meetings are being held to present findings and next steps for staff who may be directly impacted by potential TUPE transfers.
- ✓ Accounts Payable and Receivable sessions are being arranged to bring together Treasury Managers to begin collaborative planning and alignment.
- ✓ Oversight heard that whilst the workstream is on track there is an emerging risk regarding the Board approval of the end host which could impact the timing of staff TUPE

Next Steps

- Finalisation of the Finance Target Operating Model is expected mid November, which will allow further progress in terms of finance structures, and provide more detail to staff members who will be directly impacted by TUPE transfers;
- HR leads will be asked to engage with finance leads to identify staff affected by upcoming transitions, with meetings and reviews to be held with the staff likely to be directly impacted by TUPE transfers;
- Reviews of where staff are expected to move to within the One Devon (Finance Intelligence Hub/locally retained/SBS TUPE) will continue in more detail;
- Recommendations regarding Charitable funds finance processes will be reviewed;
- Collation of information to move onto the new SBS system is expected to start in the next month;

Key Performance Indicators	Baseline	Target	Current Position	Trend
Key roles in new structure fully established	TBC pending establishment of new structure			
External support procured to support transformation	N/A	Completion – 01/11/25	Completed	★
TUPE consultation completed and staff informed (% staff consulted) * - consultation will start Nov 25 and complete June 26	N/A	100%	0	↔
Successful migration of data onto new system	N/A	100% by 01/04/26	0	↔

Risk	Mitigation
No new risks have been added to the current workstream.	

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	Satisfactory

One Devon Shared Services (Procurement)

Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ An extensive review of the plan is underway with support from TSD Director of Financial Improvement, which will be used to develop a further refined project plan in the next reporting round. This has been further supported by a meeting held between Shared Service Devon, Finance and PMO to discuss Oversight’s concern about the level of savings transacted and the ambition within the plan.
- ✓ Notwithstanding Capita’s underperformance against the revenue target, Oversight heard that there was an additional £154.4k capital savings. Work is being completed to strengthen clinical engagement and develop the robustness of monitoring processes, noting and requesting a review of the impact of risk regarding resource constraints of the procurement team post TUPE transfer and the need to recruit to vacancies.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Devon PS live with agreed governance and TOM in place	TBC	Policies sign off by Trust committee	The values and trend will be finalised after completion of the procurement plan	
Accelerated savings programme in place savings delivery	Nil	£338k	Transacted £87.3k revenue savings at Month 7	
Go live of Procurement Shared Service	TBC	Service operational	The values and trend will be finalised after completion of the procurement plan	
Successful go live of SBS Fusion Phase 1 for Procurement	TBC	System operational		
Baseline procurement maturity re-assessed	TBC	Improvement in assessment level achieved		
Successful go live of SBS Fusion Phase 2 for Procurement	TBC	Service operational		

- Refine planning assumptions from meeting held on 13/11/2025 and prepare to update POP and present through governance.
- Review of the risk regarding resource constraints of the procurement team post TUPE transfer and the need to recruit to vacancies

Risk	Mitigation
No new risks	

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
Shared Procurement Service - Capita's delivery of contract schemes	338.0	87.3	0	250.7		Executive Sponsor Rating	No

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.

BUILDING A
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Future

Workforce Plan & Transformation

NHS

Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ **Pay Cost Reduction Target £20.4m:** The original target of £20.4m included £6.2m for compulsory redundancy which has not been approved. Finance have re-worked the figures and have closed the gap by £1.68m from the workforce controls which have been implemented. The figure for workforce controls is rebased to £15.88m. The gap from £15.88 to £20.4 will be closed by non-pay schemes as confirmed by finance.
- ✓ **Pay Controls- Break Glass Review:** All posts, including Front line Clinical, Medical and Workplace roles, and all CFHD posts, which don't need break glass sign off have been removed and accountability with relevant Exec/Deputy. Weekly break glass has been extended to 1 hour with a minimum of 3 Executives in attendance. Urgent posts can be approved outside the weekly meeting with a minimum of 3 Executive approvals. All posts referred to break glass are exceptions only for business critical roles, in principal this should be minimal due to vacancy freeze and Executives/CGDs can hold and decline posts without the need for break glass. Current back log will be reviewed urgently by CPO and CN and a proposal is going to Exco on 20.11.25- to agree changes to current process to make break glass more efficient.
- ✓ **MARS:** A paper has been drafted for Executive Committee, of which NHS England are aware, for a second round of MARS which will be launched in the New Year with an anticipated leaving date of 31st April 2025.
- ✓ **E-rostering: AfC.** The E-Rostering dashboard kick off meeting has been completed allowing for Data Protection approvals to allow Viridian access to Trust data to be obtained. The initial build of the dashboard will take approximately two weeks. A stakeholder meeting is planned to view first draft of the dashboard in around 4-6 weeks time.
- ✓ **E-Rostering: Medical** Resources have now been confirmed, and approval is being sought to proceed with recruitment of project resources to support the procurement activity for the medical e-rostering project which was temporarily paused pending confirmation.
- ✓ **People Digital- EVA:** Wave 2 of People Digital will provide the ability to automate onboarding and offboarding with an LMS system giving us the ability to share training records across the Devon region. The launch of Wave 2 is currently delayed; the Devon People Digital team are gathering key dates of significant pieces of work from each provider spanning Jan-June 2026 in order to make a decision on the most appropriate timeframe for launch

Next Steps

- **E-rostering Dashboard:** Data validation and mapping; Dashboard prototype created for first demo with stakeholder group
- **People Digital:** Work with PMO to translate regional plan to a local plan- tracking progress of wave 1 and confirm with region date of launch for wave 2
- **MARS:** Achieve internal and external approvals of round 2; confirm timetable with finance and payroll
- **Workforce Performance Reporting:** Develop a monthly slide pack to summarise the workforce performance figures against the operational plan; Develop CIP waterfall to represent the component parts to deliver the headcount & pay reductions

Key Performance Indicators	Baseline	Target	Current Position	Trend
Achieve Month 12 Workforce Plan of Total Workforce (WTE)	6815	Planned target: 6363 (452) Revised target: 6556 (259) (Posts identified for CR added back in and estimates for break glass included)	6671 (includes NEDs) Against a plan of 6437	↓
Total Recurrent Workforce CIP reduction (WTE)	6812.08	Planned target: -329 Revised target: -136 (removal of 205 CR plus break glass vacancies)	At M7 -73.32 recurrent vacancies were removed from the baseline establishment	↑ ↑
Pay cost reduction	£365.9m	£20.4m (reduction) £15.88m (rebase removal of CR)	£11.96m delivered £14.784m forecast	↔
MARS Scheme (50WTE reduction)	0	50 WTE	32.95 WTE	↔
Reduction in Agency spend by 30%	£10.1m	£7.1m total spend (reduction £3m)	£3.8m spend YTD (£6.1m forecast)	↔
Reduction in Bank spend by 10%	£21.1m	£19m total spend (reduction £2m)	£12m YTD (£18.7m forecast)	

Risk	Mitigation
People Digital Resource- Key member of team needs to step away to support EPIC	AD of People now in post to provide Senior oversight and PMO will provide project support- currently reviewing capacity of other team members to step in.
Procurement is currently reviewing options for a direct award; there is a potential risk to project timescales. Due to recent changes in procurement legislation, it may be necessary to undertake a mini tender exercise. This could result in delays to the planned implementation timeline.	Project Lead working closely with procurement. DOF provided support for direct award.

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
All CIP schemes which include pay elements	£20.4m	£11.96m	£14.78m	-£2.82m		Executive Sponsor Rating	Limited

TSDFT Public Board of Directors-26/11/25

257 of 300



People & Education Capability & Capacity



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ Workshops run and summarised outputs shared with SLT to inform directorate strategy, KPIs and skill requirements, noting further workshops planned for early December for strategy design.
- ✓ Amended directorate governance structure, membership and cycle of committee meetings in place.
- ✓ Skills survey ready for launch.
- ✓ A comprehensive review of all policies is currently being conducted, with the goal of ensuring that all policies are up to date by the end of the financial year. The review will be completed in two phases for policies requiring a deeper review. Phase 1 will focus on aligning each policy with current legislation, guidance, and language, and these interim versions will be ratified for 12 months while the full review is carried out.
- ✓ KPIs on effective governance refined in line with Oversight Committee request

Key Performance Indicators	Baseline	Target	Current Position	Trend
% of People and Education policies reviewed within review period.	44%	70%	33%	↔
Number of high-risk vacancies impacting delivery of workforce improvement plan.	10	0	2	↑
% progress of skills and capabilities based on People and Education gap analysis	Awaiting confirmation post survey analysis	100%	80% (directorate feedback to be triangulated with stakeholder feedback)	↑
Number of risks reported and % mitigated through effective governance	Need to baseline using current open risks	KPI under review		
Number of open formal ER cases per 1000 organisation headcount	7.5 (May 2025)	7.5	10.4 (October 2025)	↓
Reduction in the number of open long term sickness absence cases	266 (May 2025 – previously reported as 189)	245 cases	339 cases (October 2025)	↓
Governance structure in place	50%	100%	100% complete	↑
Stakeholder satisfaction with directorate governance framework using monthly Likert scale survey	First survey results to provide benchmark	> 3.5/5.0	First survey results due end Nov 25	TBC
Customer services satisfaction rating	Reporting will commence in November 2025			TBC

Next Steps

- Final KPI sign off so dashboard design can commence.
- Skill survey out to begin development of directorate training plan.
- Continue work on best practice structure review and agreement for directorate.
- Progress with strategy, which will inform work and development plans for directorate.

Risk	Mitigation
Number of policies requiring review remains static, increase in number of open ER and long term sickness cases and attrition in the ER team, affecting team capacity. This will impact on 70% review target for November 25 and trend for sickness absence and ER cases. Please see mitigations section for action being taken.	Additional ER capacity within existing team; ER KPIs agreed including <60 days to resolve grievance, disciplinary and bullying and harassment cases and >80% of long term sickness cases closed within 6 months; policy review group set up to report into People and Education Governance Group (PEGG); planning underway on review dates for policies; increase rate in case closures; policy update progress rate agreed; additional Partnership Forum meeting to be run in December 25.

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	Limited

Brighter Future Culture, Organisational Development & Learning NHS Torbay and South Devon NHS Foundation Trust					
Delivered ✓ Staff Networks: New Chairs appointed for Global majority, Disability, LGBTQ+ & Neurodiverse networks; Executive Sponsors confirmed. ✓ Staff Wellbeing: New stakeholder group convened; initial meeting held and feedback being collated. ✓ Reasonable Adjustments: Survey finalised following extended stakeholder input; due for circulation to managers. ✓ Occupational Health: Trust-wide stakeholder group established to review OH provision; first meeting scheduled. ✓ Training & Development: National Managers and Leaders Framework reviewed; competency mapping underway; joint leadership offer in development with RDUH ✓ Organisational Development: KPIs now being embedded following OD&D review; new triage system introduced to prioritise high-impact change. ✓ Staff Engagement & Experience: Scoping completed; review of wellbeing training and roles underway; evidence-based models being sourced; initial themes identified from multiple data sources. ✓ Cultural Insights Review: Group preparing to commence work; ToRs and membership being finalised; KPIs expected to underpin future cultural dashboard. ✓ KPIs: Current KPIs under review to ensure alignment with deliverables; updated set to be presented in next report.					
Next Steps ➤ Meet new staff network Chairs and confirm priority areas. ➤ Relaunch and promote staff networks across the organisation. ➤ Circulate the Project Overview Document for stakeholder feedback. ➤ Align core language and messaging across all training packages. ➤ OD team to embed measurable outcomes and identify impact-measurement tools. ➤ Establish a multidisciplinary steering group and develop a detailed delivery plan for Enhanced Care for Staff. ➤ Develop a strategic approach to debriefing support for staff managing complex or challenging situations ➤ Explore data-collection methods to assess the impact of RESET training and debriefing sessions. ➤ Complete scoping review of the Reasonable Adjustments policy with ER. ➤ Engage key leads to consolidate insights. ➤ Form the Cultural Insights Review Group					
<div><div><div><div>Key Performance Indicators</div><div>Baseline</div><div>Target</div><div>Current Position</div><div>Trend</div></div><div><div>Staff feedback: National Staff Survey</div><div>39%</div><div>45%</div><div>39%</div><div>↔</div></div><div><div>Staff Feedback: Pulse Survey response rate</div><div>1.96% (Q1)</div><div>45%</div><div>5.54% (Q2)</div><div>↔</div></div><div><div>Recommend as a place to work Staff Survey</div><div>62%</div><div>66%</div><div>62%</div><div>↔</div></div><div><div>People Pulse</div><div>34% (Q1)</div><div>66%</div><div>45% (Q2)</div><div>↔</div></div><div><div>Recommend the Trust for care Staff Survey</div><div>66%</div><div>70%</div><div>Data is not available this month</div><div>↑</div></div><div><div>People Pulse</div><div>46% (Q1)</div><div>70%</div><div></div><div></div></div><div><div>ER number of cases open</div><div>56 (May 25) – Revised figure - 55</div><div>65% Reduce to 100 by Mar 2026</div><div>73 (Oct 2025)</div><div>↑</div></div><div><div>Long Term Sickness cases</div><div>189 (May 25) - Revised figures - 266 (May 25)</div><div></div><div>339 (Sept 2025)</div><div>↓</div></div><div><div>Compliments received</div><div>332 (2024/25)</div><div>20% increase</div><div>81 Compliments (Q2 2025/26)</div><div>↑</div></div><div><div></div><div>76 (Q4 2024/25)</div><div></div><div></div><div></div></div><div><div>Datix closure from last annual period</div><div>801 (2024/25)</div><div>20% decrease</div><div>342 incidents still open from 2024/25</div><div>↑</div></div><div><div>Datix– closure rates for incidents</div><div data-cs="4" data-kind="parent">Under development by the Patient Safety Team and will be available in the next reporting cycle.</div><div data-kind="ghost"></div><div data-kind="ghost"></div><div data-kind="ghost"></div></div><div><div>Workforce and Retention data</div><div>88.90%</div><div>90%</div><div>88.63%</div><div data-kind="parent" data-rs="2">↔</div></div><div><div>Workforce and Stability data</div><div>79.41%</div><div>81%</div><div>79.31%</div><div data-kind="ghost"></div></div></div></div>					
Risk Mitigation Most risks have been closed following review, and the wording of the remaining risk associated with this plan has been refined. One risk will be transferred to Workstream 5.2 for ongoing monitoring and management. Based on the revised KPIs and deliverable plans, associated risks will be reviewed and, if required, updated and proposed for discussion at the next People Leads Group 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 No CIP associated with scheme Assurance Rating Executive Sponsor Rating Limited					

Board of Directors

SDH Developments Ltd Update

Date of meeting	Date report produced
26th November 2025	11 th November 2025

Author(s)		Report approved by	
Name and title:	Deborah Wholey Finance Manager	Name and title:	Paul Foster Director of Pharmacy
Phone:	01803 653379	Date:	14 th November 2025
Email:	deborah.wholey@nhs.net		paul.foster@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 purpose of this paper is to update the Trust Board on the annual report and financial statements of SDH Developments Limited for the year ended 31 March 2025. It is also to advise the Trust Board of the audit opinion and comments from the external auditors of SDH Developments Ltd.		
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
SDH_Ltd_Signed_Accounts 2024-25.pdf

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 is also asked to NOTE the audited financial performance of the wholly owned subsidiary of TSDFT, SDH Developments Ltd. It is recommended the Committee take satisfactory assurance that the annual report and financial statements for SDH Developments Ltd have been appropriately prepared.

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.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Robust financial controls are key to ensuring efficient and sustainable use of resources
Quality of services provided	As above
Sustainable and efficient use of resources	As above

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Robust financial controls are key to ensuring efficient and sustainable use of resources
Leadership and Governance	As above
Performance	As above
People and Culture	As above
Strategy and Business Intelligence	As above
Finance	As above

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.

Annual Report & Financial Statements of SDH Developments Ltd. 2024/24

Introduction and background

SDH Developments Ltd (SDH) is the wholly owned subsidiary of TSDFT. SDH has operated the out-patient pharmacy on behalf of TSDFT since 2013 through an agreed dispensing contract.

The SDH 2024-25 financial statements show a post-tax profit of £68,607 compared to a budgeted post-tax profit of £77,905. The variance primarily related to additional temporary staff costs due to difficulties in filling substantive vacancies.

The external auditors found no adjusted or unadjusted items required to the financial statements and their opinion per the report states:

'In our opinion, the financial statements:

- give a true and fair view of the state of the company's affairs as at 31 March 2025 and of its profit for the year then ended; the information given in the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements; and*
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and the information given in the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements; and*
- have been prepared in accordance with the requirements of the Companies Act 2006.'*

The auditors made two control observations and recommendations that would, if corrected, improve internal control in general and engender good practice, but are unlikely to have had a material impact on the financial statements:

1. From their employee verification testing, they have identified one instance where a contract was unsigned by SDH Developments Limited. They recommend that as part of the onboarding process, all contracts are reviewed to ensure they have been signed by SDH Developments Limited as well as the employee.

The management response to this recommendation was:

'As part of the onboarding process, we now ensure all contracts are reviewed to ensure they have been signed by a representative of SDH Developments Ltd. as well as the employee.'

2. Purchase orders are not retained after being checked against the order when it is received. They were therefore unable to check that the purchase order that they selected for their walkthrough of the purchasing system had been authorised by an appropriate individual, which is a key control within the system. Purchase orders should be retained so that management can evidence that they have been appropriately authorised.

The management response to this recommendation was:
‘A new pharmacy stock system is being introduced in 2026 and therefore further development on the current system was not deemed cost effective. There are also some changes to the overall structure of the Trust finance structure planned, including upgraded software systems. While SDH Developments Ltd. will maintain its reporting autonomy, we are exploring opportunities to improve the traceability of purchase orders through these systems.’

Assurance and Recommendations

The Board 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
All	Satisfactory	N/A

SDH Developments Limited

Annual Report and Financial Statements

For the Year Ended 31 March 2025

Registered Number: 08385611

SDH Developments Limited
Registered Number: 08385611

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SDH Developments Limited
Registered Number: 08385611

Company Information

Directors	P R Foster C A Lissett M A Greaves (appointed 1 May 2025) M S Stewart (resigned 28 August 2024) R A Sutton (resigned 30 April 2025)
Registered company number	08385611
Registered office	Regent House Regent Close Torquay TQ2 7AN
Independent auditors	Bishop Fleming Audit Limited Salt Quay House 4 North East Quay Sutton Harbour Plymouth PL4 0BN

SDH Developments Limited
Registered Number: 08385611

Directors' report

For the year ended 31 March 2025

The directors present their annual report and the audited financial statements of SDH Developments Limited (the "Company") for the year ended 31 March 2025.

Directors

The directors who served during the year and up until the date of signing the financial statements, unless otherwise stated, were:

P R Foster	M S Stewart (resigned 28 August 2024)
C A Lissett	R A Sutton (resigned 30 April 2025)
M A Greaves (appointed 1 May 2025)	

Statement of Directors' Responsibilities in Respect of the Financial Statements

The directors are responsible for preparing the Annual Report and the financial statements in accordance with applicable law and regulation.

Company law requires the directors to prepare financial statements for each financial year. Under that law the directors have prepared the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards, comprising FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland", and applicable law). Under company law the directors must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the company and of the profit or loss of the company for that year. In preparing the financial statements, the directors are required to:

- select suitable accounting policies and then apply them consistently;
- state whether applicable United Kingdom Accounting Standards, comprising FRS 102, have been followed, subject to any material departures disclosed and explained in the financial statements;
- make judgements and accounting estimates that are reasonable and prudent; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Company will continue in business.

The directors are also responsible for safeguarding the assets of the company and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors are responsible for keeping adequate accounting records that are sufficient to show and explain the Company's transactions and disclose with reasonable accuracy at any time the financial position of the Company and enable them to ensure that the financial statements comply with the Companies Act 2006.

Directors' confirmations

In the case of each director in office at the date the Directors' Report is approved:

- so far as the director is aware, there is no relevant audit information of which the company's auditors are unaware; and
- they have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the company's auditors are aware of that information.

Directors' indemnities

As permitted by the Articles of Association, the Directors have the benefit of an indemnity which is a qualifying third party indemnity provision as defined by Section 234 of the Companies Act 2006. The indemnity was in force throughout the last financial year and is currently in force.

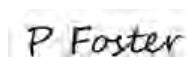
Independent auditors

The auditors, Bishop Fleming Audit Limited, will be proposed for reappointment in accordance with section 485 of the Companies Act 2006.

Small companies provisions

This report has been prepared in accordance with the special provisions relating to small companies within Part 15 of the Companies Act 2006.

This report was approved by the Board of Directors and signed on its behalf.



P R Foster
 Director
 Date: 30 October 2025

SDH Developments Limited
Registered Number: 08385611

Independent Auditors' Report to the Members of SDH Developments Limited

Opinion

We have audited the financial statements of SDH Developments Limited (the 'company') for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, the Balance Sheet, the Statement of Changes in Equity, and notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the company's affairs as at 31 March 2025 and of its profit for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the director's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the company's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report and Financial Statements (the 'Annual Report'), other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the Annual Report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinions on other matters prescribed by the Companies Act 2006

In our opinion, based on the work undertaken in the course of the audit:

- the information given in the Directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the Directors' report has been prepared in accordance with applicable legal requirements.

Matters on which we are required to report by exception

In the light of the knowledge and understanding of the company and its environment obtained in the course of the audit, we have not identified material misstatements in the Directors' report.

We have nothing to report in respect of the following matters in relation to which the Companies Act 2006 requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- certain disclosures of directors' remuneration specified by law are not made; or
- we have not received all the information and explanations we require for our audit; or
- the directors were not entitled to prepare the financial statements in accordance with the small companies regime and take advantage of the small companies' exemptions in preparing the directors' report and from the requirement to prepare a strategic report.

Responsibilities of directors

As explained more fully in the Statement of Directors' Responsibilities in Respect of the Financial Statements, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the company or to cease operations, or have no realistic alternative but to do so.

SDH Developments Limited
Registered Number: 08385611

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The specific procedures for this engagement and the extent to which these are capable of detecting irregularities, including fraud is detailed below:

- We have considered the nature of the sector, control environment and financial performance;
- We have considered the results of enquiries with management and directors in relation to their own identification and assessment of the risk of irregularities within the company;
- We have reviewed the documentation of key processes and controls and performed walkthroughs of transactions to confirm that the systems are operating in line with documentation;
- Any matters identified having obtained and reviewed the company's documentation of their policies and procedures relating to:
 - Identifying, evaluation and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - Detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud;
 - The internal controls established to mitigate risks of fraud or noncompliance with laws and regulations;
- We have considered the matters discussed among the audit engagement team regarding how and where fraud might occur in the financial statements and any indicators of fraud.

As a result of these procedures, we have considered the opportunities and incentives that may exist within the company for fraud and identified the highest area of risk to be in relation to income recognition, with a particular risk in relation to year-end cut off. In common with all audits under ISAs (UK) we are also required to perform specific procedures to respond to the risk of management override.

We have also obtained understanding of the legal and regulatory frameworks that the company operates in, focusing on provisions of those laws and regulations that had a direct effect on the determination of material amounts and disclosures in the financial statements. The key laws and regulations we considered in this context included the Companies Act 2006, FRS 102 and UK tax legislation.

In addition, we considered the provisions of other laws and regulations that do not have a direct effect on the financial statements but compliance with which may be fundamental to the company's ability to operate or avoid a material penalty. These included pharmaceutical regulations, data protection regulations, occupational health and safety regulations, and employment legislation.

Our procedures to respond to risks identified included the following:

- Reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- Performing analytical procedures to identify unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- Reviewing board meeting minutes;
- Enquiring of management in relation to actual and potential claims or litigations;
- Performing detailed transactional testing in relation to the recognition of income, with a particular focus around year-end cut off; and
- In addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgments made in accounting estimates are indicative of potential bias; and evaluating the business rationale of significant transactions that are unusual or outside the normal course of business.

We also communicated identified laws and regulations and potential fraud risks to all members of the engagement team and remained alert to possible indicators of fraud or non-compliance with laws and regulations throughout the audit.

As a result of the inherent limitations of an audit, there is a risk that not all irregularities, including a material misstatement in financial statements or non-compliance with regulation, will be detected by us. The risk increases the further removed compliance with a law and regulation is from the events and transactions reflected in the financial statements, given we will be less likely to be aware of it, or should the irregularity occur as a result of fraud rather than a one-off error, as this may involve intentional concealment, forgery, collusion, omission or misrepresentation.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our Auditor's report.

Use of our report

This report is made solely to the company's members, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006. Our audit work has been undertaken so that we might state to the company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the company and the company's members as a body, for our audit work, for this report, or for the opinions we have formed.

Bishop Fleming Audit Limited

Charles Martin (Senior Statutory Auditor)
 for and on behalf of Bishop Fleming Audit Limited, Statutory Auditor
 Salt Quay House
 4 North East Quay
 Sutton Harbour
 Plymouth
 Devon
 PL4 0BN

Date: 10 November 2025

SDH Developments Limited
Registered Number: 08385611

Statement of Comprehensive Income

For the year ended 31 March 2025

	Note	2025 £	2024 £
Turnover	4	12,856,123	11,832,706
Cost of sales		(11,727,719)	(10,849,459)
Gross profit		1,128,404	983,247
Administrative expenses		(1,021,871)	(919,426)
Operating profit	5	106,533	63,821
Interest payable and similar expenses	8	(17,898)	(19,857)
Profit before taxation		88,635	43,964
Tax on profit	9	(20,028)	(14,966)
Profit for the financial year		68,607	28,998
Total comprehensive income for the year		68,607	28,998

There were no recognised gains or losses for 2025 or 2024 other than those included in the Statement of Comprehensive Income.

The notes on pages 10 - 17 form part of these financial statements.

SDH Developments Limited
Registered Number: 08385611

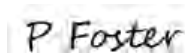
Balance Sheet

As at 31 March 2025

	Note	2025		2024	
		£	£	£	£
Fixed assets					
Intangible assets	10		-		54
Tangible assets	11		67,437		88,187
			<u>67,437</u>		<u>88,241</u>
Current assets					
Stocks	12	893,869		686,367	
Debtors	13	1,184,450		828,004	
Cash and cash equivalents	14	122,836		557,967	
		<u>2,201,155</u>		<u>2,072,338</u>	
Creditors: Amounts falling due within one year	15	(1,002,768)		(921,483)	
Net current assets			<u>1,198,387</u>		<u>1,150,855</u>
Total assets less current liabilities			1,265,824		1,239,096
Provision for deferred tax	16		(11,085)		(16,404)
Creditors: amounts falling due after more than one year	17		(265,020)		(301,580)
Net assets			<u>989,719</u>		<u>921,112</u>
Capital and reserves					
Called up share capital	18		1		1
Profit and loss account	19		989,718		921,111
Total equity			<u>989,719</u>		<u>921,112</u>

The financial statements on pages 7 - 17 were approved by the Board of Directors on 28th October 2025 and signed on its behalf by:

The financial statements have been prepared in accordance with the provisions applicable to companies subject to the small companies regime.



P R Foster
Director
Date: 30 October 2025

The notes on pages 10 - 17 form part of these financial statements.

SDH Developments Limited
Registered Number: 08385611

Statements of Changes in Equity

For the year ended 31 March 2025

	Called up share capital £	Profit and loss account £	Total Equity £
1 April 2023	1	892,113	892,114
Comprehensive income for the year			
Profit for the financial year	-	28,998	28,998
Total comprehensive income for the year	-	28,998	28,998
At 31 March 2024	1	921,111	921,112
Comprehensive income for the year			
Profit for the financial year	-	68,607	68,607
Total comprehensive income for the year	-	68,607	68,607
At 31 March 2025	1	989,718	989,719

The notes on pages 10 - 17 form part of these financial statements.

SDH Developments Limited
Registered Number: 08385611

Notes to the Financial Statements for the year ended 31 March 2025

1 General Information

SDH Developments Limited's ('the "Company"') principal activity is that of a registered pharmacy, that provides a dispensing service to the patients of Torbay and South Devon NHS Foundation Trust.

The Company is a private company limited by shares and is incorporated and domiciled in England in the United Kingdom. The address of its registered office is: Regents House, Regent Close, Torquay, TQ2 7AN.

2 Accounting policies

2.1 Basis of preparation of financial statements

The financial statements have been prepared on a going concern basis, under the historical cost convention and in accordance with Financial Reporting Standard 102, the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland and the Companies Act 2006.

The preparation of financial statements in compliance with FRS 102 requires the use of certain critical accounting estimates. It also requires management to exercise judgment in applying the Company's accounting policies (see note 3).

The following principal accounting policies have been applied consistently throughout the financial year:

2.2 Going Concern

The financial statements have been prepared on a going concern basis, which the directors consider appropriate. The Company is a wholly owned subsidiary of Torbay & South Devon NHS Foundation Trust and operates under contractual arrangements with the Trust, including the provision of dispensing services.

The directors have assessed the Company's financial position and future cash flow requirements and have a reasonable expectation that the Company will continue to operate and meet its obligations as they fall due for at least 12 months from the date of approval of these financial statements.

A key factor in this assessment is the agreement reached with the Trust to extend the current dispensing contract with the Company until March 2027. This extension provides continued operational and financial support, ensuring the Company maintains a stable revenue stream and remains aligned with the strategic objectives of the Trust.

The directors also note that the Company benefits from the ongoing support of the Trust, including access to shared services and governance oversight. Based on these considerations, the directors believe that the going concern basis of preparation is appropriate.

2.3 Financial Reporting Standard 102 - Reduced Disclosure Exemptions

The Company has taken advantage of the following disclosure exemptions in preparing these financial statements, as permitted by the FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland".

- the requirements of Section 4 Statement of Financial Position;
- the requirements of Section 7 Statement of Cash Flows;
- the requirements of Section 3 Financial Statement Presentation;
- the requirements of Section 11 Financial Instruments;
- the requirements of Section 12 Other Financial Instruments; and
- the requirements of Section 33 Related Part Disclosures.

This information is included in the consolidated financial statements of Torbay and South Devon NHS Foundation Trust as at 31 March 2025 and these financial statements may be obtained from Torbay and South Devon NHS Foundation Trust, Torbay Hospital, Torquay, TQ2 7AA.

2.4 Revenue

Revenue is recognised to the extent that the economic benefits will flow to the Company and the revenue can be reliably measured. Revenue is measured as the fair value of the consideration received or receivable, excluding discounts, rebates, value added tax and other sales taxes.

Rendering of services

The Company has a contract with Torbay and South Devon NHS Foundation Trust to dispense drugs to patients which sometimes includes delivering drugs to patients' homes.

Revenue from a contract to provide a service is recognised in which the services provided in accordance with the stage of completion of the contract when all of the following conditions are satisfied:

- the amount of revenue can be measured reliably;
- it is probable that the Company will receive the consideration due under the contract;
- the stage of completion of the contract at the end of the reporting period can be measured reliably, and;
- the costs incurred and the costs to complete the contract can be measured reliably.

Sale of Goods

The Company dispenses drugs to private patients. Revenue is recognised when payment is received from the patient.

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Notes to the Financial Statements for the Year Ended 31 March 2025 (continued)

2 Accounting policies (continued)

2.5 Intangible assets

Intangible assets are initially recognised at cost. After recognition, under the cost model, intangible assets are measured at cost less any accumulated amortisation and any accumulated impairment losses.

All intangible assets are considered to have a finite useful life. If a reliable estimate of the useful life cannot be made, the useful life shall not exceed five years.

The estimated useful lives range as follows:

-	Computer software - 5 years

2.6 Tangible assets

Tangible assets are stated at cost (or deemed cost) less accumulated depreciation and accumulated impairment losses. Cost includes the original purchase price, costs directly attributable to bringing the asset to its working condition for its intended use, dismantling and restoration costs.

i. Plant and machinery

Plant and machinery and fixtures, fittings, tools and equipment are stated at cost less accumulated depreciation and accumulated impairment losses.

ii. Depreciation and residual values

Depreciation is calculated, using the straight-line method, to allocate the depreciable amount to their residual values over their estimated useful lives, as follows:

-	Plant and machinery - 10 years

The assets' residual values and useful lives are reviewed, and adjusted, if appropriate, at the end of each reporting period. The effect of any change is accounted for prospectively.

iii. Derecognition

Tangible assets are derecognised on disposal or when no future economic benefits are expected. On disposal, the difference between the net disposal proceeds and the carrying amount is recognised in the Statement of Comprehensive Income and included in 'Other operating (losses)/gains'.

2.7 Operating Leases

Rentals under operating leases are charged to the profit or loss on a straight line basis over the period of the lease.

2.8 Stocks

Stocks are stated at the lower cost and net realisable value, being the estimated selling price less costs to complete and sell. Cost is based on the cost of purchase on an average cost basis.

2.9 Debtors

Short term debtors are measured at transaction price, less any impairment. Loans receivable are measured initially at fair value, net of transaction costs, and are measured subsequently at amortised cost using the effective interest method, less any impairment.

2.10 Cash and cash equivalents

Cash is represented by cash in hand and deposits with financial institutions repayable without penalty on notice of not more than 24 hours. Cash equivalents are highly liquid investments that mature in no more than three months from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

2.11 Financial instruments

The Company only enters into basic financial instruments transactions that result in the recognition of financial assets and liabilities like trade and other accounts receivable and payable, loans from banks and other third parties and investments in non-puttable ordinary shares.

Debt instruments (other than those wholly repayable or receivable within one year), including loans and other accounts receivable and payable, are initially measured at present value of the future cash flows and subsequently at amortised cost using the effective interest method. Debt instruments that are payable or receivable within one year, typically trade payables or receivables, are measured, initially and subsequently, at the undiscounted amount of the cash or other consideration, expected to be paid or received. However if the arrangements of a short-time instrument constitute a financing transaction, like the payment of a trade debt deferred beyond normal business terms or financed at a rate of interest that is not a market rate or in case of an out-right short-term loan not at market rate, the financial asset or liability is measured, initially, at the present value of the future cash flow discounted at a market rate of interest for a similar debt instrument and subsequently at amortised cost.

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Notes to the Financial Statements for the Year Ended 31 March 2025 (continued)

2 Accounting policies (continued)

2.11 Financial instruments (continued)

Financial assets that are measured at cost and amortised cost are assessed at the end of each reporting period for objective evidence of impairment. If objective evidence of impairment is found, an impairment loss is recognised in the Statement of Comprehensive Income.

Financial assets and liabilities are offset and the net amount only reported in the Balance Sheet when there is an enforceable right to set off the recognised amounts and there is an intention to settle on a net basis or to realise the asset and settle the liability simultaneously.

2.12 Creditors

Short term creditors are measured at the transaction price. Other financial liabilities, including bank loans, are measured initially at fair value, net of transactions and are measured subsequently at amortised cost using the effective interest method.

2.13 Finance costs

Finance costs are charged to the Statement of Comprehensive Income over the term of the debt using the effective interest method so that the amount charged is at a constant rate on the carrying amount. Issue costs are initially recognised as a reduction in the proceeds of the associated capital instrument.

2.14 Pensions

Defined contribution pension plan

The Company operates a defined contribution plan for its employees. A defined contribution plan is a pension plan under which the Company pays fixed contributions into a separate entity. Once the contributions have been paid the Company has no further payment obligations.

The contributions are recognised as an expense in the Statement of Comprehensive Income when they fall due. Amounts not paid are shown in accruals as a liability in the Balance Sheet. The assets of the plan are held separately from the Company in independently administered funds.

2.15 Taxation

Tax is recognised in the Statement of Comprehensive Income, except that a change attributable to an item of income and expense recognised as other comprehensive income or to an item recognised directly in equity is also recognised in other comprehensive income or directly in equity respectively.

The current income tax charge is calculated on the basis of tax rates and laws that have been enacted or substantively enacted by the balance sheet date in the countries where the Company operates and generates income.

Deferred tax arises from timing differences that are differences between taxable profits and total comprehensive income as stated in the financial statements. These timing differences arise from the inclusion of income and expenses in tax assessments in periods different from those in which they are recognised in financial statements.

3 Judgements in applying accounting policies and key sources of estimation uncertainty

In the application of the company's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based upon historical experience and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates are underlying assumptions and are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of revision and future periods if the revision affects both current and future periods.

Stocks impairment

Stock impairments of £20,000 (2024: £20,000) have been made where it is considered unlikely that stocks will be sold before the expiry date of the product.

4 Turnover

The majority of the turnover is attributable to the principal activity of the Company for rendering of services.

All turnover arose within the United Kingdom.

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Notes to the Financial Statements for the year ended 31 March 2025 (continued)

5 Operating profit

	2025	2024
	£	£
The operating profit is stated after charging:		
Amortisation of intangible fixed assets	54	644
Depreciation of fixed assets	20,750	20,750
Lease costs	67,500	67,500
Stocks expensed during the year	11,727,719	10,849,459

The directors did not receive any emoluments in respect of their services to the company (2024: £Nil). The services provided by the directors could not be distinguished from those provided to the parent Trust and as such they did not receive any emoluments from SDH Developments Limited.

6 Auditors' remuneration

	2025	2024
	£	£
Fees payable to the Company's auditors for the audit of the Company's annual financial statements	22,610	21,850

7 Employees

	2025	2024
	£	£
Staff costs were as follows:		
Wages and salaries	186,328	306,023
Social security costs	14,976	23,487
Pension costs	5,414	8,574
	206,718	338,084

The average monthly number of employees, during the year was as follows:

	2025	2024
	Total	Total
	Number	Number
Pharmacy staff	9	13

8 Interest payable and similar expenses

	2025	2024
	£	£
Loans from group undertakings	17,898	19,857

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Notes to the Financial Statements for the year ended 31 March 2025 (continued)

9 Tax on profit

a. Tax expense included in Statement of Comprehensive Income

	2025 £	2024 £
Current tax		
Tax on profits for the year	25,376	15,350
Adjustment in respect of prior periods	(29)	161
Total current tax	<u>25,347</u>	<u>15,511</u>
Deferred tax		
Origination and reversal of timing differences	(5,319)	(545)
Total deferred tax	<u>(5,319)</u>	<u>(545)</u>
Tax on profit	<u>20,028</u>	<u>14,966</u>

b. Reconciliation of tax charge

The tax assessed for the year is lower than (2024: higher than) the small profits rate of corporation tax in the UK of 25% (2024: 25%). The differences are explained below:

Profit before tax	88,635	43,964
Profit before taxation multiplied by main rate of corporation tax in the UK of 25% (2024: 25%)	22,159	10,991
Difference between capital allowances and depreciation	5,113	5,241
Unpaid Accrued Employer Pension Contributions	206	(19)
Expenses Not deductible for Tax Purposes	-	38
Adjustment to Tax Charge in Respect of Previous Periods	(29)	161
Unexplained Difference	-	(1)
Sub-total	<u>27,449</u>	<u>16,411</u>
Marginal Relief for Corporation Tax	(2,102)	(900)
Origination and reversal of timing differences	(5,319)	(545)
Total tax charge for the year	<u>20,028</u>	<u>14,966</u>

Factors that may affect future tax charges

Deferred taxes at the balance sheet date have been measured using the enacted tax rate of 25% (2024: 25%) and are reflected in these financial statements.

10 Intangible assets

	Computer Software £
Cost	
At 1 April 2024	12,305
At 31 March 2025	<u>12,305</u>
Accumulated amortisation	
At 1 April 2024	12,251
Charge for year	54
At 31 March 2025	<u>12,305</u>
Net book value	
At 31 March 2025	-
At 31 March 2024	<u>54</u>

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Notes to the Financial Statements for the Year Ended 31 March 2025 (continued)

11 Tangible assets

	Plant & Machinery	Total
	£	£
Cost		
At 1 April 2024	207,500	207,500
At 31 March 2025	207,500	207,500
Accumulated depreciation		
At 1 April 2024	119,313	119,313
Charge for year	20,750	20,750
At 31 March 2025	140,063	140,063
Net book value		
At 31 March 2025	67,437	67,437
At 31 March 2024	88,187	88,187

12 Stocks

	2025	2024
	£	£
Raw materials and consumables	893,869	686,367

Stock impairments of £20,000 (2024: £20,000) have been made where it is considered unlikely that stocks will be sold before the expiry date of the product.

13 Debtors

	2025	2024
	£	£
Amounts falling due within one year		
Amounts owed by group undertakings	967,533	665,995
Other debtors	212,055	155,285
Prepayments and accrued income	4,862	6,724
	1,184,450	828,004

Amounts owed by group undertakings are unsecured, interest free and repayable on demand.

14 Cash and cash equivalents

	2025	2024
	£	£
Cash at bank and in hand	122,836	557,967

15 Creditors: Amounts falling due within one year

	2025	2024
	£	£
Trade creditors	600,765	469,358
Amounts owed to group undertakings	36,560	36,560
Corporation tax	25,376	15,379
Other taxation & social security	1,096	5,273
Other creditors	2,866	1,778
Accruals and deferred income	336,105	393,135
	1,002,768	921,483

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Notes to the Financial Statements for the Year Ended 31 March 2025 (continued)

16	Provision for deferred tax	2025 £	2024 £
	Fixed asset timing differences	16,455	21,568
	Short term timing differences	(5,370)	(5,164)
		<u>11,085</u>	<u>16,404</u>

17	Creditors: Amounts falling due after more than one year	2025 £	2024 £
	Amounts owed to group undertakings	<u>265,020</u>	<u>301,580</u>

Secured loans

SDH Developments Limited's loan with the Trust has conditions associated with it, namely that the Company cannot enter into an arrangement without the express permission of the Lender to: i) create or permit to subsist any security over any of its assets, ii) to borrow further monies from another lender. There is no preferred security placed on any of the Company's assets by the lender. The interest rate of the loan is 5.5% per annum and the loan is repayable over a twenty year period. The loan is repayable in full by 20th June 2033.

Included within the group loan above are amounts falling due as follows:

	2025 £	2024 £
Between one and two years	36,560	36,560
Between two and five years	109,680	109,680
Over five years	118,780	155,340
	<u>265,020</u>	<u>301,580</u>

18	Called up share capital	2025 £	2024 £
	Allotted, called up and fully paid		
	1 Ordinary share of £1	<u>1</u>	<u>1</u>

Each share is entitled to one vote in any circumstance, is entitled pari passu to dividend payments or any other distribution, and is entitled pari passu to participate in a distribution arising from a winding up of the Company.

19	Profit and loss account
	The profit and loss account represents the accumulated profits, losses and distributions of the Company.

20	Pension commitments
	The Company operates a defined contribution pension scheme. The assets of the scheme are held separately from those of the Company in an independently administered fund. The pension cost charge represents contributions payable by the Company to the fund and amounted to £5,414 (2024: £8,574).

21	Commitments under operating leases	
At 31 March the Company was committed to making the following annual payments under non-cancellable operating leases as follows:		
Expiry date:	2025 £	2024 £
Not later than 1 year	67,500	67,500
Later than 1 year and not later than 5 years	270,000	270,000
Later than 5 years	219,375	286,875
Total	556,875	624,375

22	Controlling party
	SDH Developments Limited is a wholly owned subsidiary of Torbay and South Devon NHS Foundation Trust, which is the ultimate parent undertaking. There is no ultimate controlling party.
	The Torbay and South Devon NHS Foundation Trust is the parent undertaking of both the smallest and largest group to consolidate these financial statements. The consolidated financial statements of the Torbay and South Devon NHS Foundation Trust are available from: Torbay and South Devon NHS Foundation Trust, Torbay Hospital, Torquay, TQ2 7AA.

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23 Related party transactions

The Company has not disclosed transactions with any other group members as it has taken advantage of the exemption available to them under Financial Reporting Standard 102 Section 33 'Related Party Disclosures', on the grounds that it is a wholly owned subsidiary and that the consolidated financial statements in which the group is included are publicly available.

There are no other related parties.

Board of Directors

Committee Chairs' Report

Date of meeting	Date report produced
26 November 2025	21 November 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, Safety and Patient Experience	All
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

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 – 22 October 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)

- Information Governance Compliance Report- limited/satisfactory/significant
- SIRO Annual Report – satisfactory
- Losses and Special Payments – satisfactory
- Internal Audit Recommendations – satisfactory
- Freedom to Speak Up Bi-Annual Report
- External Audit Recommendations – satisfactory

- EPRR Quarterly Update – satisfactory
- Counter Fraud Interim Report
- Corporate Documents Position Statement – limited
- Board Assurance Framework – satisfactory
- ASW Assurance Interim Report
- Committee Annual Report – satisfactory
- Waivers of Competition – limited
- Cybersecurity Update – limited/satisfactory

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)

Internal audit noted limited assurance on certain aspects of cyber security, and this was also noted in other reports, with focus around resources especially as EPIC is implemented, and the need for more focus on future risk here. As has been noted in other committees, there remains concern about system wide and trusts' lack of CIOs (RDUH has this as a strategic BAF risk).

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

Significant work is required (and being invested) into risk reporting, especially with triangulation with the BAF itself. There remain a significant number of overdue internal audit recommendations (although on a decreasing trend) many of which relate to Torbay Council Assurance LGA Review. There are a large number of corporate policy papers that are overdue for review due to capacity issues. It was discussed this needs a focused approach here, with people policy updates being urgently addressed. Whilst many reports have been received through the FTSU system, the lack of specific actions being taken from these reports undermines the staff's confidence in the system, which reduces the assurance we can take that it is operating effectively.

ASSURE: Inform the Board where positive assurance has been received

Information Governance systems have been much improved, but lack of direct resources means we are behind (as with many others) in areas such as Freedom of Information requests. A report on EPRR was well received and significant work and progress had been made in this area.

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

We discussed the assurance we have around the accurate reporting of operational statistics that would support our exit from National Oversight - this was also noted in our recent self assessment framework. This will be revisited in Spring to avoid any additional pressure on operations during Winter, and informal comfort has been obtained from operations about inbuilt control systems.

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

Significant progress has been made in updating the BAF and this has led to some good engagement and discussions from sub committees, with more work being undertaken to adapt to the outcome of these discussions.

Committee Chairs' Report

Finance and Performance Committee – 22 October 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 6 Finance Report – limited/satisfactory
Underlying Financial Position - satisfactory
Adult Social Care Debt - satisfactory

PIR – Mortuary Expansion Business Case - satisfactory
Planning 2026/27 - satisfactory
IPQR – limited/satisfactory
IA Report – Business Governance Arrangements - satisfactory
CFHD Integrated Governance Report

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)

No matters for escalation

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

The Committee took limited assurance on the forecast outturn due to an identified risk to delivery of £19.8m through unachievable CIP plans (Redundancies and Wholly Owned Subsidiaries) and demand pressures (ASC, CHC) and has developed a recovery plan to mitigate £16m (of which £4.8m high risk) leaving a gap of £3.8m where further plans need to be developed.

Whilst recognising the improvement across some performance standards the committee took limited assurance on delivery across UEC, Planned care and Workforce

ASSURE: Inform the Board where positive assurance has been received

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

Committee Chairs' Report

Finance and Performance Committee – 18 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):

- Month 5 Finance Report – Satisfactory/Limited
- Medium Term Financial Plan (Update) - Satisfactory
- 2025-26 Financial Forecast – review of month 4 forecast outturn - Limited
- 25/26 Winter Plan – Satisfactory/Productivity - Satisfactory

- Post Implementation Review - Reconfiguration of St Edmunds - Satisfactory
- Planning 2026/27 - September Update - Satisfactory
- Integrated Quality and Performance Report inc. Operational Plan – Review of Performance – Limited/Satisfactory
- Quarterly Jack Sears Performance Report – Satisfactory/Significant
- Frailty Business Case - 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)

The length of reports and the need going forward to ensure that there is a strong detailed cover page covering key areas and drawing attention to successes, risks, opportunities and highlighting specific issues for the committee to be aware of linked to strategy, BAF and National Priorities.

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

The Committee took limited assurance on the forecast outturn due to an identified risk to delivery of £19.8m through unachievable CIP plans (Redundancies and Wholly Owned Subsidiaries) and demand pressures (ASC, CHC) and has developed a recovery plan to mitigate £16m (of which £4.8m high risk) leaving a gap of £3.8m where further plans need to be developed.

Whilst recognising the improvement across some performance standards the committee took limited assurance on delivery across UEC, Planned care and Workforce

ASSURE: Inform the Board where positive assurance has been received

The committee took significant assurance on the patient outcomes included in the Jack Sear report.

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

The risk of losing Deficit Support Funding in H2 was discussed and potential impact to cash flow of the Trust considered.

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

Committee Chairs' Report

People Committee – 20 October 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):

- 5.1 – Workforce Plan Transformation – Limited Assurance
- 5.2 – People and Education Capability and Capacity Work Stream: Progress Report – Satisfactory Assurance
- 5.3 – Culture Plan, Development and Learning – Limited Assurance
- F2SU Bi-Annual Report – Satisfactory Assurance
- Guardian of Safe Working Hours Report – Limited/Satisfactory Assurance
- 10-point plan internal audit and report – Limited/Satisfactory Assurance
- EPR Training and Stat Man Training implications – Satisfactory Assurance

- People Performance Report – Limited Assurance
- Quarter 2 PULSE Survey Results and 2025 National Staff Survey Preview – Limited/Satisfactory Assurance
- ER Dashboard Highlight Report – Limited Assurance
- NHSE Annual Senior Leader Visit Report – Satisfactory Assurance
- GMC National training Survey Report – Satisfactory Assurance
- Internal Audit Reports – Payroll Internal Audit Report – Satisfactory Assurance

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 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)

5.1 Workforce Plan Transformation will not deliver targeted cost savings (see note below - Advise). Board needs to seek assurance that alternative (non-pay) actions will mitigate gap.

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

5.1 limited assurance. Compulsory redundancy (CR) target will not be met due to absence of national/regional CR cost support. MARS scheme has delivered some of this target. The delta will be delivered through non-pay but this is yet to be fully understood.
5.3 limited assurance. Clarity on focus and actions for the culture plan are required.

ASSURE: Inform the Board where positive assurance has been received

Resident Doctor Ten Point Plan – working group review indicates we are delivering much of what is outlined in the Ten Point Plan with actions in place to address outstanding issues. Resident Doctor Peer Representative identified and will attend Board as required. Good engagement with Resident Doctor body.

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

- A significant number of people policies are out of review date. Specific risk relating to non-compliance with employer duties resulting from *Worker Protection (Amendment of Equality Act 2010) Act 2023* (prevention of sexual harassment in the workplace). Plan in place to risk assess outdated policies and to prioritise reviews and updates. People Committee will monitor progress.
- EPIC implementation will adversely affect statutory and mandatory training compliance rates. Modelling being undertaken to understand catch up trajectory post EPIC go-live. To be tracked as part of People Performance dashboard.

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

NHSE Multi-Professional Education Quality Review Visit Report – partnership with the Open University to deliver the Pre-Registration Nursing Programme recognised as a nationally unique education experience that provides opportunity for local employment growth and development (widening participation). A testament to the dedication and innovation of the education team within the People and Education Directorate.

Committee Chairs' Report

Building a Brighter Future Committee – 16 October 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):

- Strategy Update (verbal) – Satisfactory Assurance
- Estates Capital Highlight Report – Satisfactory Assurance
- Critical Infrastructure Update – Limited Assurance
- Teignmouth Community Hospital Update – Satisfactory Assurance
- Digital Update – Limited (trending NO) Assurance
- Cybersecurity Assurance Update – Limited Assurance
- EPR Update Report – Satisfactory Assurance

ASSURANCE RECOMMENDATION:

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)

- Estates infrastructure of main Torbay site remains fragile despite ongoing maintenance efforts. An updated infrastructure condition assessment (6 FACET survey) is planned that will highlight further risks of failure & maintenance priorities. Age & condition of overall estate such that major failures impacting provision of services should be expected. Alerting the Board to seeking to escalate risks with Commissioners as estate condition on a par with other NHS failing RAAC hospitals (receiving priority refreshed NHP wave 1 funding)

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

- Progress on the appointment of a Devon-wide CIO core implementation of the agreed Target Operating Model remain slow, lacking urgency or progress despite repeated assurances from the Devon-wide responsible team. To note, RDUH is flagging this lack of progress/commitment to a CIO appointment across Region & lack of senior CIOs in each of the Trusts as high risk in its BAF. Appointment of an interim TSD CIO to cover the next 12-18 months & oversee TSD strategic digital imperatives has been proposed but currently no clear timeline to appoint
- Active measures in place for testing & enhancing cyber security for current operations and IT services. However limited assurance provided on cyber security protection & resilience for future state. Some work with EPR programme to enhance for implementation of EPR & plans underway for independent assurance of current cyber security provision. Further work still required to determine strategy & action plans to updated cyber security for future

ASSURE: Inform the Board where positive assurance has been received

- Report received on updated remedial works to Tower block completer or in progress; positive assurance received in engagement with senior officers from Fire Service
- Positive assurance on progress with EPR programme & increasing focus of attention & effort on business readiness, & role-based validation activity; further assurance being sought at next meeting on detail of benefits delivery plan including early transactional benefits
- Plan to exit all staff & patient services from Teignmouth Hospital shared; timelines for completion of exit to be finalised & subject to finalisation of service & staff relocation.
- Constructive, more focused & positive discussion on revised BAF objectives, reflecting the efforts being made on restructuring/refreshing the BAF

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

- Tower fire risks discussed along with current review process (Tower Risk Summit) & action plans to complete identified/agreed mitigation works or set out risk tolerance & management approach; paper being submitted to October Board setting out works completed or in progress, & outstanding risks with risk management/tolerance recommendations
- Delays to new ED now extended from 14 to 17 weeks with potential to add to winter pressures; actions being taken by contractors to limited further delays (inc week-end working)
- Disappointing delays with Open Reach service impacting Data Centre project with potential implications for migration of data; mitigation/workaround plans being developed
- BAF risks not reviewed as currently subject to an independent risk assessment process

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

Committee Chairs' Report – 17 November 2025

Quality Assurance Committee

REPORTS RECEIVED BY COMMITTEE:

The Board are asked to note that the following reports were received by the Committee and are escalated for their attention:

- Quality Report for Healthcare – Limited/Satisfactory Assurance - Mental Health Patients occupying an acute bed for a long period of time; a discussion was required between TSD and DPT to resolve this.
- Adult Social Care Report – Limited Assurance
- CQC Well Led Action Plan Update – Satisfactory Assurance
- Perinatal Governance and Safety Report (1 September 2025) - Satisfactory Assurance - The three neo-natal death cases, with the CNO recommending a thematic review to get a better understanding and learning.
- October 2025 Mortality Safety Score Card – Satisfactory Assurance
- Report on EQIA process and outcomes to date – Satisfactory Assurance
- Health Inequalities – performance report Q2 2025/2026 – Limited/Satisfactory Assurance
- Children and Family Health Devon (CFHD) Governance Report – Satisfactory Assurance
- Patient Safety Incidents Annual Report 2024/25 – Satisfactory Assurance
- Patient Experience Service Annual Report 2024-25 – Satisfactory Assurance
- Care Quality Commission (CQC) NHS Adult Inpatient Survey 2024 Benchmark Report (published September 2025) – Satisfactory Assurance
- Research & Development (R&D) Annual Report 24/25 – Satisfactory Assurance
- Safeguarding Adults Annual report – Limited/Satisfactory Assurance

The full Committee pack reviewed can be found on Diligent here:

[Diligent Boards: South Devon Health Information Services: Current Books](#)

ASSURANCE RECOMENDATION:

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

ALERT:	Concerns raised about increasing number of patients coming through ED with primarily a mental health problem. Difficulty in providing appropriate care in a physical health setting and lack of mental health support within the system. Three cases of Neonatal deaths within 2025 including two in a water bath have raised concerns which were discussed at QAC with the recommendation the CNO ensures a local thematic review of all 3 cases in addition to the external reviews that are undertaken, to determine if more urgent learning is required.
ADVISE:	CQC well led action plan is on an improving trajectory. There remain 2 outstanding 'must do' actions (MD2) relating to EDI and Bullying and Harassment. This is progressing within Our Plan for better care 5.3 People Programme. The second outstanding action relates to reducing patient waiting times and in particular outpatient waiting times. Satisfactory assurance achieved on improvement and actions being taken which were described at QAC by Sam W-S.
ASSURE:	Satisfactory Assurance received for the Mortality Score Card Report. HSMR+ was 103.7 and within the expected range as was the SHMI 95.1 (may24-april25). Focussed Mortality reviews underway in; still birth/neonatal deaths and stroke. Challenges exist in the clinical coding team capacity and IT systems resulting in timely reporting and accuracy of recording of frailty and comorbidity data.
RISK:	QAC reviewed the new BAF pertaining to the quality objectives. We also reviewed the new Datix Risk register requesting some more narrative particularly around the red rated risks , such as 'Pharmacy Aseptic Services'. DOL's remains a risk BUT the introduction of Independent BIAs is starting to have an impact and has reduced by 101 applications. Challenges remain due to limitations in PARIS digital system storing this information.
CELEBRATE OUTSTANDING:	Satisfactory Assurance of our R&D activity with significant contributions to national multi-centred trials. This research activity attracts and retains staff, generates financial

	income and most importantly provides patients the opportunity to receive the latest treatment designs that may otherwise not be available to them. There is increasing evidence that research active trusts have improved outcomes.

Committee Chairs' Report – 19 November 2025

Finance and Performance Committee

REPORTS RECEIVED BY COMMITTEE:

The Board are asked to note that the following reports were received by the Committee and are escalated for their attention:

- Month 7 Finance Report – Satisfactory/Limited assurance
- 26/27 Budget Setting Principles – Satisfactory assurance
- Operational Performance Report – Limited/Satisfactory assurance
- Frailty Service Review – Satisfactory assurance
- Peninsula Pathology Target Operating Model (TOM) Programme Business Case – satisfactory assurance

The full Committee pack reviewed can be found on Diligent here:

[Diligent Boards: South Devon Health Information Services: Current Books](#)

ASSURANCE RECOMENDATION:

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

ALERT:

The committee noted the removal of deficit support funding in Q3 and the assumption that it will be recovered in Q4 (based on advice from the ICB) and also discussed the risk of this not being recovered in Q4 and the potential impact on the forecast outturn.

The committee also raised the impact of ambulance demand growth (2%) and the 5% growth in conveyance to ED following the implementation of THP

ADVISE:

The Committee took limited assurance on the forecast outturn and noted that whilst the risk to delivery had reduced in month 7 to £17.8m (£18.9m in month 6) and there are robust plans to deliver £10.7m (M6 £10.3m) of the further savings required there remains a further £3.6m (M6 £4.8m) of high-risk actions identified, leaving a gap of £3.8m and therefore the net risk to delivering the forecast outturn is therefore £7.4m (M6 £8.6m) and work was ongoing to close the gap in year.

ASSURE:	The committee noted the improvement in performance with both Elective waits and Cancer Targets coming back on track.
RISK:	There is a risk that operational performance targets are not delivered due to excess demand and available capacity. In addition the Trust must find investment to enable service transformation and adoption of new MedTech and Therapies to provide for greater value and efficiency,
CELEBRATE OUTSTANDING:	

Board of Directors

Information: Legal and Regulatory Updates

Date of meeting	Date report produced
26 November 2025	20 November 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:	20 November 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 since the last meeting, as follows: September Joint executive team to be set up across DHSC and NHS England - GOV.UK NHS England » 'Stress tests' and pre winter check-ins as NHS ramps up winter prep NHS England » Building on our progress in the second half of 2025/26 NHS England » Implementing integrated care board mergers and boundary changes to take effect in April 2026 and 2027 Professional strategy for nursing and midwifery - defining the next era of nursing and midwifery - NHS England - Citizen Space NHS England » New NHS online hospital to give patients more control over their care NHS England » Update on an important change in national policy regarding subsidiaries 10 Year Workforce Plan - GOV.UK AI to be trialled at unprecedented scale across NHS screening - GOV.UK

[NHS England » Implementing patient initiated follow-up: Guidance for local health and care systems](#)

[NHS to invest in pioneering tech to drive down waiting lists - GOV.UK](#)

[Independent maternity and neonatal investigation: terms of reference - GOV.UK](#)

October

[Government to tackle antisemitism and other racism in the NHS - GOV.UK](#)

[Independent maternity and neonatal investigation: terms of reference - GOV.UK](#)

[Major NHS AI trial delivers unprecedented time and cost savings - GOV.UK](#)

[NHS England » Medium Term Planning Framework – delivering change together 2026/27 to 2028/29](#)

November

[Intellectual property \(IP\) guidance for the NHS in England - GOV.UK](#)

[Top NHS trusts given new powers to improve care - GOV.UK](#)

[Billions to be redirected back into patient care with NHS reform - GOV.UK](#)

[Health boost for Britain's forces as new NHS programme launches - GOV.UK](#)

[Patients to benefit from cutting-edge NHS care from their homes - GOV.UK](#)

[NHS recovery continues with above target productivity growth - 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	All
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	
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.

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	SFIs/SoD/Sos (2026) Review of Board Workplan Risk Management Strategy/Policy Trust Strategy
Cyclical items	Patient Story Chairman's Report Chief Executive's 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 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 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 Reports from Board Committees IPQR EPR Status Report Month 5 Finance 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 Information: Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR EPR Status Report Month 5 Finance Report Mortality Safety Scorecard Maternity: - Perinatal Governance Report - Maternity CQC Patient Survey - Maternity Bi-Annual Staffing - Maternity CNST 7 Day Week Assurance End of Life Annual Report EPRR – NHSE Assessment Our Plan for Better Care Information: Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR Summary of Planning Guidance and Trust Approach EPR Status Report Month 5 Finance 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: Legal and Regulatory Updates
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 Delivery of the Workforce Plan	Safeguarding Adults Annual Report Patient Experience Annual Report Annual Adult Care Strategic Agreement Guardian of Safe Working Hours (amalgamated report) Trust Strategy Annual Plan 2024/25 (May) Delivery of the Workforce Plan Research and Development Annual Report	Charity Committee Annual Report (and montage video)	

				Advanced Clinical Practice Strategy		
Requested Reports	NHS WRES/WDES Report		Month 5 Finance Report Our Plan for Better Care People Programme 5.3 Culture Plan Information: Legal and Regulatory Updates Responding to the invited Developmental Well Led Review			Responding to the invited Developmental Well Led Review
Future Items			Green Plan			

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

Public Board of Directors - Items for Information

Date: Wednesday 26 November 2025

Time: 12 noon - 2.30 pm

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

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TSDFT Public Board of Directors - Information Pack

Board Information Pack



26/11/2025 12:00 - 14:30

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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.

QUALITY, SAFETY AND PATIENT EXPERIENCE		
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.		
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.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (November 2025)		Previous assessment: Satisfactory (October 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:	Mitigating factors:	Gaps in control & associated actions:
- Workforce vacancies - High patient acuity and increased frailty seeing a rise in demand and baseline of risks	- Daily safety huddles - Established early warning scores and risk assessments - Incident date reported and monitored by clinical governance teams - Leadership and safety walk arounds	- 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	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
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	1. Patient Safety and Quality teams monitoring incident trends and learning from review and leading QI programmes 2. Divisional and Corporate Governance structure (SQAG/QAC/Risk Group) 3. Mortality review group: structured learning and escalation of themes 4. Nursing and Medical leadership oversight through quality dashboard/IPR 5. IPQR review (EOG/ExCo)	1. Internal/external audit review 2. External regulatory assessment (CQC, NHSE, peer reviews) 3. Benchmarking against national data (Model Hospital) 4. Board level scrutiny via QAC, ARC and Board meetings

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.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (November 2025)		Previous assessment: Satisfactory (October 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:	Mitigating factors:	Gaps in control & associated actions:

- 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	- Daily operational huddles and escalation protocols - Executive oversight through Site Management and EOG - Quality Governance monitoring including focus on harm from long waits - Targeted initiatives to improve discharge planning and flow (right care week)	- 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	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Frontline operational teams managing patient flow to meet performance standards - Clinical teams implementing harm stratification for long waiting patients and escalating risks - Local ward leadership monitoring performance and addressing bottlenecks - Daily ward huddles and twice daily board rounds	- Safety and Flow meetings 3 times a day - Risk escalation committees ensuring long wait patients with potential harm are prioritised - Regular reporting to ExCo - CMO and CNO leadership	- Internal audit reviewing operational processes - CQC/NHS assess access standards and safety of long waits - Independent harm reviews associated with delayed care - Benchmarking against national standards for waiting times and elective and urgent care - Board level scrutiny via Audit committee and QAC

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.

Executive lead: Chief Nursing Officer

Board oversight Committee: Quality Assurance Committee

Current assessment: Limited (November 2025)

Previous assessment: Limited (October 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 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:	Mitigating factors:	Gaps in control & associated actions:
- 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.	- 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.	- 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	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
1. Frontline public health and community teams delivering screening, health promotion, and early intervention services. 2. Local leadership monitoring programme uptake and outreach activities. 3. Patient engagement, education, and proactive risk identification in primary and community care.	1. Population Health / Public Health teams providing oversight, reporting, and quality assurance. 2. Regional leadership reviewing programme performance and equitable access. 3. Executive oversight via quality and performance dashboards	1. Internal Audit of prevention and early intervention programme delivery and effectiveness. 2. External review from regulators or national bodies assessing public health programme outcomes. 3. 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.

Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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:	Mitigating factors:	Gaps in control & associated actions:
• 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	• 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	• 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	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:

- 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.	- 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.	- 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.

Executive lead: Chief Nursing Officer

Board oversight Committee: Quality Assurance Committee

Current assessment: Satisfactory (November 2025)

Previous assessment: Satisfactory (October 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:	Mitigating factors:	Gaps in control & associated actions:
- 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.	- 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.	- 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	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- 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.	- Corporate Performance and Quality Teams providing monitoring, analysis, and escalation support. - Executive leadership reviewing monthly performance and financial reports.	- 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.

	Quality Governance Committees and Finance & Performance Committee providing oversight.	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.

Executive lead: Chief Nursing Officer

Board oversight Committee: Quality Assurance Committee

Current assessment: Limited (November 2025)

Previous assessment: Limited (October 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:	Mitigating factors:	Gaps in control & associated actions:
- 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.	- 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 - Alignment with national IPC guidance and regulatory requirements (CQC, NHS England). - Monthly IPQR reporting to the Board.	- 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.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (November 2025)		Previous assessment: Satisfactory (October 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:	Mitigating factors:	Gaps in control & associated actions:
• 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.	• 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	• 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. • Staff completing mandatory training and participating in continuous professional development.	• Maternity Governance Group and Safety Champions monitoring compliance, harm events, and experience metrics. • Care Group leadership reviewing performance dashboards and overseeing corrective actions. • Executive oversight through Quality & Safety Committee and Board reporting.	• Internal Audit reviewing maternity compliance, harm reduction initiatives, and patient experience processes. • External regulatory review (CQC, NHS England) assessing safety, compliance, and patient experience. • NHS Maternity Incentive Scheme reporting and benchmarking against national standards. • Board-level scrutiny via Audit and Quality Committees.

LEADERSHIP AND GOVERNANCE		
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.		
SUPPORTING OBJECTIVE: Development programmes for the Board and Executive team in place and ongoing- aligned with IIP (integrated improvement plan) delivery milestones.		
Executive lead: Director of Corporate Governance and Trust Secretary		Board oversight Committee: People Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 2025)
Overarching comment & rationale for assessment: Whilst the workstream is deemed in month (November 2025) as off track overall –all milestones are being delivered in within the anticipated timescale following receipt of the Well Led review (later than anticipated), from which all governance actions aligned to ensure we have a single plan and we take actions once and well. This has been discussed at the OPBC oversight meeting. Programmes for Board and Executive Development were finalised and at Board development (29/10/2025), a further paper is enclosed in the Board papers today. Limited assurance is proposed until these actions are approved and implemented, aligned to the partial assurance confirmation for governance in the Board self-assessment.		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
- Delay in programme of development due to delayed receipt of Well Led review - Competing priorities - Conflict and division between board members	- Assessment of gaps in resource and consideration of RSP support - Oversight and priorities reviews at Executive Committee	- Board and leadership effectiveness rating – survey and 360 feedback in plans - Skills review and matrix to be completed - Board prioritising through Development sessions
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 KPIs	OPBC oversight meeting Board	NHSE RSP CQC
SUPPORTING OBJECTIVE: Develop a strong executive team with clear accountabilities and objectives- aligned with IIP delivery milestones.		
Executive lead: Chief Executive		Board oversight Committee: Nomination and Remuneration Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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. The Executive Team all have clear objectives within their individual portfolios and clear accountabilities set out in Our Plan for Better Care. 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:	Mitigating factors:	Gaps in control & associated actions:
- A number of changes in the Executive team in recent years impacts on cohesive and stable leadership or perception thereof. - CPO/CFO roles held by interims - Tension between organisational focus and system priorities	- 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	Recruitment to substantive posts planned to commence Oct / Nov 2025

including Devon ICB and wider system financial pressures • RSP resource and support is withdrawn • Potential for organisational changes / changes to group model	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	
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.

Executive lead: Director of Corporate Governance	Board oversight Committee: Audit and Risk Committee
Current assessment: Limited (November 2025)	Previous assessment: Limited (October 2025)

Overarching comment & rationale for assessment:

Whilst the workstream is deemed in month (October 2025) as off track overall –all milestones are being delivered in within the anticipated timescale following receipt of the Well Led review (later than anticipated), from which all governance actions aligned to ensure we have a single plan and we take actions once and well. This has been discussed at the OPBC oversight meeting. The implementation of the actions will also be discussed at Board development today. Limited assurance is proposed until these actions are further implemented, aligned to the partial assurance confirmation for governance in the Board self-assessment.

Risk to delivery:

Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
• 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.	• 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	• 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.

	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.	
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.

Executive lead: Chief People Officer

Board oversight Committee: People Committee

Current assessment: Limited (November 2025)

Previous assessment: Satisfactory (October 2025)

Overarching comment & rationale for assessment:

The organisation's culture sets the foundation for engagement with its people and in turn contributes to strengthening the culture. A dis-engaged workforce leads to a decline in morale and performance. Positive engagement will drive positive behaviours (including leadership), create a sense of belonging, encourage collaboration and improve performance and retention. Engagement with our people is more important than ever during this period of continued challenge and change.

The Trust has not been able to evidence demonstrable impact following its commitment to the Culture Charter and implementation of the compassionate leadership framework and metrics such as the staff survey continue to indicate staff do not feel engaged and involved in change.

Risk to delivery:

Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
- Previous culture plans have been over-complicated with no evidence to suggest improvement. - Engagement initiatives have been unclear. - There is currently no framework in place on which to measure success.	The Our plan for better care people programme has ensured engagement with our people and leadership development are priorities and that progress and improvement is monitored. This is led by the Chief People Officer and overseen by the Executive Directors, People Committee and Trust Board.	Gaps in control & associated actions: - Lack of a clear framework and triangulation of metrics and data to be able to fully assess staff experience. Actions - Implementation of the Cultural Insights Group (first meeting 21.11.25). - Clarity on engagement initiatives. Actions – Framework to be developed and shared with Cultural Insights Group 21.11.25. - No Employee Relations caseload reporting to support understanding the themes and hot spot areas. Action – new

		dashboard to be developed and reported through People and Education Governance Group 11.12.25 and People Committee 15.12.25. No evidence to demonstrate impact of compassionate leadership framework. Action – Review to be undertaken in line with leadership development plan – proposal due to Executive Committee 18.12.25.
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:
- Chief People Officer weekly review with workstream leads - 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 Our Plan for Better Care Oversight Group - Monthly review by the People and Education Governance Group (PEGG). - Monthly review of Care Group and Trust wide workforce performance at Executive Operational Group (EOG) - Corporate Risk register - Bi-monthly reviews at People Committee - Internal audit	- ICB/NHSE - NHSE Senior Leader Visit (annual). - NHSE and CQC visits and or reports.

PERFORMANCE		
OVERARCHING CORPORATE OBJECTIVE: Deliver the 2025/26 plan, including finance, quality, operational performance and workforce objectives		
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.		
Executive lead: Chief Operating Officer		Board oversight Committee: Finance and Performance Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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:	Mitigating factors:	Gaps in control & associated actions:
• 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, whilst recruiting to substantive appointments • Gaps in workforce in core specialties e.g. 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	• Action – Work with partners, e.g. ICB and SWAST on demand management plans • Action – ECIST improvement programme further right care week to be undertaken November 2025 • Action – Delivery of UEC improvement plan milestones, escalated focus on ward improvement programme and inter-professional standards for Q3. • Action – Delivery of elective care improvement plan milestones • Action – Winter Plan finalised and signed off by Board – September 25. System and regional plan testing took place on 3rd October with a further session on 7th November. There will be a weekly system meeting to undertake system learning and action. • 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 has been completed and agreed. This is awaiting formal sign off and an implementation date.	• Demand management plans are not clearly defined (Nov 25) • UEC improvement plan refocussed to deliver intended benefits (Nov 25) • Elective Care Improvement Group and performance processes strengthened, led by DCOO. • Winter plan testing complete, November 2025, mitigating actions regarding known risks, to be concluded by end of Nov 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	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- UEC recovery plan and meeting - Cancer Recovery plan and meeting - Diagnostics Recovery Plan and Meeting - Outpatient Transformation Plan	- Care Group Delivery Reviews (EOG) - Executive Committee - Our Plan for better care	- Weekly regional performance - ICB contract reviews - Regional elective recovery meeting - Cancer Alliance - FPC/ QAC - Board

- Elective Delivery Plan and Meeting		
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.		
Executive lead: Chief Operating Officer	Board oversight Committee: Building a Brighter Future Committee	
Current assessment: Limited (November 2025)	Previous assessment: Limited (October 2025)	
Overarching comment & rationale for assessment: the trust is responsible for effective fire safety which combines physical fire precautions and a robust and effective system of fire management. 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. The trust is also responsible for a Higher Risk Building (The Tower) which due to its height and its use as a hospital is subject to more stringent building safety regulations overseen by the Building Safety Regulator.		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
<u>Buildings:</u> - Substantial area of trust estate is in poor condition and life expired. - Insufficient capital to undertake required remediation and replacement of infrastructure - Fire safety condition of some trust buildings will not meet condition B - Lack of capacity in technical resource to optimise fire maintenance schedules and to proactively optimise fire safety assessment and management systems - Lack of equipment storage results in item in corridors and lobbies - Implementation of EPR will require additional IT devices and infrastructure that will require additional storage or charging areas - Lack of 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 Management system in place. - Fire Safety Policy and protocols in place - Fire Safety Management Structure audited in August 25 with satisfactory outcome. - Specific operational framework/manual being developed for the Tower given level of operating risk. (Underway September 2025) whats the completion date - Dawn - Fire Risks Assessment capacity review and case for additional resource – November 25 - 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) - ? Q3 too - Dawn - 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.	- 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) - 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)
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 -	- Trust Annual Fire Audit (Authorising Engineer) - Devon and Somerset Fire and Rescue Service Annual Audit - Property Assurance Model - - National ERIC Return - BBF Committee - Board

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.

Executive lead: Chief Operating Officer

Board oversight Committee: Building a Brighter Future Committee

Current assessment: Limited (November 2025)

Previous assessment: Limited (October 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. Due to the extent of risk held, Limited assurance is recommended.

Risk to delivery:

Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
• 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).	• 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.	• 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.

Disruption risk to clinical services during project delivery works.		
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.

Executive lead: Chief Strategy and Planning Officer	Board oversight Committee: Finance and Performance Committee

Current assessment: Limited (November 2025)	Previous assessment: Limited (October 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.

Limited assurance reflects the need to baseline and monitor KPI's before full assurance can be provided.

Risk to delivery:

Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
Unknown baseline for KPIs impacts on understanding where services should aim in the future	Agree KPI Specification to build a KPI report to aid reporting and review.	A draft KPI specification has been shared with key stakeholders. This has been

Workforce capacity in order to drive review of service as indicated in the objective and drive delivery	PMO support for the substantive project lines remains outstanding – will be escalated.	- revised and further work is in hand to conclude in October 2025. - 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.

Executive lead: Chief Strategy and Planning Officer		Board oversight Committee: Finance and Performance Committee
Current assessment: Satisfactory (November 2025)		Previous assessment: Satisfactory (October 2025)
Overarching comment & rationale for assessment: - The options appraisal report for a single provider was agreed at the October Board. Move to transition plan and due diligence commenced - Engagement with CFHD staff continues as planned.		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
- Change and uncertainty resulting in loss of staff impacting on capacity to deliver service - 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.	- 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 completed	- likely in post until mid Oct 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	- Integrated 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.

Executive lead: Chief Operating Officer	Board oversight Committee: Building a Brighter Future Committee
Current assessment: Limited (November 2025)	Previous assessment: Limited (October 2025)

Overarching comment & rationale for assessment: The Torbay and South Devon NHS Foundation Trust Board approved the Trust Green Plan in September 2025.		
Dawn – please summarise – refocus and be clear on confidence levels for Green Plan 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		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
• 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 • No dedicated specialist expertise to drive improvement of energy agenda and decarbonisation • 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. • Challenging organisational context does not position sustainability objectives high on the agenda	• Processes in place to enable replacement of environmentally inefficient assets. • Capital programmes to improve the environmental efficiency of the estate are supported through the adoption of the BREEAM standard for all newly constructed units. • 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. • The Trust Green plan has been refreshed and is due for approval by the Board in September 2025. • Trust strategy for 2026 onwards we will incorporate commitments across the sustainability agenda as set out in the refreshed Green Plan 2025.	• 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). • 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

PEOPLE AND CULTURE		
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.		
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.		
Executive lead: Chief People Officer		Board oversight Committee: People Committee
Current assessment: Limited (November 2025)		Previous assessment: Satisfactory (October 2025)
Overarching comment & rationale for assessment: A workforce strategy is important to align people priorities with the Trust's overall ambition, strategy and priorities and to ensure the Trust has the right people with the right skills to meet current and future needs. The strategy will support development of a positive culture, maximise workforce productivity, improve talent acquisition and retention and support the organisation's ability to transform services. Currently, the Trust does not have a signed off workforce strategy. The Our Plan for Better Care programme 5.1 'delivery of the workforce plan' currently has 12 key deliverables; Since July the priority workstreams have been focussed on reducing workforce costs including Pay Controls, MARS, People Digital and E-rostering. The 5.2 'People Directorate Capacity and capability' and 5.3 programme 'Culture, OD and Learning' will both support the development of a workforce strategy and a re-focus is required to ensure this is prioritised and completed.		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
- Previous iterations of a workforce/people strategy have been developed but not finalised or signed off. - No clear vision, strategic priorities and deliverables for workforce. - Operational plans focus on short term workforce plans and deliverables.	The Our plan for better care people programme has ensured that the development of a workforce strategy is a priority and that progress and improvement is monitored. This is led by the Chief People Officer and overseen by the Executive Directors, People Committee and Trust Board.	- Process for finalising the workforce strategy. Actions - people directorate workshops taking place in November and December. Strategy to be shared at next People Committee 15.12.25 - People strategy to align and be co-designed alongside the refreshed Trust strategy. Actions – Chief People Officer and team working with the Chief Strategy and Planning Officer and team to co-design during November and December. - The Our plan for better care programmes need to be reset with appropriate leadership and resource. Actions – Chief People Officer and Programme Leads to review following approval of strategy. - Clarity is required for oversight and assurance for delivery of the strategy. Actions – To be agreed as part of governance review. The People and Education Governance Group, Oversight Group and People Committee will oversee during this next period.
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 People Officer weekly review with workstream lead	Monthly flash report submitted to the Our Plan	ICB/NHSE

- 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.	for Better Care Oversight Group - Monthly review by the People and Education Governance Group (PEGG). - Monthly review of Care Group and Trust wide workforce performance at Executive Operational Group (EOG) - Corporate Risk register - Bi-monthly reviews at People Committee - Internal audit	- 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.

Executive lead: Chief People Officer

Board oversight Committee: People Committee

Current assessment: Limited (November 2025)

Previous assessment: Limited (October 2025)

Overarching comment & rationale for assessment:

The Our Plan for Better Care 5.3 programme will focus on developing and delivering the culture, learning and organisational development workstreams. The draft culture plan was submitted to the People Committee and Board in August and requires further refinement and clarity on the ambition, actions and measures to deliver. Work continues to develop our cultural insights data and group who will oversee engagement, feedback and action. This programme has some delays in progress and is rated as partially assured.

Risk to delivery:

Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
- Metrics such as staff survey indicate poor culture and staff experience. - No clear workforce strategy or culture plan to focus and drive positive change. - Prior culture plans have been overcomplicated and not demonstrated positive impact. - Limited wellbeing offers and support to people in work.	- The Our plan for better care' people programme 5.3 will focus on developing and embedding a culture where our people feel valued and supported and that embeds the principles of the people promise. - Lots of people engaged with lots of ideas to improve staff experience and wellbeing.	- The Culture plan requires further review and development. Actions – To be reviewed by the Chief People Officer and 5.3 programme leads, with support of a range of stakeholders and executive colleagues during December. - An improved collective and inclusive wellbeing approach is required. Actions – stakeholder workshop took place on 4.11.25. A further workshop is arranged for the 28.11.25. A collective proposal with wide ranging input will be presented to the Executive Committee and People Committee in December.
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 People Officer 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.	- Monthly flash report submitted to the Our Plan for Better Care Oversight Group - Monthly review by the People and Education Governance Group (PEGG). - Monthly review of Care Group and Trust wide workforce performance at Executive Operational Group (EOG)	- ICB/NHSE - NHSE Senior Leader Visit (annual). - NHSE and CQC visits and or reports.

NHSE and HEI reporting.	- Corporate Risk register - Bi-monthly reviews at People Committee - Internal audit	
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.		
Executive lead: Chief People Officer		Board oversight Committee: People Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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. This comprehensive analysis and insights gained will support agreement of refreshed workstreams by end of November. 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. Due to the extent of risk held, Limited assurance is recommended		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
Challenged capacity and capability of our people and education directorate to meet the needs of the organisation and its people.	'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.	- Following the needs assessment the work plan will be updated, oversight will be maintained at OPBC meetings. - Structure review – setting up agile teams to facilitate effective and efficient completion of work, information and communications flow, including governance, reporting and assurance. - 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.
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.	- Monthly flash report submitted to the Oversight Group - Monthly review by the People & Education Leadership Team (PELT). - Monthly review of Care Group and EOG	- ICB/NHS - NHSE Senior Leader Visit (annual). - NHSE and CQC visits and or reports. - Regular review at the ICB Workforce Delivery Management Group (Tactical and Strategic Cells)

- Individual team and service reviews as part of management and team meetings. - NHSE and HEI reporting.		

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

Executive lead: Chief Medical Officer/ Chief People Officer

Board oversight Committee: People Committee

Current assessment: Satisfactory (November 2025)

Previous assessment: Satisfactory (October 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:	Mitigating factors:	Gaps in control & associated actions:
Compressed timescale for delivery – a wide range of improvements must be implemented or initiated within 12 weeks, creating pressure on capacity and coordination.	- 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. - Clear leadership & accountability: CMO supported by DME, education leadership and 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.	- Workplace wellbeing audit & facilities improvement plan –Due November 2025: - Rota management compliance (8-week/6-week rule) – Ongoing from Sept 2025: - Payroll accuracy improvement programme - Mandatory training portability – In place (October 2025) - Study leave expense reimbursement – Due November 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:
- 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.	- People Committee receive a monthly update on this objective, including a review of progress and outstanding risks. - Executive oversight is maintained via the Executive Committee and internal performance reviews. A	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

Resident Doctors' Representative Committee (RDRC).	dedicated progress report on resident doctors working lives is scheduled at the Executive Committee in October 2025 for assurance	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..

STRATEGY AND BUSINESS INTELLIGENCE		
OVERARCHING CORPORATE OBJECTIVE: Develop and deliver a clear strategic vision for the Trust		
SUPPORTING OBJECTIVE: Full definition and resourcing of Our Plan for Better Care is in place; alongside the phases of delivery contained therein.		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Satisfactory (November 2025)		Previous assessment: Satisfactory (October 2025)
Overarching comment & rationale for assessment: - Development of each workstream plan on a page identified resource requirements - 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 - 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:	Mitigating factors:	Gaps in control & associated actions:
Available resource is continually impacted by sickness absence, turnover and competing demands	Governance structure to mitigate resource escalations through support for recruitment or potential reallocation of resource	Short term resource plan was completed for Employee Relations. Funding in place to undertake ER case work and training and development to build management capability.
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.		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: People Committee
Current assessment: Satisfactory (November 2025)		Previous assessment: Satisfactory (October 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: • 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:	Mitigating factors:	Gaps in control & associated actions:
• Complexity of the partnership landscape • Challenging financial/performance position and competing pressures for staff and leaders	• Strong emphasis of process on engagement and listening • Support of communications team	• 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.

Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Building a Brighter Future Committee	
Current assessment: Satisfactory (November 2025)		Previous assessment: Satisfactory (October 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) seamless journeys of care 4) Workforce, culture and learning 5) Digital, technology and clinical innovation backed by R&D 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:		Mitigating factors:	
• 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.		• Strong alignment of our strategy with national and local direction of travel.	
Three lines of defence:		Gaps in control & associated actions:	
First Line of Defence - Operational and Management Controls		Second Line of Defence - Oversight Functions and Internal Assurance	
• Continued engagement with partners and checking alignment with emerging strategies and plans (e.g. from NHS Devon).		• N/A	
Second Line of Defence - Oversight Functions and Internal Assurance		Third Line of Defence - External Assurance:	
• 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.

Joined up care in the communities in which people live	
Executive lead: Chief Planning and Strategy Officer	Board oversight Committee: Quality Assurance Committee
Current assessment: Satisfactory (November 2025)	Previous assessment: Satisfactory (October 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 from 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:	Mitigating factors:	Gaps in control & associated actions:
Potential conflicts with other organisational perspectives – e.g. GP partners and other NHS or VCSE providers	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.	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 strategy.	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		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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 (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. At this time, due to the uncertainty of the operating environment and number of workstreams in progress, causing conflicting priorities, limited assurance is proposed.		
Risk to delivery:		
Aggravating factors: • 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: • Shared goals relating to equity across Devon and Cornwall • Focus given to strategic development and delivery	Gaps in control & associated actions: 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.		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Building a Brighter Future Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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:	Mitigating factors:	Gaps in control & associated actions:
- 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. - External approval processes (NHSE, DHSC, Treasury) are lengthy and subject to political priorities.	- 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. - New six facet survey has been commissioned and will be completed before the end of the year.	- 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.

Dependence on wider system prioritisation may dilute Trust-specific bids.		
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.		
Executive lead: Chief Planning and Strategy Officer	Board oversight Committee: Building a Brighter Future Committee	
Current assessment: Limited (November 2025)	Previous assessment: Limited (October 2025)	
Overarching comment & rationale for assessment: Current IT systems are inadequate for business needs, with significant risks from legacy system vulnerabilities, environmental and global cyber threats. While investments have been made to upgrade infrastructure, full mitigation depends on successful Epic implementation in April 2026 along with a relocation of the Trust datacentres to a fully managed environment. The EPR Programme, working with EPRR teams, is assessing datacentre cyber-attack risks and implementing safeguards to ensure rapid recovery, as well as coordinating business continuity planning in response to potential disruptions to critical services.		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:

• Non-compliance with cyber security standards. • Vulnerability to cyber-attacks. • Outdated or unsupported hardware. • Possible underfunding of critical infrastructure due to EPR investment needs. • Delays in datacentre upgrades and patching. • Limitations to ASC (Adult Social Care), and Health services due to aging PARIS platform.	• DSPT (Data Security and Protection Toolkit) standards, including Cyber Essentials, are fully met with positive assurance provided by ASW Assurance. • A cyber assurance framework protects Epic's digital infrastructure. • IT investments are prioritised by risk and backed by capital funding for 2025/26. • The shift to managed infrastructure services and Microsoft 365 InTune is in progress. • The procurement of a new system driven by Torbay Council for ASC, with the Health component transitioning into the EPR.	• Risk remains of sophisticated cyber-attacks despite existing security measures. - o Cyber Security Manager conducts best practice reviews, self-assessed and reported to the Audit & Risk Committee. • Ongoing capital and revenue investment needed to maintain and improve digital infrastructure. - o IM&T and CIDG operate a rolling 5-year capital investment plan for key infrastructure upgrades. • Datacentre relocation poses a risk to the EPR programme if not completed by February 2025. - o Contingency plans allow for project pausing (with limited financial impact) and restart after Epic go-live.
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.	DSPT/Cyber Assessment Framework with ASW validation of DSPT assertions, aiming for compliance with 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		
Executive lead: Chief Planning and Strategy Officer		Board oversight Committee: Quality Assurance Committee
Current assessment: Improving – Satisfactory (November 2025)		Previous assessment: Satisfactory (October 2025)
Overarching comment & rationale for assessment: The Digital Innovation & Development programme continues to demonstrate satisfactory progress with positive momentum. The Digital Innovation Steering Group (DISG) governance framework is now drafted and ready for launch, providing enhanced oversight through a four-gateway model for innovation projects. Digital Futures is in the process of being accepted as a testbed for the Health Innovation Network, strengthening our regional innovation capabilities position. Key developments include securing fourth-year funding for the InSites Clinical Entrepreneur Programme, success with a new UKRI partner grant, and strong alignment with national priorities including the NHS 10 Year Plan. We continue building our talent pipeline through apprenticeships (with South Devon College) and postgraduate research partnerships (with Falmouth University), though financial pressures have capped some apprenticeship opportunities. External sponsorship conversations are underway to address this. Our horizon scanning function and innovation communications plan are now drafted. The Data and AI Academy pilot with Multiverse has launched for staff development. Areas requiring continued focus include cultural transformation and regulatory compliance (both currently rated as "Limited" but improving), particularly around implementation support capacity and skillsets to ensure successful translation of innovations into practice		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
Implementation Support Capacity – Critical gap in dedicated implementation support resources		

- Regulatory Complexity – Evolving landscape for digital health innovations, particularly around AI and data governance - Skills Gap – Variation in digital literacy across staff groups - EPR focus without clearer landscape for innovation to compliment at this stage	- External partnerships provide access to implementation expertise and resources - NHS England regulatory guidance and DTAC Framework; Trust AI Policy prepared for ExCo review - Structured Digital Skills Development Programme launched on LMS with roadmap for further deployment	- Implementation Support Capacity and Skillsets – Establish dedicated implementation support through restructure activity (Q4 2025/26) - Benefits Realisation Tracking – Implement standardised benefits realisation framework with regular monitoring
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 operational oversight, clinical safety assessments, and structured project management with monthly reviews	- DISG gateway assessments (launching Q4), Quality Assurance Committee board-level oversight, and Information Governance compliance monitoring - Information Governance ensuring data protection compliance oversight and information security risk management	Health Innovation Network South West expertise, academic partnerships for independent evaluation, and NHSE InSites programme knowledge exchange

FINANCE		
OVERARCHING CORPORATE OBJECTIVE: Providing a fit for purpose environment, where our people have the conditions to succeed and deliver excellent patient care.		
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.		
Executive lead: Chief Finance Officer	Board oversight Committee: Finance and Performance Committee	
Current assessment: Satisfactory (November 2025)	Previous assessment: Satisfactory (October 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 term 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:	Mitigating factors:	Gaps in control & associated actions:

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 - National planning guidance and allocations when published increase the system requirement to deliver CIP (Convergence, Deficit repayment etc) - The Trust does not secure the required level of additional recurrent income from partners to support Adult Social Care and CHC - Impact of transformational changes either do not materialise or are delayed in implementation	Forecast review undertaken at month 4, additional mitigating actions identified and added to the cost improvement plan - 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) - 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. - Devon Wide PMO established to track and monitor delivery of transformational change	- Further work required to assess in year mitigations as recurrent/non recurrent by the end of November - Care Groups to either identify recurrent pay savings or agree to a recurrent vacancy factor being applied to their budgets by end of November - 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 November - Further work required to identify all changes with timescales and estimate financial impact by end of November
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:
CFO and CSPO update reports to ExCo, FPC and Board	Our plan for Better Care oversight and Executive Operations Group	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		
Executive lead: Chief Finance Officer		Board oversight Committee: Finance and Performance Committee
Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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 7 the Trust is reporting a deficit to plan of £2.5m, solely due to the exclusion of deficit support funding. The year to date position, including deficit support funding, remains on plan. The Trust has exceeded its CIP target to date by £1.2m, however following a review of the forecast outturn based on current run rate, there is a gross risk of £17.8m 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 £10.7m of the further savings; with a further £3.6m of high-risk actions identified, leaving a gap of £3.8m. The current risk to delivering the forecast outturn is therefore £7.4m.		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:

- Levels of growth on services exceed planned levels resulting in a requirement to increase resource to maintain performance and safety - The planned level of cost improvement is not delivered on a recurrent basis - The planned level of deficit support funding is not secured if the system does not deliver its financial plan - Digital and physical environments are not fit for purpose resulting in a significant backlog maintenance requirement and increased operating costs	- 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) - Programme Management Office 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 - System management of cash led by ICB with Devon wide cash risk management policy in place - Cash Committee meeting monthly - Daily cash flow monitoring and increased management of Debtors and credit control - Multi year capital programme and bids for additional cash backed external funding - Regular re prioritising of capital allocations to address highest infrastructure risks. - Accountability framework starting to be embedded across all domains ie Finance, Performance, Workforce, Quality and Safety through Executive Operations Group	- Further work required to analyse productivity and benchmarking information and develop plans for improvement to be included in the 2026/27 planning round - 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 November - Business cases submitted for national PDC to support critical infrastructure and constitutional standards awaiting national approval by end of November
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:
- CFO reports to ExCo, FPC and Board - Monthly review and challenge of Care Group financial performance (YTD and Outturn) at EOG, Financial Review meetings	Our plan for Better Care oversight and Executive Operations Group	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.		
Executive lead: Chief Operating Officer		Board oversight Committee: Finance and Performance Committee

Current assessment: Limited (November 2025)		Previous assessment: Limited (October 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) - Commissioner-led One Devon 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 (many 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:	Mitigating factors:	Gaps in control & associated actions:
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

APPENDIX 1

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.

Audit and Risk Committee

Items for Information

Date: 22nd October 2025

REPORTS PRESENTED TO THE BOARD FOR INFORMATION

The following reports are provided to the Board of Directors for information:

- Freedom to Speak Up Bi-Annual Report
- 2024/25 Committee Annual Report

Audit and Risk Committee

Freedom to Speak Up Bi-annual report

Date of meeting	Date report produced
22 nd October 2025	2 nd October 2025

Author(s)		Report approved by	
Name and title:	Sarah Burns Freedom to Speak Up Guardian	Name and title:	Jess Piper Acting Chief People Officer
Phone:		Date:	12 th October 2025
Email:	sarahj.burns@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 bi-annual report to People Committee and Trust Board provides an overview of the Freedom to Speak Up concerns raised by staff. The report highlights that a significant number of staff use this route to raise concerns with themes continuing to be poor behaviours impacting on staff wellbeing and patient safety, bullying & harassment and variable management response to reasonable adjustments and flexible working to support staff to stay in work. The assurance ratings in this report are based on the outcomes of the review meetings held between the Acting CPO and the FTSU Guardian. In light of the number of concerns raised, there is satisfactory assurance that staff feel able to speak up, albeit at times anonymously. However, there is limited assurance that appropriate action has been taken to address the underlying causes of the concerns relating to bullying and harassment, poor behaviours and patient safety concerns.

Appendices	
N/A	
Committees that have previously discussed/agreed the report, and outcomes of that discussion	
N/A	
Key recommendations and actions requested	
Audit and Risk Committee is asked to (a) note the nature of concerns raised, (b) the speak up function to be the responsibility of providers (c) interim arrangements for staff to speak up.	
How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?	
Patient Safety is directly correlated with the wellbeing of staff, The Freedom to Speak Up Guardian service is an essential to the creation of an environment at work where everyone feels safe, healthy, and supported to speak up.	
How does the report support the Triple Aim	
Aim	Impact
Population Health and Wellbeing	Speaking up culture is linked to continuous improvement in care quality, staff and patient well being.
Quality of services provided	Encouraging workers to speak up is linked to patient safety & continuous improvement.
Sustainable and efficient use of resources	A speaking up culture reduces harm to patients and improves staff retention.
Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Learning from FTSU reports reduces likelihood of patient harm.
Leadership and Governance	
Performance	
People and Culture	Contributes to creation of a culture where staff feel safe, healthy and supported. Contributes to creation of a culture where staff feel safe, healthy and supported.

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 Well Led
NHS National Contract
NHS Employers national policy, guidance

Freedom to Speak Up Bi-annual Report

1. Introduction and Background

People are the eyes and ears of an organisation. Their views, improvement ideas and concerns can act as a valuable early warning system that a policy, process or decision is not playing out as anticipated or could be improved. When people feel that speaking up about poor behaviour is welcomed and encouraged, and that it will be addressed at an early stage, organisations become less entrenched in formal employee relations processes. People's voices play a vital role in informing and driving improvement. However, speaking up is not always easy – especially in organisations where leaders do not welcome challenge or change. That is why putting in place effective, person-centred speaking-up processes will support people to speak up and protect them in doing so.

2. Volume and Nature of Concerns Raised

There have been 77 cases raised to the Freedom to Speak Up Guardian in the period April to October 2025, a slight decrease from the previous six months. The number of anonymous concerns have remained the same. The dominant theme continues to be poor behaviour from incivility to bullying and harassment including behaviour that has a direct impact on patient safety and quality. Lack of reasonable adjustments to support staff to stay in work and variability around flexible working has also increased. The concerns are not from hot spots, the concerns come from various departments and locations across the organisation.

3. Type of Concerns Raised

Type of Case	May 24 – Oct 24	Nov 24 – April 25	April 25 – Oct 25
Bullying and Harassment	16	25	8
Patient Safety	7	14	9
Failure to follow process	14	22	10
Diversity and Inclusion	3	0	0
Staff Safety	8	1	8
Culture of organisation	35	27	41
Fraud	3	1	1
Other	0	0	0
Total	86	90	77

4. Speaking up by Staff Group

Staff Group	May 24 – Oct 24	Nov 24- April 25	April 25 – Oct 24
Medical	5	3	1
Nurse	20	12	24
Midwife	5	8	4
AHP	23	15	15
Senior Manager	8	0	4
HCSW/AP	13	13	5
A&C	28	27	22
EFM	5	1	0
Other	0	1	2

Nurses are the highest group of staff speaking up, followed by Admin and Clerical staff and Allied Health Professionals. Anonymous concerns through the WorkInConfidence platform have involved sensitive issues including the UK Supreme Court ruling on the definition of sex as used in the Equality Act, the Trust's position on the use of gender neutral and accessible facilities, lack of multi disciplinary working in the Intensive Care Unit and violence and aggression.

5. National Guardian Office

The review of patient safety across the health and care landscape undertaken by Dr Penny Dash included a review of the effectiveness of the National Guardian Office (NGO). The Office does not have statutory functions but is part of the well led domain in CQC inspections. It was established in 2016 following the Mid Staffordshire Public Enquiry and was one of the recommendations from the Freedom to Speak Up review by Sir Robert Francis.

There is an extensive network of Freedom to Speak Up Guardians across the NHS and wider healthcare organisations. The Dash review identified that the NGO duplicates work carried out by providers and the network is now not only established but there are clear routes for staff to escalate concern that have been set out by government.

Therefore the functions of the NGO will be more aligned with other staff voice functions in NHS England (NHSE) such as the NHSE Freedom to Speak Up case management function that currently sits in the workforce, training and education directorate. This will ensure greater access by guardians to resources such as data and insights. It would also strengthen and streamline the functions bringing compliance against both NHSE policy and NGO guardian training and reinforce the importance of listening to and acting on worker voice.

The responsibility for Freedom to Speak Up Guardians will be placed within commissioners and providers but there will still be a need to ensure a level of independence to support Freedom to Speak Up functions. The role played by the senior non-executive director in Freedom to Speak Up should continue. A core function of CQC will be to assess that every commissioner and provider has effective Freedom to Speak Up functions with the right skills and training to speak up.

6. Interim Arrangements

As the National Guardian Office is due to close by March 2026 with further guidance, including the continuation of the guardian role in the National Contract, will be provided during this time period. Therefore there is an opportunity to review the speak up function with the departure of the current Freedom to Speak Up Guardian. Interim arrangements are to include the strategic element of FTSU to be held by the People Promise Manager until clear guidance received is from NHSE for providers. The generic guardian email and Work In Confidence anonymous platform will be monitored by the Wellbeing Development Facilitator who will triage and signpost concerns as appropriate with any urgent concerns escalated to the People Promise Manager or Executive Lead for Speaking Up.

Wellbeing Buddies and People Promise Ambassadors will be asked to provide a listening ear as identified people across our organisation to 'speak up' to in the workplace with a clear process for them to follow if escalation is required. Clear communication on who to speak up to in the interim period will be via ICON, Speak up intranet page and automatic response on generic email. Signposting via the culture charter will be reinforced as below:

If you want to speak up about anything that is getting in the way of you being able to do your job then you can seek help from:

- your line manager and immediate team members
- or your line manager's line manager
- our employee relations team
- your trade union representative or professional body
- Work In Confidence anonymous platform via ICON
- occupational health,
- employee assistance programme
- wellbeing team
- chaplaincy
- other wellbeing services and staff networks including our wellbeing buddies, the ethnic minority network, LGBTQ+ network, carers network, mental health forum, business equality forum
- mediation
- our speaking up policy

7. Recommendations

Audit and Risk Committee is asked to

- (a) note the nature of concerns raised.
- (b) the speak up function to be the responsibility of providers
- (c) interim arrangements for staff to speak up

Audit and Risk Committee

2024/25 Committee Annual Report

Date of meeting	Date report produced
22 October 2025	01 October 2025

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	Name and title:	Mark Greaves Committee Chair
Phone:	655409	Date:	01 October 2025
Email:	Sarah.fox@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 2024/25 Audit and Risk Committee Annual Report was first presented to the Committee in July for approval. At that time it was felt that the report was too transactional in nature and could be improved if it provided information on risks to the Trust that had occurred during the reporting year, and outcomes achieved by the Committee. An updated report is therefore presented to the Committee for approval.

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

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

n/a

Key recommendations and actions requested

The Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed. The Committee are also asked to APPROVE the 2025/26 Annual Report.

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

Good and robust oversight of the Trust's activities and strategic intent ensures resources are used appropriately and maximises benefit for the Trust's service users.

How does the report support the Triple Aim

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

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.



AUDIT AND RISK COMMITTEE

ANNUAL REPORT

1 APRIL 2024 TO 31 MARCH 2025

1. INTRODUCTION

- 1.1 The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its Terms of Reference.
- 1.2 The purpose of the Committee is laid down in its Terms of Reference. In summary, it oversees the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures that there are effective internal audit arrangements in place, reviews the work and findings of External Audit, reviews the Trust's statutory accounts before they are presented to the Trust Board and maintains oversight of the Trust's Counter Fraud arrangements. The Committee also gains assurance around the management of risk and risk processes applied across the Trust.
- 1.3 The purpose of this report is to provide assurance that the Audit and Risk Committee has carried out its obligations in accordance with its Terms of Reference.
- 1.4 This Annual Report summarises the activities of the Trust's Audit and Risk Committee ('the Committee') for the financial year 2024/25 setting out how it has met its Terms of Reference and key priorities. In particular it addresses various matters for which the Audit Committee has oversight for the Board:
 - Financial reporting (including National Oversight Framework Exit Criteria)
 - Risk management
 - External audit
 - Internal audit
 - The system of internal control
 - Governance arrangements, including the work of other Board committees.
- 1.5 The Chair escalates those matters that the Committee considers should be drawn to the attention of the Board when presenting the Committee Chair's Report to the next meeting of the Board.

2. INFORMATION SUPPORTING OPINION

2.1 Delivery of Committee's Key Responsibilities

- 2.1.1 During 2024/25, the Committee has delivered the key responsibilities as set out in the Terms of Reference. Compliance with a number of the key responsibilities is evidenced by the following actions:
 - Regular review of the Board Assurance Framework and Corporate Risk Register, with appropriate challenge to the proposed controls and risk scoring.
 - Review of the draft Annual Governance Statement.
 - Received reports on progress against local counter fraud, internal and external audit plans and issues by exception.
 - Agreed the external audit annual fee and work plan.
 - Agreed the internal audit and local counter fraud annual work plans.

- Reviewed the draft annual accounts, draft annual report and draft quality report and recommended them for approval to the Trust Board.
- Reviewed specific Internal Audit reports and proposed actions for those areas identified with limited assurance (with the relevant Executive Director present when required) and monitored the follow-up of outstanding actions.
- Reviewed the effectiveness of Internal Audit, External Audit and the Local Counter Fraud Service.
- Reviewed the accounting policies, judgements and material estimates of the Trust and made appropriate recommendations to the Trust Board.
- Reviewed External Audit reports and the Annual Audit Letter, including progress on implementation of recommendations and any corrected or uncorrected misstatements in the accounts.
- Clinical Audit Plan and Framework

In addition, over the course of the year the Committee achieved the following

- Oversaw delivery of External Auditor recommendations to improve delivery of the end of year audit
- Oversaw work to improve delivery of Internal Audit recommendations
- Improved nil declaration of interest compliance
- Review of the new HFMA handbook guidance
- Completion of the Core Financial Controls Action Plan
- Review of the process to approve the Jack Sears facility
- Review of overdue corporate documents
- Undertook a self-assessment of the Committee's effectiveness
- Held a development session which considered, among other things, new HFMA handbook; duplication of Freedom to Speak Up reporting and the need to review duplication of reporting across all committees; how the Committee could seek assurance around issues such as the Electronic Patient Record and benefits realisation, noting that the work was undertaken by other committees; the need to review the Committee's Terms of Reference, noting that this work would be completed following the Trust's Well-Led review.

2.2 Reporting Requirements

- 2.2.1 The Committee reported to the Board after each meeting during the year. Reports included a description of the business conducted, risks identified and issues for escalation.
- 2.2.2 The reports from the Committee effectively covered the key points and significant areas of discussion at each meeting. This included highlights of the results of the Internal Audit reports received at each meeting, providing more details in relation to those that were of limited assurance, which formed part of the evidence upon which the overall Head of Internal Audit opinion was based. They also included reports which considered the proper arrangements in place to secure economy, efficiency and effectiveness in the use of resources.

2.3 Work of the Committee

- 2.3.1 External Audit -The Trust's external auditor for the financial year 2024/25 was Grant Thornton. The Committee reviewed progress and will continue to review final audit reports and management letters for 2024/25 to ensure submission of the annual report and accounts prior to the published submission deadline is achieved.

Following concern raised by External Audit following the 2023/24 audit around a lack of engagement from some members of the finance team; data integrity; delayed information being presented following the disposal of Torbay Pharmaceuticals; and slow responses from the District Valuer, significant improvements have been made to address these issues, including the delivery of a number of recommendations from the Trust's External Auditor, resulting in smooth audit process for the 2024/25 financial year.

- 2.3.2 Internal Audit – The Committee works with the Internal Audit team (ASW Assurance). The Committee reviewed and approved the Internal Audit Plan and detailed programme of work. The Internal Audit Plan embraced operational as well as financial and business areas, and the Committee received a range of reports during the year for consideration.

The internal audit work for 2024/25 was on plan for completion by the year end, subject to any adjustments agreed by senior management and the Committee through the year. The workplan was revised during the year to account for changing priorities. All workplan amendments were discussed and agreed with the relevant Executive Director prior to presentation at the Committee.

Shown below are audit reviews presented to the Committee during the year and the assurance rating.

Meeting date:	Audit Review	Assurance rating
April 2024	Job Evaluation	Satisfactory
May 2024	Freedom to Speak Up	Significant
May 2024	Torbay Council Assurance – Contracts – LGA Review	Satisfactory
May 2024	Clinical Quality – PSIRF	Satisfactory
May 2024	Risk Management Arrangements and Board Assurance Framework	Design – significant Application - satisfactory
July 2024	Care Quality Commission (2023/24)	Satisfactory
July 2024	Urgent Single Tender Waivers (2023/24)	Satisfactory
July 2024	Planned Maintenance and Backlog Works – Governance Arrangements (2023/24)	Satisfactory
July 2024	Covid 19 Governance Inquiry (2023/24)	Not rated
July 2024	Financial Management – CIP (2023/24)	Satisfactory
July 2024	Payroll (2023/24)	Satisfactory
July 2024	Cyber Security (2023/24)	Significant

July 2024	EPR Programme Management (2023/24)	Satisfactory
July 2024	Core Financial Systems (2023/243)	Limited
July 2024	Torbay Council Assurance – Social Care Financial Assessment and Benefits Team (2023/24)	Satisfactory
July 2024	Data Security and Protection Toolkit DSPT (2023/24)	Moderate
October 2024	Charitable Funds (2023/24)	Satisfactory
January 2025	Emergency Planning Resilience and Response – post incident debriefs	Limited
January 2025	Children and Family Health Devon	Satisfactory
January 2025	Fit and Proper Persons	Significant
January 2025	Governance of Elective Recovery	Significant
January 2025	Third Party Hosted Digital Services	Satisfactory
January 2025	Non-Pay Controls	Limited
January 2025	Clinical Negligence Scheme for Trusts Evidence Review	N/a
January 2025	Mental Capacity Act – understanding and application	Limited

As part of the annual reporting process, the Head of Internal Audit opinion will be confirmed at the stage of finalising the annual report and accounts for 2024/25.

The Committee received regular internal audit progress reports and continued to monitor the completion of outstanding report recommendations through updates and progress reports.

ASW Assurance attend the Executive Committee on a regular basis between Audit Committee meetings to report to senior management on progress and highlight any key risks to achievement of their internal audit plan.

During the year there were a significant number of outstanding audit recommendations reported, which resulted in a need to put in place an additional process, led by the Trust's Chief of Staff, to ensure outstanding audit recommendations were closed down. This, alongside a number of limited audit assurance ratings for those reviews that informed the Head of Internal Audit opinion, led to a limited Head of Internal Audit rating being presented for 2024/25.

2.3.3 Counter Fraud - The Trust takes the prevention and detection of fraud seriously. Each year the Committee receives and considers the Annual Counter Fraud Plan, regular progress reports and updates, and the Annual Counter Fraud Report.

The Local Counter Fraud Specialist (LCFS) is invited to attend the Committee on a regular basis to give a presentation and update on the Plan, fraud prevention and cases reported and under investigation.

No material frauds were identified during the year.

3. RISK MANAGEMENT

- 3.1 During the year, the Committee continued to review the risk management approach across the Trust. The Committee reviewed the Corporate Risk Register and the Board Assurance Framework ('BAF').
- 3.2 The BAF focuses on the key risks against achievement of the Trust's strategic objectives. The BAF is a 'live' document and is continuously reviewed and updated. This process is managed by the Director of Corporate Governance and Trust Secretary.
- 3.3 The Committee reviewed the BAF at each meeting to ensure there is an appropriate spread of strategic objectives and that the main inherent/residual risks have been identified, to ensure there are no major omissions.
- 3.4 The work of the Committee is not to manage the process of populating the BAF or to get involved in the operational development of the risk management processes, either at an overall level or individual risk level. These are operational issues that the Committee is satisfied are being carried out appropriately by management.
- 3.5 The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.
- 3.6 A review was carried out by ASW Assurance during the year which concluded that the Trust's arrangements for the management of the corporate level risks continue to be implemented satisfactorily through the Trust Board and the delegation to its sub-committees and the Risk Group for oversight and monitoring of risk.
- 3.7 During the course of the year the Committee identified and discussed a number of risks as follows:
 - A number of consultants, as decision-makers, not completing nil declarations at the end of the financial year – following a dedicated piece of work this had been resolved.
 - Concern around the number of waivers processed by Trust and a lack of understanding around how many times a waiver had been requested for the same issue.
 - Size of the Adult Social Care debt
 - Lack of clinical engagement with national clinical audits and concern around implementation of clinical guidelines
 - Concern around the Trust's status as a 'going concern' and its financial sustainability
 - The Trust's exit from the National Oversight Framework

4. LOOKING FORWARD

- 4.1 During 2025/26, alongside its regular workplan, the Committee will seek to ensure internal audit recommendations are completed on time alongside the delivery of satisfactory audits to ensure a satisfactory Head of Internal Audit option would be delivered at the end of the financial year; and have oversight of the external audit process to ensure that the improvements made in 2024/25 continue to be delivered.

5. MEMBERS AND MEETINGS

- 5.1 During 2024/25, the Committee met formally on six occasions and held one development session. The formal meetings were quorate all times.
- 5.2 The record of Committee attendance is shown below:

Non-Executive Director	Number of meetings attended
Robin Sutton (Chair)	6 (6)
Martin Beaman	6 (6)
Chris Balch (until 31.05.24)	1 (2)
Richard Crompton (until 02.10.24)	4 (6)
Paul Richards	4 (6)
Sian Walker-McAllister (wef 01.02.25)	0 (0)
Robert Williams (wef 01.06.24)	3 (4)
Required attendees	Number of meetings attended
Mark Brice, Chief Finance Officer	5 (6)
Nicola McMinn, Chief Nurse	4 (6)
Emily Long, Director of Corporate Governance and Trust Secretary	6 (6)

- 5.3 Senior management representatives also in regular attendance included the Corporate Governance Manager. Other senior managers also attended at the Committee's invitation. A Governor observer was in attendance at the majority of meetings.
- 5.4 The Trust's internal auditor and external auditor were in attendance at every meeting.

6. COMMITTEE EFFECTIVENESS

- 6.1 The Committee undertook a self-assessment review during the year, which concluded that the Committee had delivered the majority of its responsibilities as set out in the Terms of Reference, attendance at meetings has been quorate and the cycle of business has been completed.

- 6.2 Areas for action identified as part of that self-assessment of the Committee's effectiveness to identify any gaps in the Committee's workings were noted and addressed.
- 6.3 The Committee will undertake an annual assessment to ensure continual improvement.

7. RECOMMENDATION

The Committee is asked to review and approve the report, subject to any changes agreed in discussion, prior to its formal submission to the Trust Board.

Mark Greaves
Chair, Audit and Risk Committee
October 2025

Building a Brighter Future Committee

Items for Information

Date: 16th October 2025

REPORTS PRESENTED TO THE BOARD FOR INFORMATION

The following reports are provided to the Board of Directors for information:

- EPR Update

BBF Committee

EPR Update

Date of meeting	Date report produced
16 th October 2025	16 th October 2025

Author(s)		Report approved by	
Name	Kevin Pirie - EPR Lead	Name	Adel Jones EPR SRO
Phone:	07901 696807	Date:	7 th October 2025
Email:	Kevin.pirie2@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 summarises the progress of the 1 Devon EPR program.

The Trust is maintaining good Progress against Phase 2 (User and System Readiness) of the Epic Implementation program

At the date of the latest Epic Progress Report (8th October) the overall program status is reported by Epic as “Good”, our consistently high score of 8 / 10 is maintained, this compares favourably with the average score of 6.7/10 for other Epic implementations at the same User and System Readiness stage.

To remain at a good status One Devon must complete the actions identified in Issues Needing Executive Oversight and:

1. Pass 90% of Integrated Testing Round 2 scripts by 7 November.
2. Complete core training environment build and testing by 7 November, ahead of Train-the-Trainer (24 November) and Super User training (8 December).

Of 45 application areas, one (Beacon) is reported as serious. 21 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

Matters requiring Executive oversight

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.

- Beacon protocol build and validation
Capacity to build and validate 783 regimens for go live is currently insufficient.
- Estates work at TSD is lacking a comprehensive plan for completion
- Lack of a unified project plan and associated validation of resourcing for Haemonetics SafeTrace integration

Additional Progress Information (see Appendix 2):

- Readiness Measures
- Benefits Realisation
- Community Engagement
- Comms & Engagement

Key Program risks –

- Current recruitment controls may impact programme activities.
- Visibility of Trust and Regional interdependent projects / competing priorities.
- Potential affordability risks associated with End User Devices

Active mitigations are in place or being developed.

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

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
EPR Program Update	Satisfactory	Satisfactory

Appendices

Appendix 1 - EPR Progress Report Exec Summary

Appendix 2 - Readiness, Benefits, Community Engagement & Comms and Engagement updates

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

1 Devon EPR Board

Key recommendations and actions requested

The BBF Committee are asked to AGREE the recommended assurance rating and take SIGNIFICANT assurance as to those matters reviewed.

It is recommended the BBF Committee 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 pathway information.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	The EPR will support self-managed 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, Safety and Patient Experience	The networked EPR enables standardisation of pathways across Devon based on best practice. Patients will have more control and involvement with their care pathways.
Leadership and Governance	As the key enabler in Devon’s strategic and transformation plans. This program provides our leaders with the tools and oversight to improve care across Devon, measured against best practice processes and clinical pathways.
Performance	The many operational benefits of a single EPR will support better performance across all constitutional standards
People and Culture	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.
Strategy and Business Intelligence	Signature development in Devons Strategy and transformation plans
Finance	Critical enabler for the development of best practice standardised pathways and reductions in quality and cost variation.

Risk: Risk ID (as appropriate)	
Risk	Risk 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
Failure to meet cybersecurity and information governance standards	2831, on Datix, no escalation
	2838, on Datix, no escalation

External Standards affected by this report and associated risks

National policy – NHS digitisation

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.



Epic
One Devon Monthly Progress Report
15 September – 8 October 2025

OVERALL PROJECT STATUS		OVERALL SCORE: 8.0/10.0	
		AVERAGE EPIC CUSTOMER SCORE FOR PHASE 2: 6.7/10.0	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, Neil MacDonald, Sam Higginson, Sarah Brampton, Paul Richards From: Tara Kneller, Implementation Director cc: Kath Potts, Kevin Pirie, Gervaise Khan-Davis, Helen Vigne, Richard Collins			
OVERVIEW			
The programme remains at a status of good, as we remain on track with configuration, data migration and training. This provides a strong foundation as teams shift focus from build and configuration to testing, technical and staff readiness for go-live. Configuration teams have completed 98% of Build Waves 1–5, 92% of application testing, and passed 100% of integrated testing scripts in Round 1. Integration and data migration teams began full-scale validation, this has included significant engagement from clinical and operational subject matter experts and helps ensure staff have the historical information needed to provide safe and efficient care at go-live. At TSD, managers completed staffing validation to confirm training and security assignments, and they began identifying super users. This work, which depends on accurate ESR data and strong organisational coordination, is one of the most challenging aspects of go-live readiness. It ensures that every user is configured with the correct security access and linked to the right training, so they can perform their role effectively from day one. Achieving this level of accuracy at this stage represents a real success for One Devon and positions the team well to ensure staff are aligned to the appropriate pre-live training and readiness plans and to avoid user access issues at go-live. Key areas of focus for the month of October include the configuration teams completing specialty build and progressing with integrated testing, the training team building the Super User training schedule into the LMS, change teams engaging with the organisation to start implementing high-risk change plans and TSD completing Super User identification. To ensure success, these activities will depend on increased involvement from clinical and operational teams and broader participation from staff beyond our core subject matter experts who have participated in design workgroups to date. To remain at a good status One Devon must complete the actions identified in Issues Needing Executive Oversight and: 1. Pass 90% of Integrated Testing Round 2 scripts by 7 November. 2. Complete core training environment build and testing by 7 November, ahead of Train-the-Trainer (24 November) and Super User training (8 December).			
ISSUES NEEDING EXECUTIVE INTERVENTION			
<i>No issues require executive intervention at this point in time.</i>			



One Devon Monthly Progress Report

15 September – 8 October 2025



ISSUES NEEDING EXECUTIVE OVERSIGHT

Estates work at TSD is lacking a comprehensive plan for completion by end of year and planning permission requirements may prevent changes in inpatient wards. This puts the deployment of end user devices at risk, as the Tower Block also requires unplanned power and network upgrades and now full-building planning approval—not just for floors 5–8. Sal Williams and Dawn Butler will work with Nevada (the estates contractor) to confirm the contracting timeline and critical path, while DD Electrical will complete the electrical assessments by 24 October. Josh Langdon will escalate to Kevin Pirie on 27 October if these milestones are not met.

Beacon protocol build remains at risk for the 3 April 2026 go-live due to ongoing resourcing delays and slow validation throughput, with consultant review posing the most significant constraint. While the build team exceeded targets last week by completing 27 of 15 expected protocols, cumulative progress remains low at 28% (215 of 783), and the two additional locums needed to sustain this pace are not yet onboarded. Pharmacist validation improved, with one validator starting on 22 September and completing all targeted reviews last week, but overall throughput remains behind—only 109 of 162 pharmacist reviews, 23 of 75 consultant reviews, and 0 of 4 final sign-offs are complete. Jason Scott will confirm onboarding of two additional build locums by 13 October to sustain a 40-protocol weekly throughput; Amandeep Kaur will monitor velocity and validation bottlenecks weekly, and Pete Sankey will continue coordinating consultant review sessions. Richard Collins will escalate to Adrian Harris by 21 October if consultant validation remains below plan or builder locum onboarding is incomplete.

Lack of a unified project plan and associated validation of resourcing for Haemonetics SafeTrace integration threatens timely Blood Workflow integration at One Devon's TSD and UHP go-lives. This dependent project currently lacks a consolidated plan for SafeTrace integration, testing, and validation, and all labs face resource gaps that risk delaying readiness for the April and July 2026 go-lives. Haemonetics interface testing is currently paused until 28 October due to supplier constraints and Epic upgrade dependencies, further compressing already tight timelines. Next steps:

- Becky Skelton, Stefan Ichim, and Steph Reynolds to identify strategies to accelerate Epic upgrade testing, enabling an earlier restart of EPR Haemonetics interface testing by 22 October.
- Becky, Stefan, Steph, David Pope and Laura Bleiel to confirm a unified project plan, define validation resourcing needs, and establish critical milestones and go/no-go thresholds by 21 October, to be reviewed with CADA on 3 November.



One Devon Monthly Progress Report

15 September – 8 October 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

15 September – 8 October 2025



PROJECT ASSESSMENT – AREAS OFF TRACK

CROSS APPLICATION AREAS

Day Cases		Day Cases decreases to watch, as the IAR uncovered several workflows and build, including live build, that needs additional review. To improve to good, the team must complete analysis and build for 42 remaining units by 1 November. Additionally, Dorothy Oldach, Hannah Hall, and Natalya Maynard must review IAR follow-ups, including plans to update current procedure configuration for the generic day case procedure and workflow engine rule build.
Benefits		Benefits realisation decreases to watch. The team missed several target dates for assessing and escalating benefits impacted by scoping concerns for go-live putting the business case at risk of not being realised to the expected value year one post-live. To increase to good, Jocelyn Geany will work with the Benefits and Finance teams to finalise quantification of at-risk benefits.
Materials Management		Materials Management remains at watch, as RDUH, TSD, and UHP do not have inventory catalogues prepared for Supply File Cleanup. Kath Potts and Adrian Harris organised a workgroup across SBS, EPR, and Procurement to manage and track progress. Colin Dart completed a PO for RDUH to procure Genesis to replace Unit4 on 1 April. To improve to good, Peter Sewell will deliver the RDUH and TSD supply catalogues by 13 October. Pete Sewell, David Blake, and Natalie Garratt will identify clinical SMEs for supply file cleanup by 27 October.
Interfaces		Interfaces remain at watch. We did not meet last month's criteria to complete ITR/MRTR for GE MUSE (TSD) or Philips ISCV; however, we began Data Innovations (UHP) testing. The Interface team will increase the frequency of testing sessions to meet our mitigation dates for GE MUSE (TSD) and Philips ISCV (all). See issues needing executive oversight for more on Haemonetics.
Staffing, Training & Certification		Staffing and certification are at watch as 17 of 24 net new application analysts achieved certification and due to several team departures including: OpTime Principal Trainer and a Cadence analyst. Tara Kneller and Jason Scott are actively coordinating and executing contingency plans for uncertified roles.
Technical		Technical status remains at watch as estates remain at risk due to lack of timelines on job completion, and timelines for network infrastructure are longer than expected. To improve to good, Richard Price will complete device ordering for printers, scanners, laptops, and PCs at TSD by 10 October and at UHP by 7 November. Missing these deadlines will delay deployment, which is scheduled to start on 13 October at TSD and 24 November at UHP
Device Integration		Device Integration (DI) remains at watch, as the workgroup has not confirmed scope or the patient device list. To improve to good, Aaron James will work with clinical engineering to finalise the beds and wards in scope for Go-Live by 16 October. Harrison Kirwin, Amy Johnson, Yetunde Adewumi, and Claire-Marie Hunt will build patient monitor and anaesthetic carts by 23 October.
Specialty Review		Specialty Review remains at watch as engagement from Mike Green, Mia Jones, Simeon Brundell, Gemma Taylor and the wider IO team continues to drive responses from most specialties. There are 4 UHP and 3 TSD specialties without sufficient clinical data collection returned. To increase to good, all data collection clarification questions must be promptly

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



One Devon Monthly Progress Report

15 September – 8 October 2025



		resolved, and analysts must complete 50% of assessment and questionnaire build by 28 November.
APPLICATION AREAS		
Beacon Protocol Build & Validation		See issues needing executive oversight for more.
Beaker Dependent Project: Data Innovations		Beaker remains at watch as the Data Innovations (DI) Instrument Manager dependent project remains off track; functional testing began with the Abbott AMS middleware but MRT did not begin by 22 September due to changes and re-testing required during functional testing. To improve to good, Mark Ogier (DI Project Manager) will confirm mapped record testing schedule by 10 October and all sections should begin CCV or have a clearly defined, resource-backed plan for beginning CCV by 20 October.
Patient Letters		Patient Access/Springboard remains at watch, as outstanding contracting with Synertec and Netcall for Letters/SMS workflows and communications content collection and SME identification is incomplete from both trusts. To increase to good, 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 31 October.
Application Build		The following applications are at watch this month as they have outstanding build remaining in the Build Waves 1-5 Ambulatory, ASAP, Beacon, Beaker, Beans, Cupid, HIM, Kaleidoscope, Research, Phoenix, Springboard, Stork, and Willow. These build tasks are required for integrated testing and/or training environment build. 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 at watch this month as they are more than 10% behind with Application testing as of 8 October: Beans, Cupid, Phoenix, Springboard and Stork. 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		

Appendix 2 - User and System Readiness (Phase 2)

Operational and Clinical Readiness

The main focus under this heading in the last month has been the process of Manager Validation, the identification of Super-Users and the finalisation of the Training Program.

- **Management Validation**

Using ESR as our baseline over 5,700 staff will be validated by c.150 managers to ensure each member is assigned to the correct role and training track. This critical piece of work ensures that every member of staff is given the correct access to Epic and completes the appropriate training. Epic report this process has typically taken 3-4 months to complete at other Epic sites. As of Fri 3rd Oct after 3 weeks of validation 88% of our staff are validated.

- **Training Program**

Resourcing of the training program including Medic to Medic training has been agreed and training staff identified. Included within these training resources will be 5 BAU trainers who will support optimisation and routine end user training post Go-Live. Training for our nominated trainers will begin on 24th November and end on 23rd January ahead of End User Training beginning on 9th February.

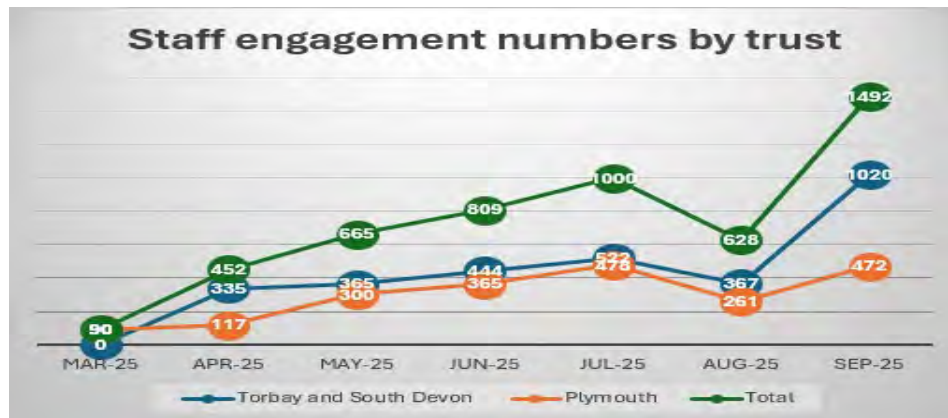
- **Super Users**

c.700 Super-Users have been identified through the Manager Validation process and expressions of interest. All will be invited to attend “What is a Super-User” sessions from the 6th-14th October. This level of enrolment is more than was first anticipated, the higher numbers will augment our training activities and most importantly create a strong support structure for our teams during go-live.

- **Other Readiness Measures**

Comms & Engagement

Our Communication & Engagement activities have increased in line with our C&E plans and the introduction of the “Managers Pack”. This pack sets out the deliverables for our Operational Teams up to go live. Management Validation (described earlier) is the 1st deliverable within the Managers Pack.



- **Readiness Assurance**

We continue to attend Go Live Readiness Assessments (GLRA) at East Sussex and North Essex (ESNEFT) and the Royal National Orthopaedic Hospital (RNOH). These experiences are invaluable for our Operational and Clinical leaders. Staff from TSD will also be attending ESNEFT’s Go-Live in the first half of October. Some of the attendees will be observing but importantly many of our Information Officers will be supporting the ESNEFT teams throughout the go-live period.

Planning for our own GLRA has begun, our 120 day assessment will take place on December 9th. Care Group Directors have attended RNOH and ESNEFT as part of their own preparation for GLRA.

- **Benefits Realisation**

The benefits program is at the User and System Readiness Phase where activities include:

- o Completion of benefits profiles – complete and in monitoring
- o Sign off of change plans with Benefits and Readiness owners – Completion October
- o Incorporate enablers into Benefits and readiness checklists – Continuous into go-live

- o Creation and sign off of reports and dashboards – Specification created, awaiting sign off

The detailed work undertaken in the workgroups is identifying existing, planned benefits that may be challenged and also new unplanned benefits not reflected in the FBC. Both existing and new benefits are being fully validated and reviewed to ensure full compliance with the ambitions described in the FBC.

- Community Engagement

The way that Epic is implemented across our Community based services has co-dependencies with the decision taken by Torbay Council to procure Liquid Logic as its primary digital clinical platform. The Council and our Community Care Group lead have been engaged with to ensure the future state of supporting systems provides the optimised configuration for services in Torbay. This work has been delayed due to a prolonged unplanned absence in the Epic Change (Community) role.

Progress is now being made to understand the scope of the 30 separate services being delivered and the digital platforms that will be used to support them – either Liquid Logic or Epic. The question of interoperability between Liquid Logic and the Devon and Cornwall Care Record (DCCR) has been raised with Torbay Council, their current thinking is to delay any progress in this direction on the grounds of cost (£100K) and a preference to wait until after go-live.

Our next steps are to agree and finalise the supporting systems for the 30 services within our scope and explore how interoperability between Liquid Logic and DCCR can be achieved at pace.

People Committee

Items for Information

Date: 20th October 2025

REPORTS PRESENTED TO THE BOARD FOR INFORMATION

The following reports are provided to the Board of Directors for information:

- 5.1 Delivering the Workforce Plan
- Guardian of Safe Working Hours Report

People Committee

Guardian of Safe Working Hours Report

Date of meeting	Date report produced
20 th October 2025	8 th October 2025

Author(s)		Report approved by	
Name and title:	Dr Claire Blandford, Guardian of Safe Working (GOSW).	Name and title:	Dr Cathine Lissett CMO
Phone:	X 54311	Date:	13 October 2025
Email:	tsdft.guardianofsafe.workinghours@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 Quarterly Report is prepared by the Guardian of Safe Working Hours to provide the Committee/Board with a summary of the number and status of exception reports received from our resident and locally employed doctor workforce, highlighting areas of concern.

Dr Blandford, as GOSW, had recommended a “no assurance rating” regarding the exception reports from Turner ward; however, as CMO, I am aware of several steps in place to address this issue and thus feel that a limited assurance rating is more appropriate.

Specifically:

- 1) I have reviewed the “escalation SOP” prepared by the haematology and oncology teams
- 2) I have supported an advert for an IMT3 (generally 5-year experienced) or above locum doctor to support the ward, as well as increasing the staffing to 4 in the short term.
- 3) the oncology team are working on a business case to be submitted as part of business planning to substantially change the model of care on the ward.
- 4) I have met the regional medical education team to discuss the above, in addition to the support available to the resident and locally employed medical staff

5) A “triggered” visit is planned, which will review the impact of these changes later this month.

Reporting Period: 1 August – 30 Sept 2025

Total Exception Reports: 104 (↑3 from previous report, but only 2 month period)

By Speciality:

General Medicine: 69

Others: General Surgery 21, Acute Medicine 10, Emergency Dept 1, ICU 1, Cardiology 1, Obs & Gynae 1

By Grade:

F1: 38 | F2: 7 | CT1-3: 56 | ST4-9: 0

Nature:

Additional Hours: 97

Immediate Safety Concern: 3

Others: Minor

Outcomes:

TOIL: 24 | Payment: 52 | Work Schedule Review 7 | No further action: 7
| Unresolved: 15

Key Issues & Trends

Turner:

Concerning the pattern of excess working hours, residents cite burnout risk, challenges accessing timely senior support, and limited supervision/support for F1 doctors. NHS Quality & Foundation School is involved.

Cause: Complex patients with specialist needs, no job planned time for oncology senior doctors to review inpatients, difficulty accessing timely specialist guidance (haematology & oncology), and volume of work.

Assurance: Limited (new trend)

Recommendation:

New Forrest Ward:

Reports have decreased in number but are still felt to be under-reporting rather than indicating genuine improvement. Feedback confirms a high workload and excess hours persist.

Cause: High patient acuity + redeployment of doctors.

Assurance: Limited (static trend).

Recommendation: As the previous board, stop redeployments; add +1 doctor to the ward, actively encourage exception reporting.

Immediate Safety Concern:

3 reports, 2 relating to Turner ward, 1 Allerton

Fines: None this quarter.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from the previous report
Turner Ward	Limited	New
New Forrest	Limited	Static
Immediate Safety Concern reports	Limited– Turner Ward Satisfactory – Allerton Ward	New

Appendices	
Nil	
Committees that have previously discussed/agreed on the report, and the outcomes of that discussion	
N/A	
Key recommendations and actions requested	
Recommendations for the Board Agree assurance ratings Note the workforce pressure at Turner & New Forrest Support actions to mitigate risk (staffing adjustment).	
How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?	
Ensuring issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation, as appropriate	
How does the report support the Triple Aim	
Aim	Impact
Population Health and Wellbeing	Healthy Resident doctors providing services.
Quality of services provided	Healthy Resident doctors providing services.
Sustainable and efficient use of resources	Optimising the efficiency of resident doctors
Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Healthy RDs are better able to provide appropriate and efficient care.
Leadership and Governance	
Performance	More efficient care
People and Culture	Healthy RDs are better able to provide appropriate and efficient care In line with policy
Strategy and Business Intelligence	

Finance	Healthy RDs are better able to provide appropriate and efficient care.

Risk: Risk ID (as appropriate)	
Risk	Risk ID

N/A

External Standards affected by this report and associated risks
<i>National Policy on Terms and Conditions for Resident (Junior) Doctors Contract 2016.</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 the absence of controls, flaws in their design, or inconsistencies in their application. Urgent corrective action is necessary if controls are to effectively mitigate the risks to achieving key objectives.

Introduction and background

The following report aims to ensure that Resident Doctors are working contracts compatible with their Contractual Terms and Conditions of Service 2016, which are sustainable and fair, and that they can claim money/time off in lieu should they need to work extra hours to maintain patient safety/attend educational opportunities, or complete career-enhancing objectives.

Exception reporting is encouraged and supported by the trust. There have been 104 Exception Reports in the period 1st August 2025 up to 30th September 2025. This represents an absolute increase of 3 exception reports from the previous report. However, the last report period was 3 months, and this one is just 2 months; therefore, there has been a substantial increase in exception reporting during this period.

Table 1 – Exception Reports by Area

Specialty	No. Exceptions raised in the reporting period	No. exceptions closed	No. exceptions outstanding	Comment
General Medicine	69	58	11	
Emergency Medicine	1	0	1	
Acute Medicine	10	7	3	
General Surgery	21	16	5	
Anaesthetics*	1	0	1	
Cardiology	1	1	0	
O&G	1	1	0	
Total	104	83	21	

* This report relates to ICU, but there is at present no specific designation for ICU on Allocate, so it appears incorrectly as Anaesthetics.

Table 2 – Exception reports by Grade

Grade	No. Exceptions raised in the reporting period
F1	51
F2	12
CT1-3	41
ST 4-9	0

Total	104

Table 3 – Nature of Exception

Additional Hours	97
Immediate Safety Concerns	3
Pattern of Work	0
Educational Opportunities	1
Service Support	3

Table 4 – Outcome of Exceptions

TOIL	24
Payment	52
Work Schedule Review	6
Agreed, no further action required	7
Unresolved	15

Comments on Exception Reporting

Any areas of high reporting:
 33 exception reports on Turner Ward
 New Forrest ERs have dropped considerably

Assurance and Recommendations

1. 3 x Immediate Safety concern submission this period. Each submission has been reviewed within 24 hours of submission by the Guardian of Safe Working Hours. Two of these relate to Turner Ward, and one to General Surgery.
 - a. **Turner Ward**
 - i. Below minimum staffing (1 F1 + 1LED only – 19 complex patients), minimal senior support, acute medical patient transferred to ward without post take acute medical consultant review. Datix completed. Escalated through the medical leadership team.
 - ii. Direct quote from exception report summarises this well:
 “Multiple complicated, deteriorating patients requiring peri-arrest calls, ITU support and advice from outreach - consistent workload completed by a junior staff with minimal senior support requiring consistent additional hours outside scheduled working hours - this is not sustainable or safe”

Recommendation: See further commentary in point 2 about Turner Ward

- b. **General Surgery** – short notice sickness absence compounded by challenging rota allocation, critically reduced staffing levels on Allerton ward on one day. The distribution of workload and simultaneous ward rounds for different specialities also created challenges. Delays to patients being seen/ investigations acted upon, but no evidence of compromise to safety. The resident surgical rota management team has been contacted, who have advised they have now introduced a new rota software tool which should improve allocations and gap detection in day-to-day workforce cover going forward.

Recommendation: For the board's note.

2. Submissions from **Turner Ward** have raised concerns this quarter. In addition to the two immediate safety concern reports detailed above, there have been high levels of exception reporting along with concerning commentary. These cite challenges of high workload, high acuity patients and difficulties accessing senior specialist support. This ward has patients from Haematology, Oncology and also some general medical patients.

Currently, there is no planned time allocated in oncology consultant or oncology registrar programmes for oncology ward patient cover. Patients are typically only reviewed daily by an F1 doctor, who then has to telephone or email for further specialist guidance. There have also been issues raised within Haematology regarding the ability to obtain senior support when required, as well as residents being asked to complete prescriptions for blood transfusions late in the day due to a lack of specialist guidance documentation. Direct quote from one exception report: *"We had 5 (transfusion prescriptions) to complete, with only 2 having notes and three without proformas. We are getting multiple instances of inaccurate or incomplete data that is dangerous and given the burnout and timings they are given to us, it is only a matter of time until a patient is prescribed the wrong amount, which could be harmful to a patient."*

These concerns have been fed back to the clinical teams and escalated within the trust's senior management. More recently, residents agree there has been improved access to timely specialist support. Residents in this ward, however, continue to work excessive hours (sometimes up to 2-3 additional hours per night) and have raised concerns about their personal well-being and risk of burnout. Additionally, concerns have been raised regarding the level of clinical supervision available for the F1 doctor placed on this ward, which is currently under review by representatives from NHS Quality and the Foundation School. The Director of Medical Education and the F1 lead are also actively involved, and the medical education team supports resident doctors.

Recommendations: *Urgent risk mitigation required. i) The leadership triumvirate to consider increasing the resident doctor minimum staffing level on Turner ward from 3 to 4 resident doctors in line with other wards ii) urgent review of oncology senior doctor job programmes to enable allocated time provide ward reviews for oncology inpatients iii) await further guidance from*

NHS quality/foundation school regarding the placement, supervision & support of the F1 doctor on this ward iv) internal review within Haematology of practices around transfusion prescriptions v) work schedule review of residents on this ward

3. In the previous quarterly report, **New Forrest was highlighted as having high exception reporting, and a recommendation was made to avoid moving doctors away from this ward and to look at increasing the workforce by +1.** The previous report had 47 exceptions from this location; however, this current report has only 14 exceptions. Report numbers in this period are lower. Exploration via the Residents' Doctors Representative Committee (RDRC) indicates that there are still ongoing issues with frequent late finishes, poor staffing levels, and difficulties for residents in taking leave. The appointment of a middle-grade doctor is still in progress. It is believed that the drop in exception reports from this location is due to a lack of reporting, rather than a genuine improvement in the working situation.

Recommendation: *Continue to monitor the situation. RDRC to encourage residents in this location to engage with the exception reporting process. Previous recommendations from the August board report still apply: aim to avoid relocating doctors from this ward, and consider increasing the minimum number of doctors allocated to this ward area by one doctor.*

4. Fines – no new fines this quarter for rota breaches to report.
Recommendation: for the board to note the above
5. This report is based on the data received. There will be an unreported element of additional work completed by our resident doctor/ LEDs, which, for various reasons, is not being captured. *Recommendation: for the board to note the above*
6. Latest update from NHS Employers indicates the planned introduction of the exception reporting reform processes has been delayed from 12th September 2025 to 4th February 2026. Further information and final guidance are still formally awaited.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from the previous report
Turner Ward	Limited	New
New Forrest	Limited	Static
Immediate Safety Concern reports	Limited– Turner Ward Satisfactory – Allerton Ward	New

People Committee

Our Plan for better Care People Programme 5.1 Delivering the Workforce Plan Report

Date of meeting	Date report produced
20 th October 2025	10 th October 2025

Author(s)		Report approved by	
Name and title:	Kelly Ebdon-Marks, Associate Director of People	Name and title:	Jess Piper, Acting CPO
Phone:		Date:	13 th August 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
The purpose of this report is – • To provide an update on progress made to the priority deliverables as set out in programme 5.1 of the 'our plan for better care' to meet the £20.4m workforce cost saving and 452.52 WTE reduction target. • To summarise the plans, progress so far and actions going forward. This report is focussed on the following priority deliverables – Pay Controls, MARS, People Digital and E-rostering Please note that regular progress reviews are already undertaken by the weekly People Programme Leads Group (supported by the RSP team) who has responsibility for overseeing and monitoring all three priority programmes (5.1 Workforce Plan, 5.2 People & Education Directorate capacity & capability, 5.3 Culture, OD & learning). This Group is chaired by the Acting CPO who as the SRO reports to the Executive Oversight Group (also supported by the RSP team).

The below table is taken from the 'our plan for better care' Oversight Group flash report and provides the latest position on the programme's delivery against the KPI's as of M6 data from finance.

Key Performance Indicators	Baseline	Target	Current Position
Achieve Month 12 Workforce Plan of Total Workforce (WTE)	6815	Planned target: 6363 Revised target: 6556 (inclusion of 205 CR and 50% of breakglass vacancies removed)	6713 against M6 target of 6666
Total Recurrent Workforce CIP reduction (WTE)	6812.08	Planned target: -329 Revised target: -136 (removal of 205 CR plus breakglass vacancies)	At M6, -46 WTE recurrent vacancies removed from the baseline establishment
Pay cost reduction	£365.9m	£20.4m (reduction) £15.88m (rebase removal of CR)	£10.8m delivered against £14.4m forecast
MARS Scheme (50WTE reduction)	0	50 WTE	32.95WTE
Reduction in Agency spend by 30%	£10.1m	£7.1m (reduction 3m)	Year to date spend £3.2m Forecast Spend: £5.8m
Reduction in Bank spend by 10%	£21.1m	£19m (reduction £2m)	Year to date spend £10.4m Forecast Spend: £18.4m

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. Introduction	Satisfactory	N/A
2. MARS	Satisfactory	N/A
3. Pay controls	Satisfactory	N/A
4. E-Rostering	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 Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Committee take satisfactory assurance that progress is being made against the priority deliverables under 'our plan for better care' people programme 5.1. This is based on the overview and summary provided, specifically noting the progress made to date within a short period of time, high-level risks identified and the work being undertaken to mitigate these.

The programme will continue reporting progress through the 'our plan for better care' governance.

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

Best use of NHS resources and funding

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	
Quality of services provided	
Sustainable and efficient use of resources	Yes – best use of resources & funding

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Yes ensuring we have our staff rostered effectively and meeting safer staffing requirements
Leadership and Governance	
Performance	Yes- effective e-rostering will support overall performance
People and Culture	
Strategy and Business Intelligence	Yes – developing plans that include a review and transformation of our corporate services, admin and clerical functions and leadership and management structures in line with the Trust strategy and operational requirements
Finance	Yes – ensuring best use of resources and funding and that the Trust meets its operational plan and target CIP / cost reduction

Risk: Risk ID (as appropriate)

Risk	Risk ID

N/A

External Standards affected by this report and associated risks

NHSE
NOF4 exit criteria
Delivery of operational 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.

Our Plan for better Care People

Programme 5.1 Delivering the Workforce Plan Report

1. Introduction

1.1 Programme 5.1 outline

High level objectives -

- Deliver a sustainable, workforce plan that delivers an efficient, agile and high performing workforce aligned to system and organisational priorities.
- Develop, profile and deliver a workforce reduction plan with regular assurance reporting.

Target workforce cost reduction: £20.4m

Target workforce WTE reduction: 452.52 WTE

12 priority deliverables have been identified as part of the 5.1 programme. These are:

Key High-level Deliverables		Target Date
1	Reduce recurrent vacancies to support workforce stability and enable delivery of recurrent CIPs	31 Mar 26
2	Conduct a strategic review of employee relations cases, this includes undertaking an analysis of operational, financial and ER issues with current AfC staff on-call	30 Sep 25
3	Achieve National temporary staffing controls - requirements (30% agency and 10% bank spend reduction compared to 2024/25 Month 8 baseline) through the robust execution of the Trust bank and agency action which responded to NHS Devons directive on temporary staffing controls, including e-rostering. To include the implementation of department dashboards to monitor delivery	30 Sep 25
4	Deliver ICS-aligned workforce vacancy and spend controls, ensuring system-wide workforce planning and resource optimisation	31 Oct 25
5	Strengthen collaboration between workforce and finance teams, improving data alignment and shared decision-making; scope the benefits of introducing the Viridian Finance & Workforce integrated software	Completed
6	Implement a bank uplift (AfC staff only) communications plan, ensuring proactive engagement and uptake	Completed
7	Introduce and embed enhanced overtime review and control processes to manage expenditure and ensure equity	31 Dec 25
8	Deliver a refreshed organisational sickness management approach, including top 20 long-term cases, revised policies, and clear leadership expectations	31 Dec 25
9	Review and enhance rostering systems to improve clarity, consistency, and efficiency across all staff groups – including implementation of medical e-rostering	31 Mar 26

10	Assess the organisation's workforce model, identifying opportunities through consolidation, redesign, and system collaboration to ensure sustainability - Develop and deliver digital transformation plan to include phase one role of People Digital and delivery of the EPR workforce plan as well as the administration review	31 Mar 26
11	Achieve required workforce reductions & deliver targeted reductions in corporate services and infrastructure through transformation and redesign including acceleration of One Devon Corporate Services. In line with the 25/26 plan, ensuring implementation is safe, measured and aligned to service priorities	31 Mar 26
12	Implement a MARS programme for non-patient-facing staff to support workforce redesign and cost reduction.	31 Oct 25

This report will focus on providing a progress summary on the deliverables with the most progress in the last month:

- Mutually Agreed Resignation Scheme (MARS)
- Pay Controls
- E-Rostering

1.2 High level risks to delivery

The main risks of not delivering the workforce plan are related to:

- £6.4m savings aligned to running a compulsory redundancy scheme (no national funding support confirmed at this stage) which has now been replaced by a plan to deliver a Mutually Agreed Resignation Scheme (MARS) which may deliver savings of circa £2.4m – this will be confirmed in September/October, and a second round of MARS will be considered this financial year. The full year effect of this will not be realised until 2026/27 financial year.
- No direct cost benefit to the Devon CCS programmes this financial year due to the length of time the shared service programmes are taking to implement and expectation that re-modelling is done once services transferred (e.g. procurement). Some programmes will incur a cost rather than result in any cost benefit this year (e.g. People Digital).
- Late start of workforce transformation workstreams to benefit from any cost benefit this financial year (A&C, corporate and leadership restructures). Currently scoping opportunities such as with the benefits from the EPIC implementation.

2. Mutually Agreed Resignation Scheme (MARS)

Summary position and progress

The MAR scheme is now complete and the Trust received 49 applications of which 44 were approved by panel on 4 September. The closing date to receive signed settlement agreements was the 30 September and the Trust received 39 signed agreements; these staff will have a leaving date of 31 October 2025.

- Total Severnace cost (including NI, excluding any outstanding annual leave)= £1,058,754
- Total savings 2026/27= £1,384,838
- Total reduction of WTE= 32.95

Next Steps and Recommendations

Seeking approval for a second round of MARS in January. Already supported by Executives, we will need to submit the relevant paperwork to the national team for approval

3. Pay controls (including temporary staffing and overtime)

a. Vacancy Control

Summary position and progress

The vacancy freeze is fully embedded for the whole workforce with exceptions being supported by the Executives to ensure patient safety and care is not compromised; where there are statutory requirements or where posts are externally funded through a specific funding route.

A review of the impact of the vacancy freeze between April and September 2025 has been undertaken with support from finance:

- A total of 28 posts were declined at break glass
- These equate to 24.32WTE and salary costs of £1,027,357

Next Steps and Recommendations

There has been some concern raised that the process is not flowing as effectively as it should and causing extended delays, this is currently being reviewed by the acting CPO but mostly relates to availability of the Execs to attend and timeframe of the meeting. The plan is to extend the meeting to 1 hour and the Acting CPO will ask Executives to prioritise diaries or provide a deputy with decision making authority.

b. Overtime, Bank and Agency

Summary position and progress

Regular oversight groups have been established for all high usage areas; this includes Medical, nursing, AHPs and Workplace. Areas now have individual datasets showing spend against their reduction targets of 30% for agency and 10% for bank spend. The request in ADNPPs is to discuss this with Matrons and for Matrons to review with Ward Managers.

ADNPPs have also set up a monthly meeting which focuses on recruitment drives to reduce the reliance on bank and agency.

4. Rostering

5.1 Medical and Dental Staff E-rostering

Summary position and progress

E-rostering will ensure the Trust can make efficiencies through better rota management, with rotas aligned to job plan which will be key to achieving the workforce savings aligned to this workstream. An electronic system will also provide opportunity for significant improvements to the current approval processes for medical payments such as annual leave and overtime which is in most cases currently approved retrospectively via a manual paper trail.

The business case for the system was signed off in the summer however, ensuring that we have the right resource will be critical to successful implementation and to ensure we maximise the benefits of the system. The Head of Medical Workforce has met with the E-rostering company who have confirmed the implementation plan and the support they provide; they have also met with the Medical E-rostering lead at the University Hospital Coventry and Warwickshire NHS Trust who have recently implemented E-rostering systems.

These discussions have provided us with the intelligence to truly understand the resource required. This will include project management support for implementation and an E-rostering manager and administrator for ongoing management of the system.

Next steps and recommendations

- Resource to be agreed and job description/s developed if necessary

5.2 Agenda for Change

Summary of progress

The Trust has secured funding from the Regional Support Programme (RSP) to produce an E-rostering dashboard. The dashboard will provide a wide range of metrics and analysis including:

- Roster fill rates
- Unavailability analysis
- Additional hours
- SafeCare acuity
- Red flag incidents
- Bank/Agency usage
- Roster approval timelines
- Net hours management

The dashboard will support us to target roster improvements and optimise roster design, compliance and utilisation. Providing with the tools to identify efficiency improvements and reduce avoidable costs.

5. Assurance and Recommendations

The Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Committee take satisfactory assurance that progress is being made against the priority deliverables under 'our plan for better care' people

programme 5.1. This is based on the overview and summary provided, specifically noting the progress made to date, high-level risks identified and progress to KPIs

The programme will continue reporting progress through the 'our plan for better care' governance.

Quality Assurance Committee

Items for Information

Date: 17th November 2025

REPORTS PRESENTED TO THE BOARD FOR INFORMATION

The following reports are provided to the Board of Directors for information:

- Mortality Safety Scorecard
- Patient Experience Service Annual Report 2024/25
- Patient Safety Incidents Annual Report 2024/25
- Research and Development Annual Report 2024/25
- Safeguarding Adults Annual Report
- Care Quality Commission NHS Adult Inpatient Survey 2024 Benchmark Report
- Advanced Clinical Practice Strategy
- Perinatal Governance and Safety Report

Quality Assurance Committee

Patient Experience Service Annual Report 2024-25

Date of meeting	Date report produced
17 th November 2025	13 th October 2025

Author(s)		Report approved by	
Name and title:	Faye Sutton, Patient Safety Specialist Feedback and Engagement Natalie Herring, Deputy Chief Nurse	Name and title:	Nicola McMinn Chief Nurse
Phone:	07798745891	Date:	9 th November 2025
Email:	faye.sutton@nhs.net		

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

Not applicable.

Executive summary

This report provides the Committee with assurance that during 2024/25 the Trust met its statutory and regulatory responsibilities for patient experience. This report sets out how the Trust hears the voice of patients, service users and their families and puts their experience at the centre of our services.

This report provides patient and service user feedback about their experience of accessing and using services provided by the Trust and how they are managed and responded to effectively by services. Where learning is identified and change is required, this is implemented at a local or Trust wide level to support continual improvement.

The report includes:

- An overview of the current Feedback and Engagement services provided across the Trust during 2024/25
- The challenges experienced in 2024/25
- Review of services through the voice of the patient in 2024/25

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
1.0 Introduction and Background	Not applicable	
2.0 Context	Not applicable	
3.0 Accountability and Responsibility	Satisfactory	On track
4.0 Governance Framework	Satisfactory	On track
5.0 Discussion	Satisfactory	On track
6.0 Feedback – Patient Voice	Satisfactory	On track
7.0 Care Group Update	Satisfactory	On track
8.0 Healthwatch	Satisfactory	On track
9.0 Conclusion	Satisfactory	
10.0 Recommendations	Satisfactory	

Appendices

None.

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

Feedback and Engagement Group Meeting 21 October 2025.

Key recommendations and actions requested

The Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Committee take satisfactory assurance that 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 report provides the committee with a summary of the experience of people who use the services provided by Torbay and South Devon NHS Foundation Trust. The feedback provided to the organisation supports focused work to enable the provision of better experiences of care to those who use our services.

Improving Care Quality: By highlighting issues or areas for improvement, patients feeding back their experience helps the Trust to make changes that lead to safer, more effective treatments, better health outcomes, and positive experiences.

Empowering Patients: When patients share their experiences, they feel heard and involved in their care. This sense of empowerment can boost their confidence in managing their health and in making decisions about their health.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	The experience of our service users, patients and families is a strong indicator of their overall wellbeing
Quality of services provided	The experience of our service users, patients and families is a strong indicator of the quality of services we provide.

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Improved patient experience and patient safety and quality
People	Supporting staff to provide care that promotes improved outcomes for patients
Financial Sustainability and Productivity	Not applicable
Estates	No impact
Operations and Performance Standards	Not applicable
Digital and Cyber Resilience	Something about FFT resilience or not???
Building a Brighter Future	Supporting staff to provide care that promotes improved outcomes for patients
Strategy and Transformation	Supporting the delivery of a front of house Patient Advice and Liaison Service (PALS)
Sustainability: Green Plan/ Environmental	Not applicable
Equality, Diversity, and Inclusion	Feedback provides an opportunity to consider individual needs and to make reasonable adjustments
Provision of Community and Care Services Delivered in Partnership	Working with Healthwatch to improve the experience of our patients wherever they use our services

Risk: Risk ID (as appropriate)

Risk	Risk ID
Risk score: 15	4286 Patient Experience Team Capacity Concerns

External Standards affected by this report and associated risks

Laws or regulations

National Health Service Reform and Health Care Professions Act 2002

UK Statutory Instrument 2004 No 1768 The National Health Service (Complaints) Regulations 2004

NHS Act 2006 Section 13E (inserted by Health and Social Care Act 2012)

UK Statutory Instrument 2009 No 309 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Care Quality Commission

CQC: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16 Receiving and acting on complaints

Terms of authorisation, NHS England licence, and regulations

National policy, guidance

NHS Constitution for England

Parliamentary and Health Service Ombudsman NHS Complaint Standards (Dec 2022)

Local Government & Social Care Ombudsman Adult Social Care Complaints, Reviews and Appeals (Feb 2025)

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.

Patient Experience Service Annual Report 2024-25

1.0 Introduction and background

1.1 This is the Annual Report for Patient Experience for the year 2024/25, comprising complaints and other forms of feedback received by Torbay and South Devon NHS Foundation Trust (the Trust) as part of its regulatory and statutory requirements.

1.2 This report will provide oversight of the Trust's Patient Experience service delivery and key insights into the experience of patients and service users. The report also outlines the work undertaken to redesign, relaunch and enhance the Patient Experience service across the Trust during 2024/25.

2.0 Context

2.1 The Trust has a small Patient Experience Team that sits within its corporate functions. Historically this team has also been referred to as the Feedback and Engagement team, the Complaints Team and the Patient Advice and Liaison Service (PALS). While PALS remains a core function of the work the team undertake, the term 'Patient Experience Team' encapsulates all aspects of work undertaken by them. This ranges from providing information (signposting), through positive feedback (compliments) to the management of expressions of dissatisfaction (complaints) and collating and reporting on the Friends and Family Test (FFT).

2.2 Members of the Patient Experience Team oversee and coordinate this activity on behalf of the Trust and work directly with patients, service users, families, and carers. They provide information, facilitate speedy resolution to queries, and refer on to external or specialist support and advocacy services as required. The team works with clinical, operational, and administrative colleagues across the organisation, together with external stakeholders, to promote and develop the service and create robust, effective links and working relationships. The team also liaise with other patient experience teams and services in both health and social care communities to support a seamless service for patients and service users.

2.3 The previous report identified that the Patient Experience Team were impacted by limited capacity due to staff absence and increased activity throughout the year 2023/24. A staffing/capacity review, supported by the Deputy Chief Nurse Officer (DCNO), enabled the team establishment to be increased and, while staffing continued to be an issue impacting capacity over much of the year 2024/25, the team reached full establishment in January 2025. During Q3 and Q4 of 2024/25, the Patient Experience Team also benefited from additional management and oversight from the B8a Patient Safety Specialist tasked with providing this additional support. Also, in January 2025, risk 3568, raised to identify team capacity issues, was closed.

2.4 Q3 saw an engagement meeting between the Patient Experience Team the Quality Improvement Team, with both the DCNO and Patient Safety Specialist also attending, to discuss the findings of the QI review. The QI team had identified several actions from their observation of working practices and team culture. Actions included:

- Redesign the team rota to ensure a stronger onsite presence, supporting the delivery of a public-facing service through a more flexible and effective schedule
- Identify and assess areas in the hospital for face-to-face PALS service: a physical space suitable for in-person support for public engagement
- Address the need for a confidential working environment to improve immediate work efficiency and focus
- Explore options to refresh the team name, to reflect a team identity, the evolving service and full range of the team's responsibilities

2.5 As Q4 of 2024/25 unfolded, the stability of the team proved to be short-lived. Early February saw a request by two B5 team members to be seconded to work as part of the Trust's electronic patient record (EPR) project delivery team. These requests were supported by the B7 team manager, and by the Patient Safety Specialist and DCNO. Early March saw the B7 team manager resign, to work in another Trust. This was then followed by a part-time B5 resigning to take another post within the Trust and the resignation of the B3 FFT administrator, to leave the NHS entirely. The varying notice periods, and annual leave to be taken, conspired to mean that all five staff would leave the team in early May 2025. Five staff, 4.76 WTE, equates to 60.5% of the team establishment (excluding the B8a). The impact of these vacancies on the remaining team and their capacity will be reported in the annual report for 2025/26.

2.6 During the remainder of Q4, the anticipated changes to the team limited the progress being made on the QI actions. A small increase to on-site presence had been established, facilitated by the identification of additional office space in Vowden Hall. While the plan was, and remains, to have a patient-facing open access walk-in service, it has not been possible to bring this to fruition without sufficient staff on site to support it. Additionally, a specific location for this service has not yet been confirmed. However, this remains a stated goal to be achieved and is discussed with all new staff as they join the Patient Experience Team. The ongoing support of the Committee is required to ensure workforce is continuously aligned to activity and accepts and understands the reasons for the ongoing delay in offering a front door service as part of the Patient and Service User Experience of Health and Care Strategy – *What Matters to You Matters to Us*.

2.7 The continuing leadership provided by the DCNO saw the introduction to the team of the Patient Safety Specialist, who has prior experience of leading a patient experience team. This strengthened leadership model has enabled the provision of a consistent level of leadership, oversight and strategic direction for the team and the Trust.

3.0 Accountability and Responsibility Framework

3.1 The Chief Executive is accountable for ensuring the Trust complies with NHS complaints regulations. The Chief Executive delegates the responsibility for the effective delivery of the Trust's policy to the Chief Nurse Officer. In addition, the Trust Board and senior managers have key responsibilities for ensuring that the organisational culture is one that is open to receiving all feedback, positive and negative, reflecting on and taking people's experiences seriously, and acts appropriately in response.

3.2 Under the management of the DCNO, the Patient Safety Specialist is responsible for the strategic management and oversight of the Patient Experience Team and provides direct line management for the Patient Experience Manager (B7). In turn, the Patient Experience Manager is responsible for the operational management of the Patient Experience Team who are collectively responsible for the facilitation of complaints, PALS, and FFT.

3.3 The Patient Experience Team support the Trust in the delivery of feedback and complaints processes aligned with the policy that underpins practise. Their roles and responsibilities include:

- ✓ Treating people with respect and courtesy
- ✓ Ensuring that feedback is dealt with efficiently and complaints are investigated
- ✓ Communicating with people to properly understand and resolve their concerns in the best way possible
- ✓ Helping people to understand the complaints procedure and offering advice on where they can obtain assistance with this procedure
- ✓ Ensuring people receive a response that provides an explanation and clear outcome of their complaint investigation
- ✓ Documenting what action is taken and what learning has been identified following investigations into the feedback the Trust receives
- ✓ Signposting to individuals who are seeking advice and support
- ✓ Recognising and acknowledging good practise

3.4 The Associate Directors for Nursing and Professional Practice (ADNPPs) or Associate Directors for Operations (ADOs) are responsible for ensuring complaints are investigated and responded to in line with the Trust policy. They lead on ensuring, where appropriate, that lessons are learnt and remedial action is implemented, evaluated, and embedded to sustain change.

3.5 ADNPPs or ADOs within each Care Group are responsible for allocating a lead person for the complaint investigation. They will then be responsible for updating the ADNPP/ADO on the progress of the investigation. The ADNPP or ADO will be responsible for reviewing the relevant investigation documentation and draft letter of response. This draft response is then reviewed by either the Deputy Chief Nurse Officer or Deputy Chief of Allied Health Professionals before progressing to the Chief Executive to review, approve and sign. Once approved and signed by the Chief Executive, the final letter of response is sent to the complainant or their representative.

4.0 Governance Framework

4.1 The Feedback and Engagement Group (F&E Group) oversee patient experience activity undertaken across the Trust. This group is chaired by the Patient Safety Specialist and has a varied membership which includes a broad range of Trust staff and representatives from the wider health and care community such as Healthwatch the NHS Devon Integrated Care System, Rethink Advocacy, Torbay Carers Service and Mount Stuart Hospital. This forum provides staff and wider system partners, responsible for, or involved with, the patient/service user experience of the Trust, to discuss issues and to share learning and best practice.

4.2 A key focus of the F&E Group is to review patient experience activity across the Trust and compliance with both local (trust determined) and national quality standards. The group also reviews all CQC patient experience survey results and

monitors action plans for service specific CQC surveys, such as for Maternity, and the wider CQC Adult Inpatient Survey. Additionally, Healthwatch present relevant reports via this group, which also has oversight of the Trust's action plan aligned to previous relevant Healthwatch publications. The F&E Group meets monthly and invites/co-opts specific colleagues to enhance the group with additional skills, knowledge, and competence. The sharing of good practice and continuous development of a patient-centred culture across the Trust is pivotal to the work of this group.

4.3 ADNPPs/ADOs retain oversight of patient experience work within their Care Groups, and a report of this monthly activity is presented by the ADNPPs to the F&E Group. These reports include: complaints; concerns; compliments; FFT; survey action plans where appropriate; and any other service user experience. The ADNPPs highlight learning identified and actions being progressed within their Care Groups and, where applicable, the wider Trust, to enhance and improve the patients' experience of Trust services.

4.4 A monthly status, escalation, and exception report, arising from the F&E Group, is presented at the Safety and Quality Assurance Group (SQAG). In addition to this report, patient experience information is also presented via other groups and reports to ensure that patient and service user experience is disseminated and escalated appropriately within the Trust's corporate governance framework:

- Quality Report for Healthcare, reported at the Trust's Quality Assurance Committee
- Integrated Safeguarding Group
- Mortality Board Report
- Trust Membership Committee

4.5 The Safety and Quality Assurance Group reports to Executive Committee.

5.0 Discussion

5.1 Statutory Regulations and Responsibilities

NHS complaints, and those related to Adult Social Care (ASC), are managed in line with the Trust's Feedback, Complaints and Patient Advice and Liaison policy and in line with NHS and Social Care complaints regulations. These regulations stipulate only two time-limited quality standards, which are that the Trust:

- ✓ must acknowledge the complaint not later than 3 working days after the day on which it receives the complaint
- ✓ will send the complainant a response as soon as reasonably practicable, and within a period of 6 months commencing on the day on which the complaint was received, or such longer period as may be agreed before the expiry of that period by the complainant

A total of 199 complaints were recorded during the year 2024/25. 95% of complaints were acknowledged within the 3-day timeframe, which is an increase of 14% compared with 2023/24. The number of complaints that are recorded as having breached the 6-month timeframe for the year 2024/25 is 10 (5%), which is a reduction of 2 compared with the previous year. Both improvements noted are likely to result from the team having a small increase in staff numbers and by being at full establishment. In addition, an extra field was added to DCIQ by the Patient Safety

Specialist, to identify if a complaint has breached the 6-month deadline at the point it was closed, making it easier to accurately gauge and report these breaches.

While NHS/ASC regulations stipulate a 6-month deadline for complaint completion, the Trust has determined its own internal timeframe for completion. This timeframe was extended from 6 to 12 weeks in Q4 of 2023/24, with the hoped for outcome of fewer complaint deadline extensions. The Trust's internal timeframe for response recognises that delays can hinder the effectiveness of the complaint investigation and may cause increased distress to the complainant.

Of the 199 complaints received during 2024-25, 49% (n=98) were extended at least once. Of those extended, 58% (n=57) were extended a second time, 21% (n=21) a third time, 10% (n=10) for a fourth time and 1% (n=1) for a fifth time (as seen in figure 1 below).

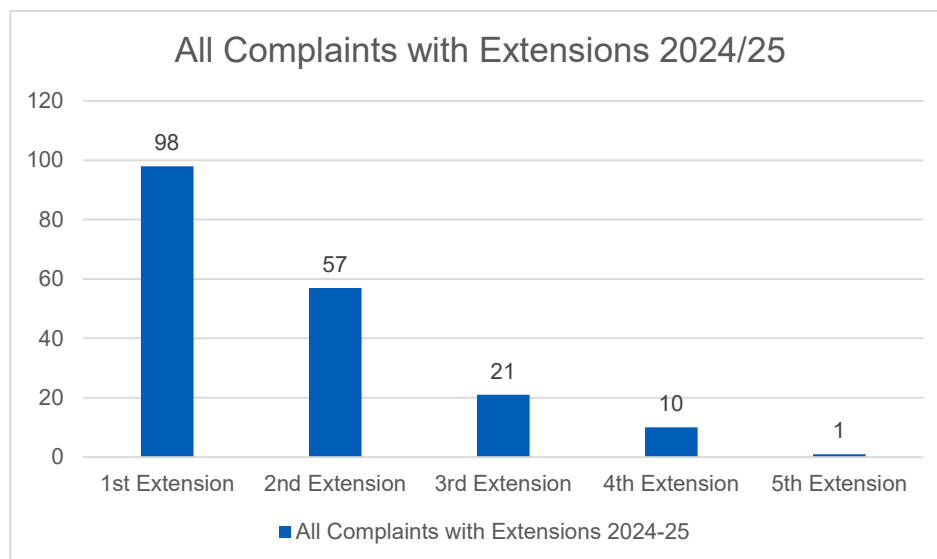


Figure 1: Complaints with extensions for 2024/25

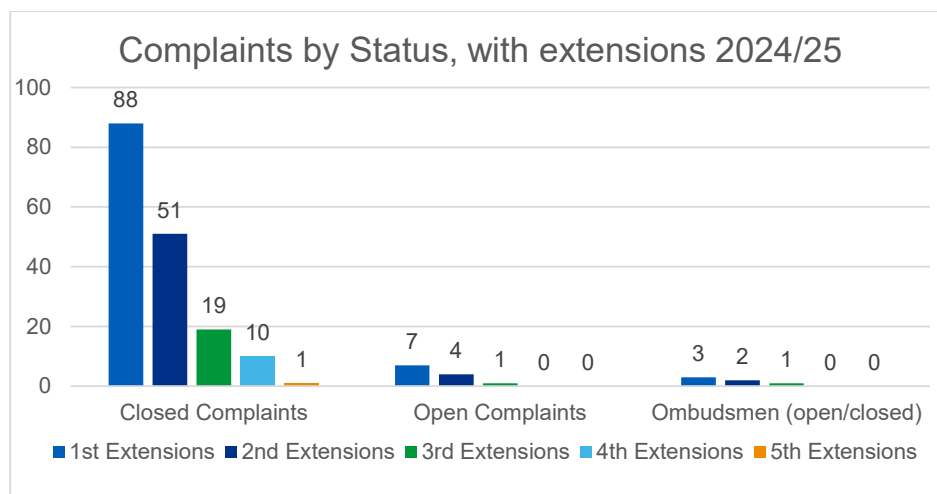


Figure 2: Complaints by status, with extensions for 2024/25

Of the extended complaints, the majority are now closed, as seen in figure 2 above.

The primary reasons provided for deadline extension requests are ‘operational pressure’ and ‘staffing (Absences)’ and this applies to all extensions, whether first or fourth.

To support the reduction in number of extensions timeframes where reviewed and while extensions do not appear to have been significantly impacted by the change from 6 to 12 weeks for completion, it does seem to have impacted the number of 5th extensions, with only one case extended for a fifth time over the entire year.

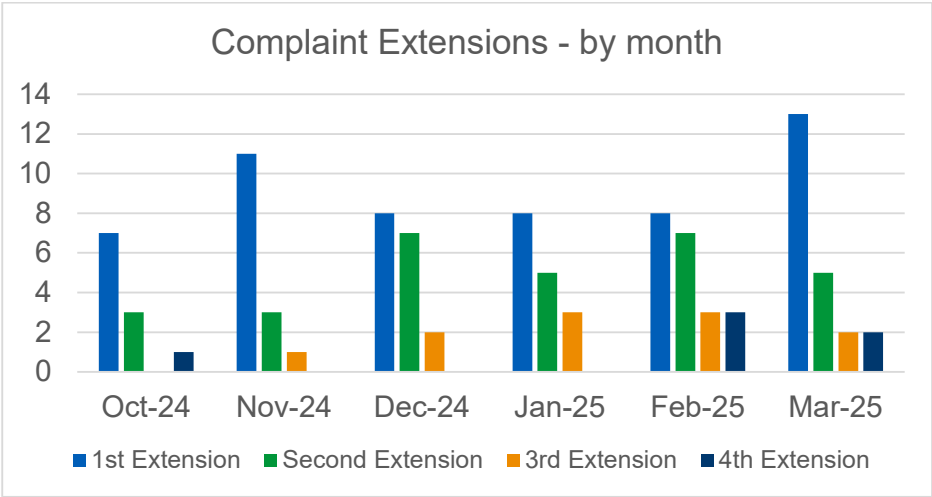


Figure 3: Complaint with extensions for Q3 and Q4 2024/25

No requests for 5th extensions were made during the second half of 2024/25 as result of the timeframe changes (see figure 3 above).

5.2 Ombudsman Cases

There is often a significant gap between the Trust responding to and closing a complaint, and any subsequent review by the Parliamentary and Health Service Ombudsman (PHSO) or Local Government and Social Care Ombudsman (LGSCO).

There were 3 cases already under review by the PHSO (none by the LGSCO) prior to the year 2024/25 and subsequently closed in that year.

Of these, 2 were closed with the PHSO outcome ‘not investigated’:

Number	Date complaint received	Date of PHSO outcome
COM-1	10/10/2022	04/03/2025
COM-2	26/06/2023	28/10/2024

One complaint was closed with the PHSO outcome ‘partially upheld’:

Number	Date complaint received	Date of PHSO outcome
COM-3	01/12/2022	31/01/2025

COM-3 – This complaint related to an area under Urgent and Emergency Care. The daughter of the patient was upset about the care her mother received in the ambulance, and on the ward. The PHSO found that there was a delay in admission to the Trust, and although a delay of almost 13 hours between being moved from the ambulance to the emergency department was not appropriate, it was accepted that

the Trust recognised this and that it was out of their control. The PHSO also felt that the patient should have seen a doctor sooner and been referred to the gastroenterology team sooner. The PHSO investigation found no failings in the decisions made about clinical care and treatment. However, they noted failings in record keeping which meant it took longer for them to complete their investigation and led to uncertainty and additional distress for the patient's family. The PHSO recommendations were shared with the Associate Director of Nursing and Professional Practice for action.

There is one case from 15/09/2023 that was opened to the PHSO in March 2025.

In addition to those cases closed to the PHSO during 2024/25, the Trust has been contacted by the PHSO in relation to 7 complaints received and processed in that year. There were no contacts from the Local Government and Social Care Ombudsman.

The 7 complaints were opened between April and October 2024, and the PHSO contacts were received between July and September 2025. These will be reported via the interim reporting mechanisms, e.g. F&E Group, as well as in the annual report for the year 2025/26.

5.3 Contact Analysis

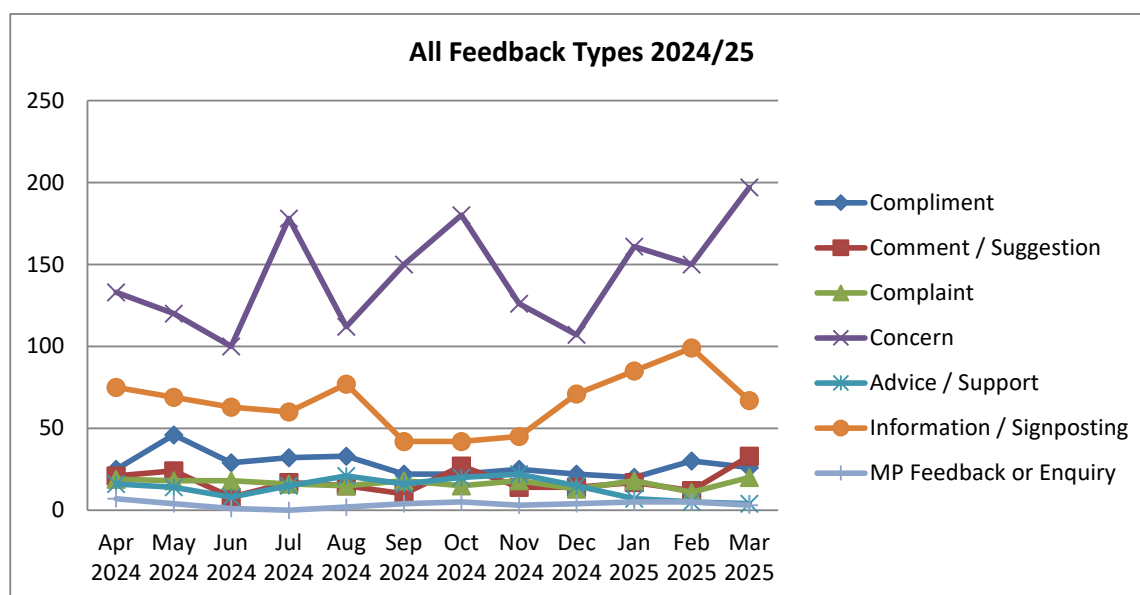


Figure 3: All feedback received by month

In total, 3459 contacts were received over the year 2024/25 (figure 3 above), this is a 29% increase on the data for 2023/24 (n=2463). These 3459 contacts equate to an average of 67 per week, a 30% increase on the weekly average for the previous year (n=47). Figure 4 below shows the total contacts by quarter.

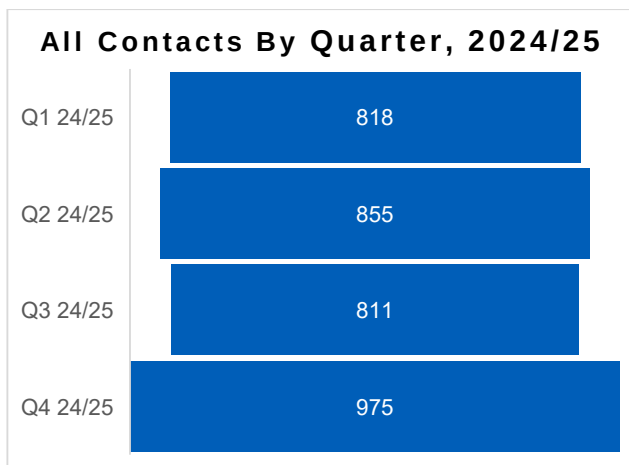


Figure 4: All feedback received by Quarter

Compared with previous years, as seen in figure 5 below, complaints have increased, with 200 received in 2024/25.

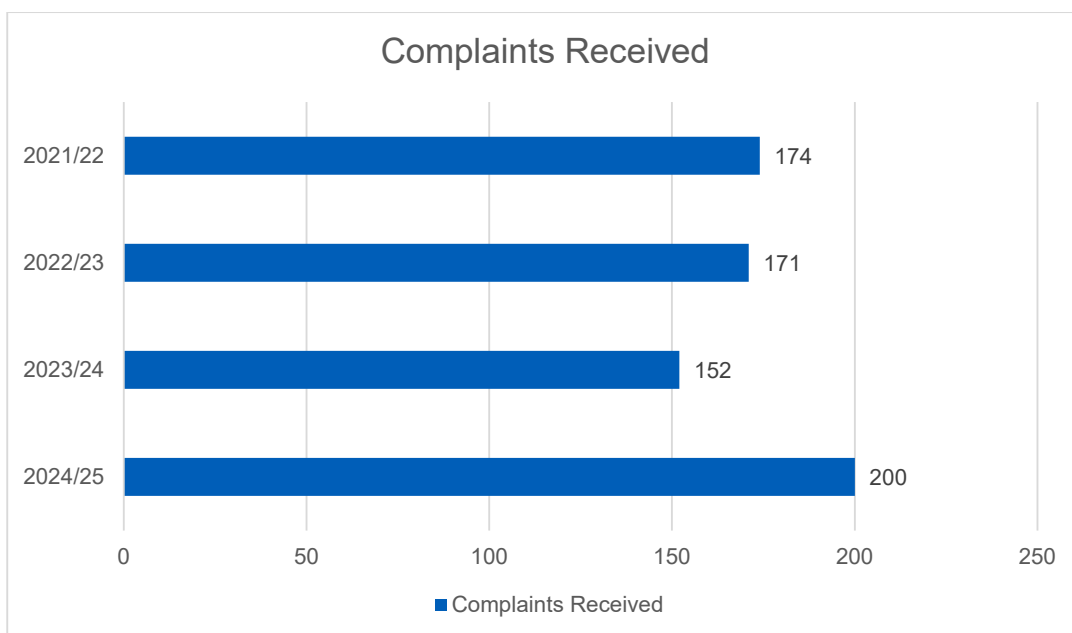


Figure 5: Complaints received by year

The increase in complaint numbers appears to be genuine and coincides with a concurrent increase in the number of concerns reported over 2024/25.

There were 1713 concerns reported in 2024/25, 162 more than the preceding year (n=1551), equating to a 10% increase.

The Care Group ADNPPs manage these concerns and complaints and where themes and trends are identified, local action plans are developed to improve patient/service user outcomes. Where appropriate, and where further learning can be undertaken, these outcomes are shared across the organisation.

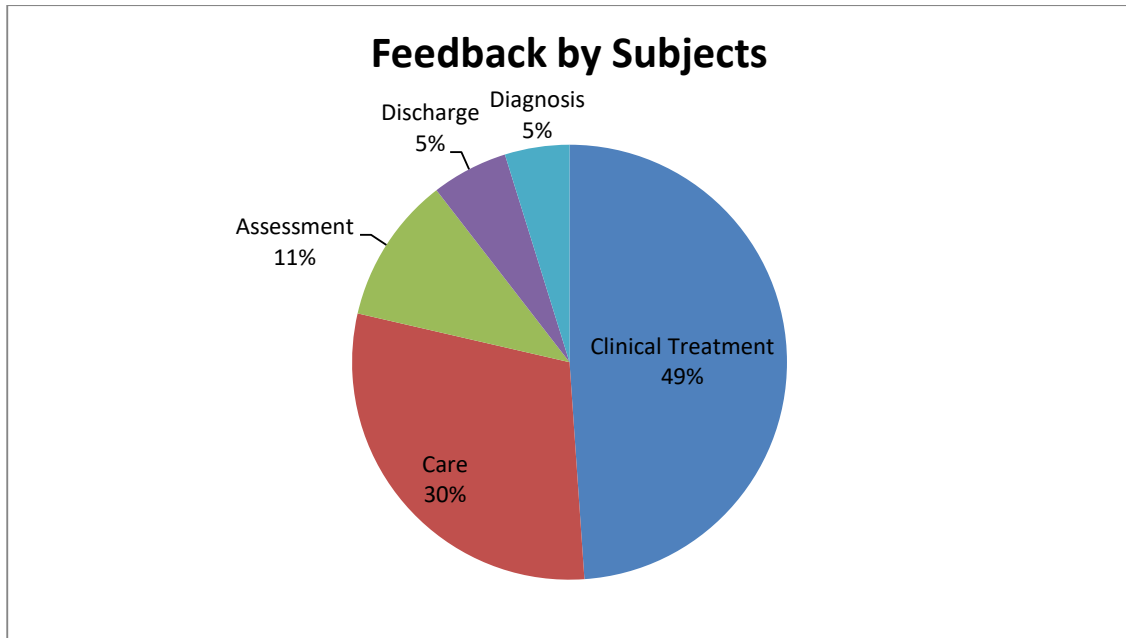


Figure 6: Complaints by high level subject

Almost half of all complaints have been categorised as relating to Clinical Treatment (49%) with Care following closely at 30% of the total.

Further detail can be seen in figure 7 below, which shows the breakdown of complaints topics.

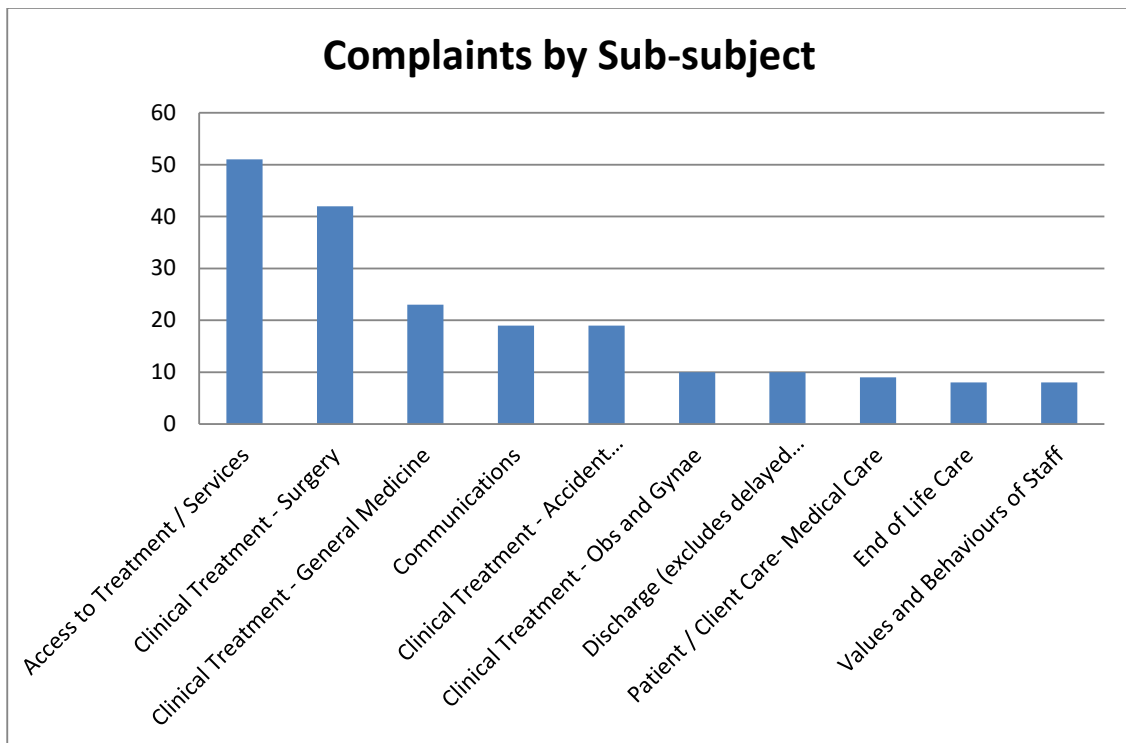


Figure 7: Complaints by sub- subject

The complexity and diversity of services involved, and the range of complaint topics will generally require bespoke service level change, which is managed within the Care Groups.

It is important to ensure we review and learn from the positive experiences expressed through compliments that services receive (see figure 8 below).

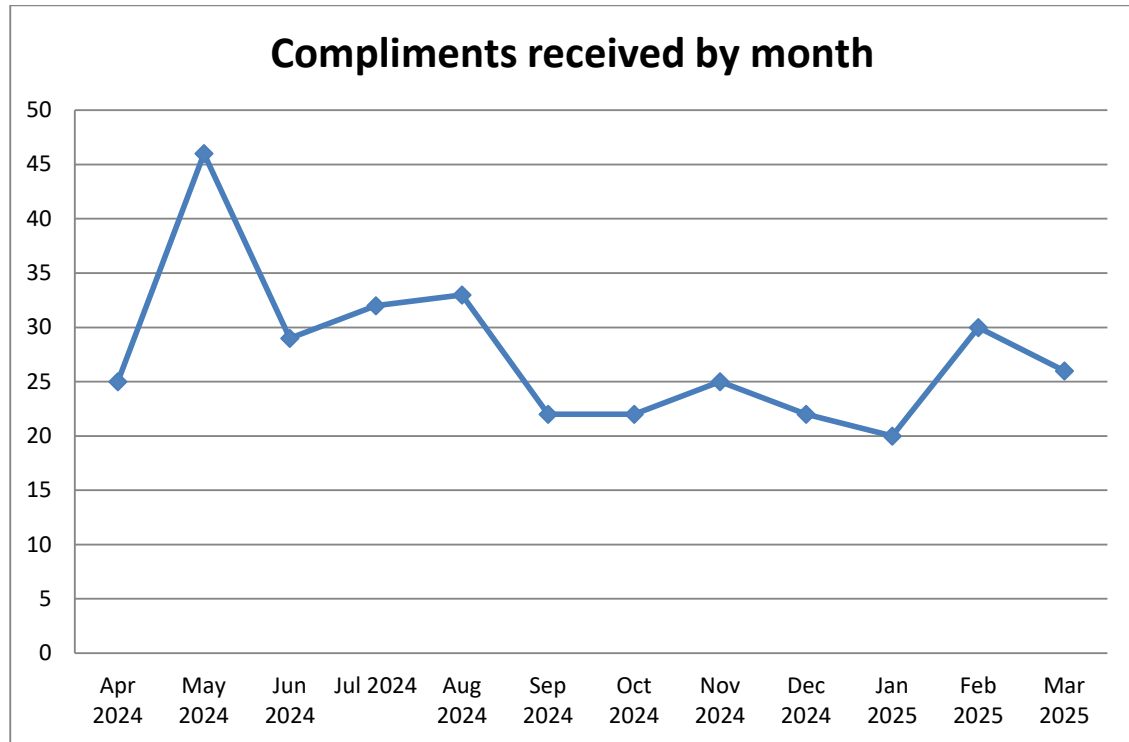


Figure 8: Compliments received by month, 2024/25

Compliments are frequently spontaneous, and are often expressed through informal acts of appreciation, for example the box of chocolates left for the clinical team on the ward, and many of these do not make their way into formal reporting structures, such as Datix.

However, in 2024/25, the Trust received 332 compliments via Datix. This compares with 393 in 2023/24, and 337 in 2022/23.

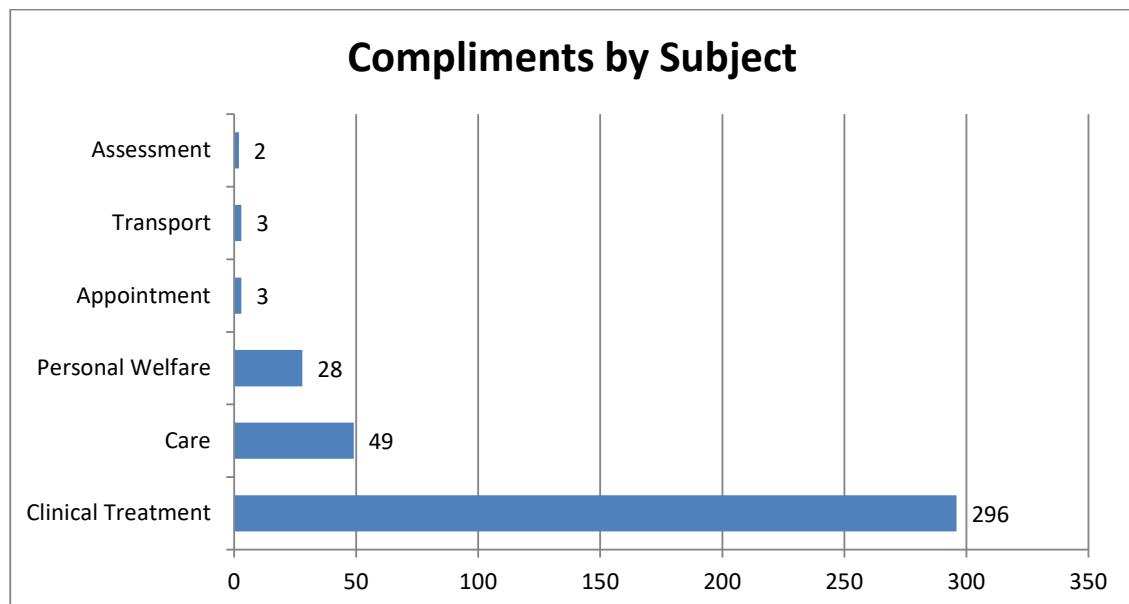


Figure 9: Compliments by subject, 2024/25

Clinical Treatment and Care are the main reasons for the compliments received which aligns with Trust core business as a health and care organisation.

In addition to feedback received on the Trust's risk management system, Datix, a further 55 feedback reports were also received via Care Opinion (figure 10). The majority of this feedback (87%) was positive, with people expressing their thanks to the individuals and team who they met and received care from.

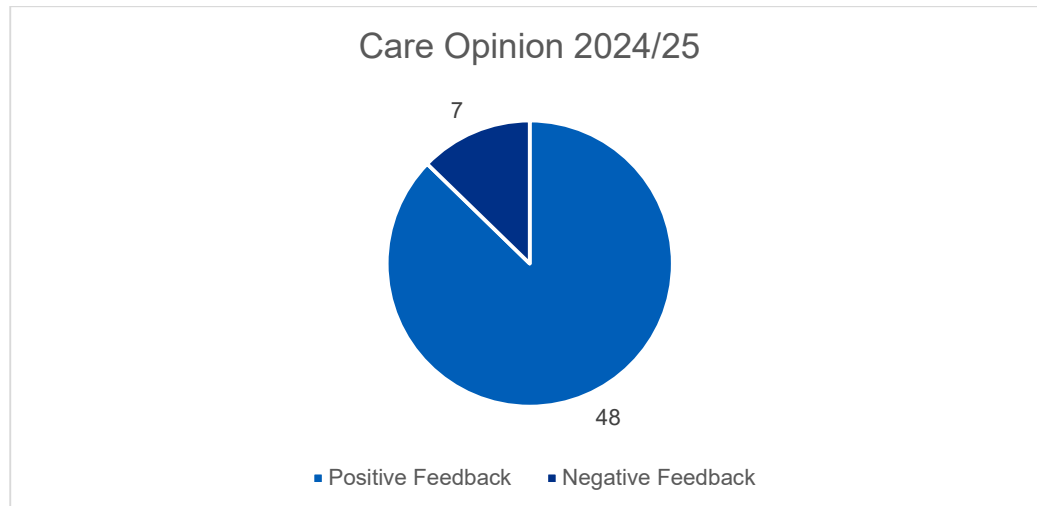


Figure 10: Feedback via Care Opinion, 2024/25

5.4 Friends and Family Test (FFT)

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements may be needed. It is a quick and anonymous way for people to give their view after receiving NHS care or treatment. While the FFT has been a mandatory requirement across all NHS Trusts since 2013, and every person must be given the opportunity to provide feedback on the service they have accessed, patient can choose whether to respond.

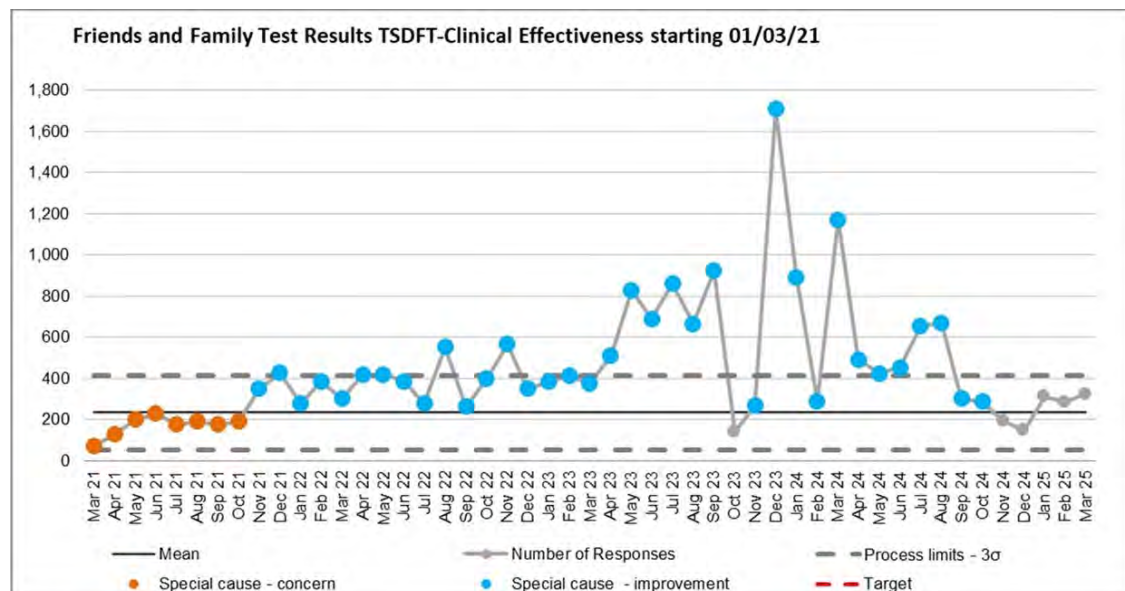


Figure 11: FFT, from 01/03/2021 to 31/03/2025

The improvement work noted in the 2023/24 Annual Report resulted in a significant increase in returns, seen in figure 11 above, between November 2023 and March 2024.

However, the service entered a period of extended challenge resulting from the long-term absence of the postholder responsible for inputting FFT data. This was partially mitigated by some part-time cover to support but was not sufficient to address the backlog of completed FFT returns. Additional mitigation was sought via the staff Bank and through the potential of using redeployed staff but was unsuccessful. The previously identified improvement trajectory was put on hold pending the remedial work required to upload the backlog.

Despite this, FFT data that was processed continued to support the previously reported trend of most respondents (92-96%) indicating their care was either 'very good' or 'good' and very few (1-3%) saying their experience was 'poor' or 'very poor'.

6.0 Feedback – the Patient Voice

6.1 What matters to patients, matters to us

All staff have a responsibility to acknowledge where care has not been of the required standard and to do everything in their power to learn and to amend practice.

Learning from complaints should happen throughout the organisation depending on the issues of concern. In some instances, the issue may relate to a single department, but the theme may be applicable to other areas. It is the role of the senior leadership team in the Care Groups to ensure that issues and the resulting action plans are appropriately shared. The Patient Experience Team will work with the Care Groups to ensure actions identified by the Care Groups are monitored and accurately recorded on the risk management system. Where appropriate, staff should incorporate the learning into their annual achievement review with their manager.

6.2 What people have said

The following is a small selection of feedback received across the year 2024/25:

- My severely autistic daughter had to have her ears cleaned of foreign bodies and a few teeth removed and absolutely everyone involved in her care where wonderful pleasant and all- round amazing
- Very kind considerate very professional thank you all
- Received a letter asking me to phone to make a mammogram appointment. The person answering the phone was rude and snappy every time my partner made a comment. Their job is answering the phone not tutting and sighing on the phone - very unprofessional!
- The whole team made us feel at ease, couldn't do enough to help and were always there whenever we needed.
- I just want to thank everyone involved in the birth of our girl!! You are all amazing !! :)
- Reception closed sign up till 0840 this morning yet appointment for 0830. Lady serving- no "good mornings" or even a hello, no smile. Second time didn't even look at me just stuck her hand out to get the paperwork. Poor Staff to Patient front desk attitude. It's not hard to smile and be polite

- Thank you for everything you do for us as a family, you go above and beyond your 'nurse' role
- I just wanted to say thank you for being so brilliant today. I really appreciated your professionalism and your dedication to the child."

6.3 Learning and changing

The capture and sharing of significant learning from complaints is led by the Trust's Feedback and Engagement Group. Examples of complaints which have identified either learning or good practice are shared. There is further work required to strengthen our approach to disseminating learning from concerns raised by patients and families and how we capture the actions required on Datix. Section 7 below provides examples from the Care Groups demonstrating how they have or are responding to feedback received.

7.0 Care Group Updates

The following are some examples of work that has been undertaken within Care Groups:

6.1 Maternity

- The Maternity leadership team receive excellent engagement from and feedback through their Maternity and Neonatal Voices partnership (MNVP). Collaborative working is key to this relationship and work on the MNVP 15 Action Plan was reported as progressing.
- Work was undertaken to collect feedback from both Maternity and SCBU staff around extended visiting and aligning visiting for TCW.

6.2 Planned Care

- Waiting list Improvement Equity improvement plan - to reduce inequity within elective waiting lists by flagging those most in need, without increasing waiting times for those not flagged.
- Noise at Night - observations of care undertaken and 'sleep well' packs have been relaunched. A focus on Supper and Settle was planned, SOP written, with a task & finish group set up. Supper and Settle is purposeful activity for night staff and following medication round. For example - Snack, drink, made comfortable, Sleep well pack offered, lights dimmed.
- Improving communication shared with patients was also a focus:
 - o Ophthalmology patients on waiting lists
 - o Pilonidal abscess pathway patients, on discharge

6.3 Children and Family Health Devon (CFHD)

- Recruitment of CFHD Participation workers x2, who will start in April 2025, with a focus on building parent care group and participation with CYP in physical health pathways
- Starting a 12-month contract for Parental Minds to support our CFHD Parent Carer group
- Work began on the Parents Charter for improving access to mental health services for CYP with autism. This was initiated by a group of parents in Torbay. We have an agreed action plan and are working with the group to implement their recommendations. First actions are:
 - o Virtual tour of Annexe buildings and clinical rooms

- o Photo display board of the team in the waiting area

6.4 Place Based Care

- Focus on access to education and support for B7 managers to improve skills to support complaint reviews and responses
- Undertake a thematic review of discharge related complaints, to inform and learn

6.5 Medicine and Long-Term Conditions

- Implementation of Patient Safety Support workers (PSSW) on wards - supernumerary for 2 weeks with intensive training
- Enhanced Therapeutic Observations and Care (ETOC) Steering Group formed
- Turbo training across all medical wards with an emphasis on MCA and DOLs documentation
- Your Next Patient initiative in escalation being embedded across all wards- expanded to weekends when:
 - o In OPEL 3 or 4
 - o Ambulances are queuing
 - o Patients in ED longer than 12 hours

8.0 Healthwatch

The Feedback and Engagement Group work in collaboration with Healthwatch. Healthwatch attend the monthly meetings providing updates on what our public and patients are telling us. The Deputy Chief Nurse Officer and Patient Safety Specialist hold an overall Healthwatch action plan that is reviewed through the Feedback and Engagement Group.

9.0 Conclusion

9.1 Through 2024/25 the Patient Experience Team have continued to provide a coordinated service to our local population. The Patient Experience Team and organisational colleagues who review, investigate, and respond to feedback in the form of concerns, complaints, Ombudsman and MP enquires, and compliments, demonstrate a continued commitment to providing comprehensive, compassionate responses and identifying local and Trust wide learning.

9.2 Capacity within the team, previously an issue, improved in Q4 of 2024/25, but over the year this again impacted on the Trust's ability to progress the Patient and Service User of Health and Care Strategy and the development of a front-door service.

10.0 Recommendations

10.1 To note the content of the report and the achievements aligned to Patient Experience during 2024/25.

10.2 To support the programme of work set out in the Patient and Service User Experience of Health and Care Services Strategy and Delivery Framework to enhance and underpin the provision of high-quality health and care services as we strive to consistently provide an excellent patient experience.

Assurance and Recommendations

1. This report provides an overview of the work undertaken from that of the Patient Experience Team and wider stakeholders to provide assurance that feedback is acted on appropriately and in a timely manner.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1.0 Introduction and Background	Not applicable	
2.0 Context	Not applicable	
3.0 Accountability and Responsibility	Satisfactory	On track
4.0 Governance Framework	Satisfactory	On track
5.0 Discussion	Satisfactory	On track
6.0 Feedback – Patient Voice	Satisfactory	On track
7.0 Care Group Update	Satisfactory	On track
8.0 Healthwatch	Satisfactory	On track
9.0 Conclusion	Satisfactory	
10.0 Recommendations	Satisfactory	

Quality Assurance Committee

Patient Safety Incidents Annual Report 2024/25

Date of meeting	Date report produced
17 th November 2025	11 th November 2025

Author(s)		Report approved by	
Name and title:	Andrea Blake – Interim Patient Safety Specialist	Name and title:	Maria Patterson – Associate Director of Patient Safety and Quality
Phone:	Ext. 54843	Date:	11 th November 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

The purpose of the report is to provide the Trust with an annual summary of principal activity and outcomes relating to the patient safety incidents that occurred in the Trust during the year April 2024 to March 2025.

Key areas to note:

- A marginal increase of 0.3% in incident reporting activity across the Trust
- 14 incidents reported onto StEIS as patient safety incident investigations (PSII) and reports commissioned. 6 never events were reported during the period of review which were investigated individually and thematically reviewed into a PSII
- The Trust has now fully implemented PSIRF
- An overview of litigation incidents is also provided in section 2.0. The Trust can take assurance that we, as a relatively small Trust, our level of claims is low, and we are commensurate with other Trusts of a similar size.
- As part of PSIRF work is being undertaken to ensure that safety incidents and claims data (alongside other safety insight) is being used to inform patient safety incident investigation priorities

- This data will be used to inform part of our revised patient safety incident response 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
1.0 Incident overview	satisfactory	same
2.0 Claims overview	Satisfactory	same

Appendices

N/A

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

Incidents are discussed weekly at the Executive Safety Review Group (ESRM) for safety oversight and to ensure that PSIRF standards regarding investigations are followed.

All outstanding Serious Incidents (SI) have been closed. Patient Safety Incident Investigations (PSII) are reviewed and agreed at Patient Safety Incident Review Group (PSIRG) before being shared with the Chief Nurse or designated deputy for sign off and shared at Safety and Quality Assurance Group (SQAG).

Key recommendations and actions requested

The Quality Assurance Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance that processes are in place to monitor safety incidents within the Trust. This is based on monitoring of incidents reporting trends.

Further assurance should be taken from the regular reports provided to QAC regarding the quality and safety of services which are informed by incident reporting trends.

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

This report provides assurance that the Trust is responding and reviewing patient safety incidents to ensure learning and quality improvement to improve the health and wellbeing and outcomes of our community

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	
Quality of services provided	Evidence to support quality and safety of services
Sustainable and efficient use of resources	

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	X
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
Laws or regulations: 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.

1.0 Patient Safety Incidents and litigation overview Annual Report 2024/25 (report title)

1.1. Introduction and background

The purpose of the report is to provide the Trust with an annual summary of principal activity and outcomes relating to patient safety incidents that occurred in the Trust during the financial year April 2024 to March 2025. This report provides evidence to support the Board with the Trust's patient safety and quality priorities. It is intended to provide information from which the Board can take assurance regarding compliance with external requirements for Patient Safety Incident Investigations (PSIIs), Never Events and other patient safety incidents.

1.2 Context

The year 2024-2025 marked an important time in patient safety for the Trust with the embedding of the Patient Safety Incident Response Framework (PSIRF). This has altered the way the Trust responds to patient safety incidents primarily focussing on learning and quality improvement. PSIRF advocates a co-ordinated and data-driven approach that prioritises compassionate engagement with those affected by patient safety incidents (patients, families and staff) and it embeds the patient safety incident response within a wider system of improvement, which prompts a significant cultural shift towards systematic patient safety management. The Trust made the transition from Serious Incident Framework (SIF) to PSIRF on 1st February 2024.

This financial year saw the Medical Examiner's Office transition to use Datix Cloud IQ (DCIQ) from DatixWeb, and work is underway for the Risk Management Module to also transition to DCIQ from DatixWeb.

1.3 Analysis of Incident Data

From April 2024 to end of March 2025 a total of 12,146 patient safety incidents were reported onto the Trust's Local Risk Management Systems (DCIQ). This was an increase of 37, or 0.3% from the previous financial year (April 2023 to March 2024). [n=12,109]

Of the 12,146 patient safety incidents submitted during 2024/25, 75% (9,170) are reported to have occurred whilst the patient has been in the care of the Trust i.e. 'caused by us' as per question of DCIQ, meaning that they directly impacted patient care, outcomes and experience. Incidents may have been considered not "caused by us" when they have occurred outside of Trust-provided care, such as: pressure ulcers reported on admission where the patient is not in Trust funded social care or community nursing; incorrect advice by 111 Service – patient attending ED for non-emergency matters; incidents reported locally but relating to care from another NHS provider.

1.4 Key Themes: All Patient Safety Incidents Reported

Initial analysis of the data for 2024/25 identifies that a theme which emerged in previous reports of the top 3 category of incidents has continued with 'pressure ulcer', 'accident/injury – patient' and 'access or admission to NHS services' being the highest volume of patient safety incidents reported. Following the transition to DCIQ the categorisation of incidents was updated; 'access, admission, transfer and discharge' was updated to 'access or admission to NHS services' and 'discharge' became a separate category.

Top 10 categories of patient incidents (caused by us)	Count of Ref
Pressure Ulcer	1499
Accident / Injury - Patient	1215
Access or Admission to NHS Services	1083
Blood Transfusion and Sampling	643
Medication	595
Behaviour that challenges (includes use of restrictive practice)	532
Treatment or Procedural Issue	343
Communication Issue	305
Ongoing Monitoring or Care	267
Medical documentation	242
Grand Total	6724

Table 1: Top 10 categories of patient safety incidents 'caused by us' (data source DCIQ)

Review of table 1 above shows a total of 6,724 incidents recorded in the top 10 categories, where the incident appears to have been caused by the Trust. The remaining 2,446 patient safety incidents reported include categories with relatively low incident occurrence. Examples of these include 'skin damage (not associated with pressure); clinical assessment (including tests / scans); and discharge.

The majority of patient safety incidents reported were assessed as causing Low or No Harm to patients, as can be seen in figures 1 and 2 below.

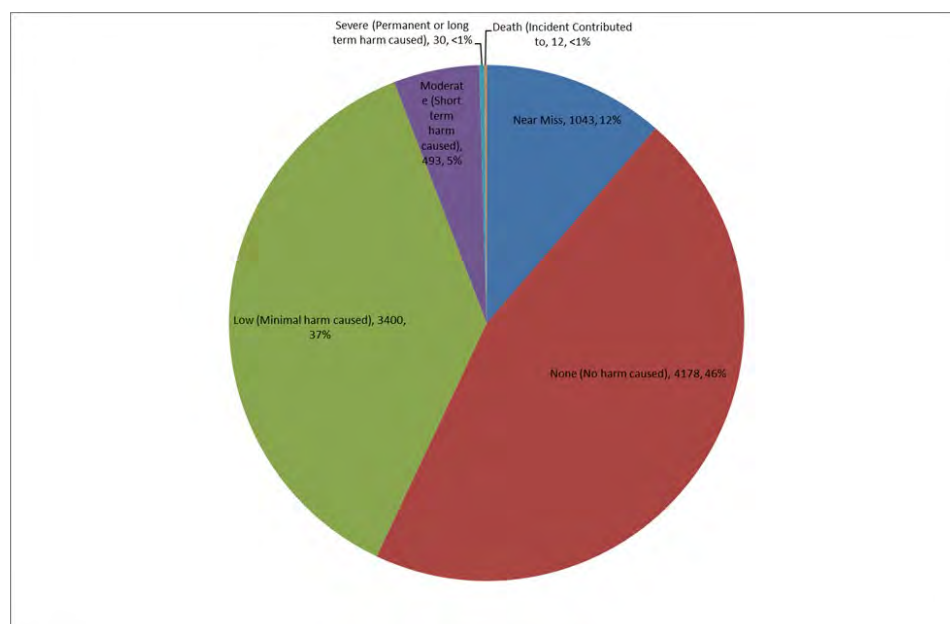


Figure 1: Incidents "caused by us" by severity (data source DCIQ)

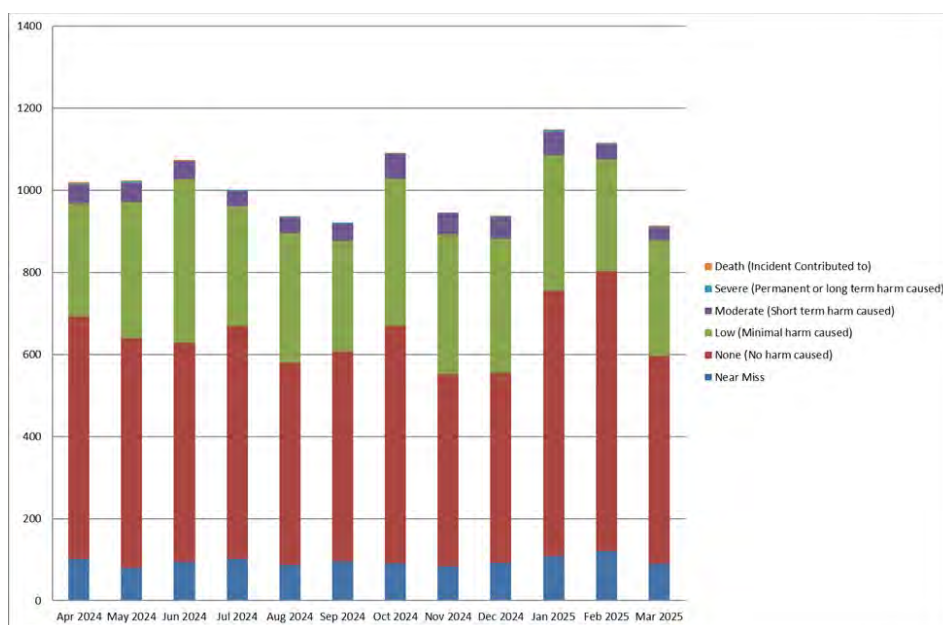


Figure 2: Total Patient Safety Incidents reported per month by severity

Incident reporting within the organisation appears to be relatively steady, and the spread of harm categorisation is also consistent. The observable variation in numbers of incidents reported is broadly in line with the Trust's activity and escalation status.

1.5 Near Miss Incidents

Of all patient safety incidents reported, 11.4% (1,043 of the 9,156), were categorised 'near miss'. A near miss incident is one that could have harmed the patient but did not actually cause harm, as a result of chance, prevention, or mitigation.

Of the Trust's near miss incidents, the top four incident types are:

Near Miss Incidents (Top 4)	Corporate Response
Blood Transfusion and blood sample incidents	The blood transfusion committee has been reestablished in Spring 2024. This meeting and the patient safety group has oversight of all blood related safety incidents. Additional resource has been identified to support the Senior Specialist Practitioner of Transfusion to ensure that clinical areas are supported and that learning from safety incidents is shared. The Trust has commissioned a thematic review of blood safety incidents, and this is underway
Medication related issue	The medicines governance committee has oversight of medication related incidents, with additional oversight via patient safety incident response group (PSIRG) and safety and quality assurance group (SQAG). Missed doses are a theme that have been identified and there is a focus on time critical medication in the emergency department to ensure prompt prescribing and administration.

Medical and nursing documentation	The trust is working towards implementing an electronic paper record (EPR) which will increase patient via improvements in documentation and communication. EPR's have been proven to improve quality, safety and patient experience. Until EPR we are continually reviewing processes to increase the safety of our paper-based system, this is an area that has been identified as a safety theme in our PSII's. The expected go-live date for the EPR is April 2026.
Communication issue	Communication incidents are generally related to information sharing between professionals; inadequate handover of care; and information sharing within the Trust. These incidents are reviewed at locality, care group level to allow for individual actions to be taken. Care group will highlight concerns of themes at PSIRG and SQAG. The implementation of the EPR is expected to improve this position.

1.6 Overview of Moderate and Above Incidents

Of the 9,170 patient safety incidents where harm was “caused by us”, a total of 535 (5.8%) were reported to have harm caused that was graded as either Moderate, Severe or Death. There is a consistent average of around 178 patient safety incidents, with these gradings, reported in each quarter. The majority of the higher harm-level incidents are graded as moderate harm:

Analysis identifies the top 3 themes for moderate and above harm as:

1. Pressure Ulcers
2. Venous Thromboembolism Events (VTE)
3. Accident / Injury (including slips, trips and falls)

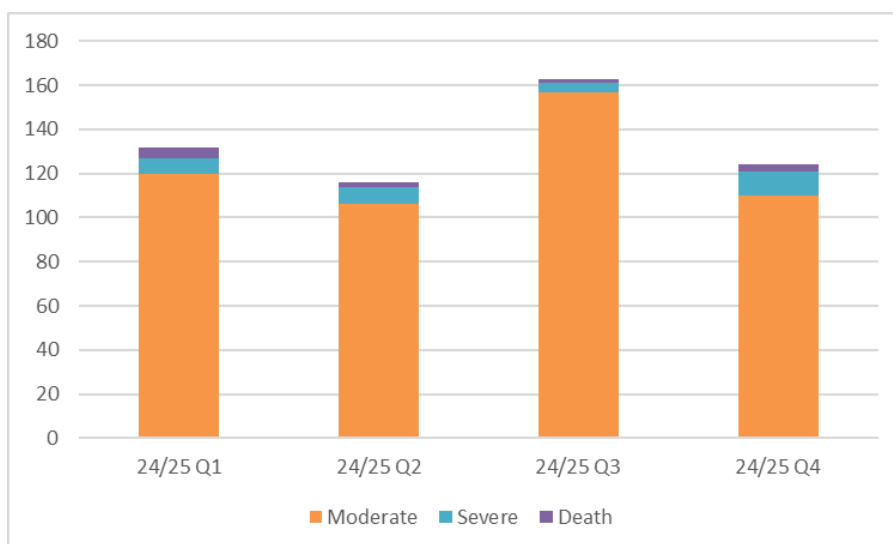


Figure 4: Moderate or above reported patient safety incidents “caused by us”.

StEIS Reportable Incidents

In February 2024 the Trust transitioned from the Serious Incident Framework (SIF) to PSIRF (Patient Safety Incident Response Framework). A Patient Safety Incident Investigation (PSII) will be commissioned by the Trust if an incident meets the National Criteria (Never event, criteria meeting learning from death, child death or incidents where care may have contributed to the outcome) or one of the 3 locally agreed criteria.

TSDFT local criteria for PSII:

1. Delayed access to elective/planned care
2. Delays across our urgent and emergency care pathway related to the frail or elderly
3. Diagnostic tests and testing – safety incidents related to errors or delays across diagnostic and testing pathways.

During the financial year 2024/25 there were 14 StEIS reported PSII's. 9 PSII's were reported due to meeting the national criteria and 5 met the local criteria, 3 relating to delays across our urgent and emergency care pathway related to the frail or elderly and 2 relating to diagnostic test and testing – safety incidents related to errors or delays across diagnostic and testing pathways.

Figure 5 below identifies the Trust's categories of PSII's reported during 2024-25.

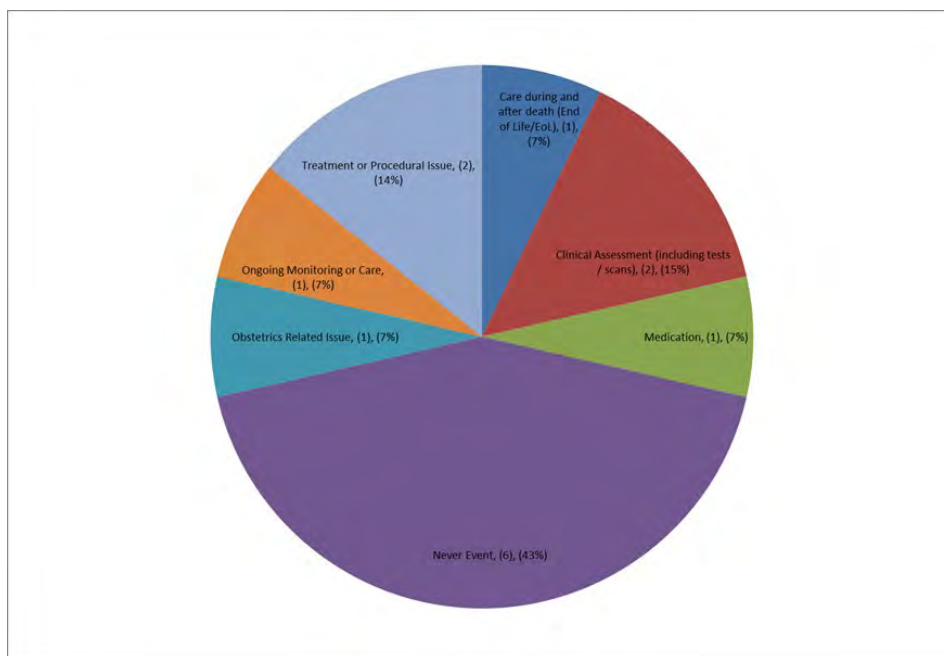


Figure 5: Category of StEIS reportable incidents

1.7 Never Events

Never events are serious incidents that are considered entirely preventable.

There is national guidance, or safety recommendations, which provide strong systemic protective barriers that should have been adopted, and which should stop never events from occurring. There were 6 never events reported in the financial year 2024/25, this is an increase from the previous financial year where none were

reported. The 6 never events were reviewed initially as Patient Safety Reviews (PSR) and thematically analysed as one patient safety incident investigations (PSII) with themes identified and actions undertaken. The Trust has participated in joint improvement work with University Hospital Plymouth to provide peer assurance.

1.8 External Assurance

Members of the ICB attend the Trust's Patient Safety Incident Review Group meeting (PSIRG) which takes place weekly to provide a quality review of incident investigation reports. Patient Safety Incident Investigation (PSIIs under PSIRF) reports undergo a quality review at PSIRG, but the report will also be reviewed by the Chief Nursing Officer or designated deputy for executive approval. A summary of the PSII will then be shared to Quality Assurance Group (QAC) and the executive board.

Regular contact is maintained between the Trust's CQC Compliance Manager and the CQC assigned inspector. These meetings address questions and queries relating to reported serious incidents and other incidents the CQC may be aware of, such as those reported to the Health and Safety Executive, or those reported under the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER).

No concerns have been expressed by the ICB or CQC regarding the Trust's handling of PSII's during the year under review.

1.9 Internal Assurance

The Trust has a number of internal quality meetings through which the Board can take assurance regarding the management of patient safety incidents and investigations. There were changes to the meetings during the year 2023/24 which are shown below:

- Executive Incident Review Meeting – weekly
- Patient Safety Incident Review Group (PSIRG) – weekly
- Safety & Quality Assurance Group - monthly
- Quality Assurance Committee (QAC) – bi-monthly

The weekly Executive Incident Review Meeting considers patient safety initial reviews to determine next steps which could be:

- a) Report on to StEIS as a PSII
- b) Not a PSII, but for further internal Trust investigation, or Patient Safety Review 2 (PSR2) with review of the final report at PSIRG to ensure that learning is shared wider
- c) A patient safety review 1 (PSR1) is a review to be investigated by the local management team

This scrutiny provides probity as well as a robust and transparent structure to the overall decision-making process.

Reports submitted to the QAC meeting provide information relating to PSIIs and other patient safety incident activity across the Trust.

1.10 Further Review and Analysis

This annual report provides an overview and analysis of patient safety incident activity from the year 2024-25. The Trust encourages and supports a reporting culture, and by establishing a culture where staff report safety indicators such as incidents and near misses, problems are acknowledged, assessed and acted upon. Patient safety incident reporting has marginally increased during this financial year by 0.3%. In addition, the Trust has experienced prolonged periods of operational pressure.

Patient safety incident activity is managed by the central Patient Safety and Quality team and the Governance Coordinators, and Governance Support Nurses, who support the various clinical areas, (Care Groups). Trust patient safety activity is overseen by the Associate Director for Patient Safety and Quality, supported by the Head of Patient Safety and Patient Safety Managers.

The patient safety team are a recognised resource for clinical managers across the organisation, and they have established a reputation for excellence both within and outside the Trust. This team of patient safety professionals continues to provide the strong foundation through which the national Patient Safety Strategy will be delivered.

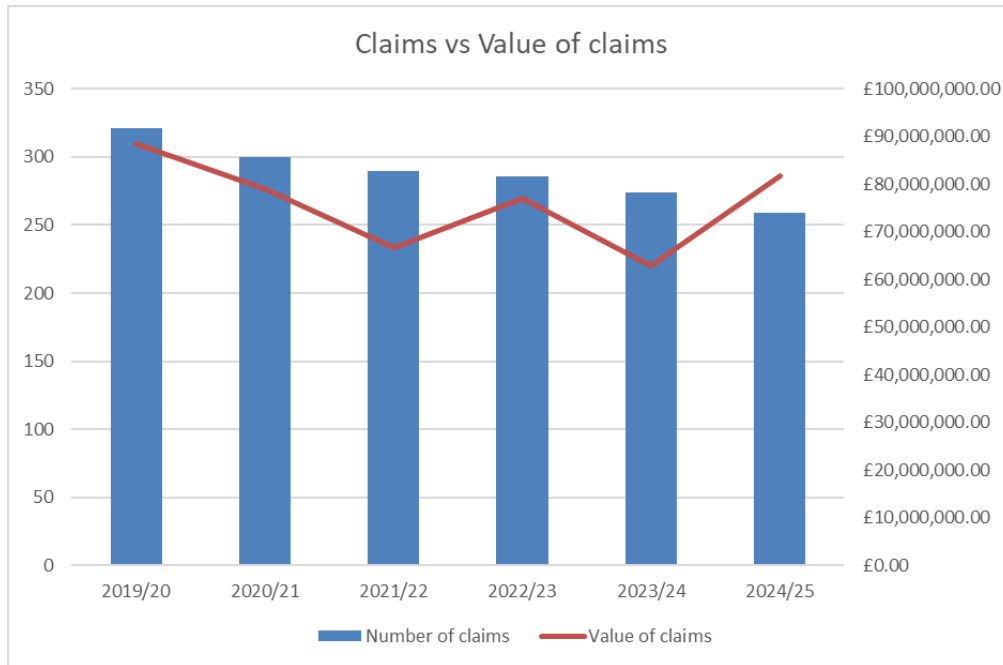
Now that the Trust has fully transitioned to PSIRF, the Board can have confidence that patient safety remains a core priority and central focus for staff across the organisation.

2.0 Litigation Incidents Overdue

This paper includes an overview of litigation claims activity. Each year NHS Resolution provide a scorecard in relation to claims. This looks at 10 years of data for closed and open claims. The scorecard provides information across the specialities within the Trust as well as an overview.

The Trust can take assurance that we, as a relatively small Trust, our level of claims is low, and we are commensurate with other Trusts of a similar size. Due to the limited size of claims data, we have it is difficult to establish themes. As such work is being undertaken to triangulate the claims with incidents and complaints. Having a rounded approach will let us consider the learning from incidents which will hopefully impact on the claims the Trust sees moving forward.

The most recent scorecard provides information from claims between 1st April 2015 through to 31st March 2025. In that period there were 259 claims considered. The value of the claims considered was £81,802,220. As can be seen from the graph below the number of claims has fallen year on year since 2019/20. However, the value of these claims fluctuates each year.



The value of claims is impacted significantly on the speciality. Although Obstetrics and Gynaecology relate to only 15% of total claims (Obstetrics 8% Gynaecology 7%) they equate to almost half of the total value of claim (excess of £38 million).

The scorecard is split into 4 areas. High volume high value claims, high value low volume claims, low value high volume and low value low volume claims. High value is a claim in excess of £1 million. High volume is where there are 3 or more claims.

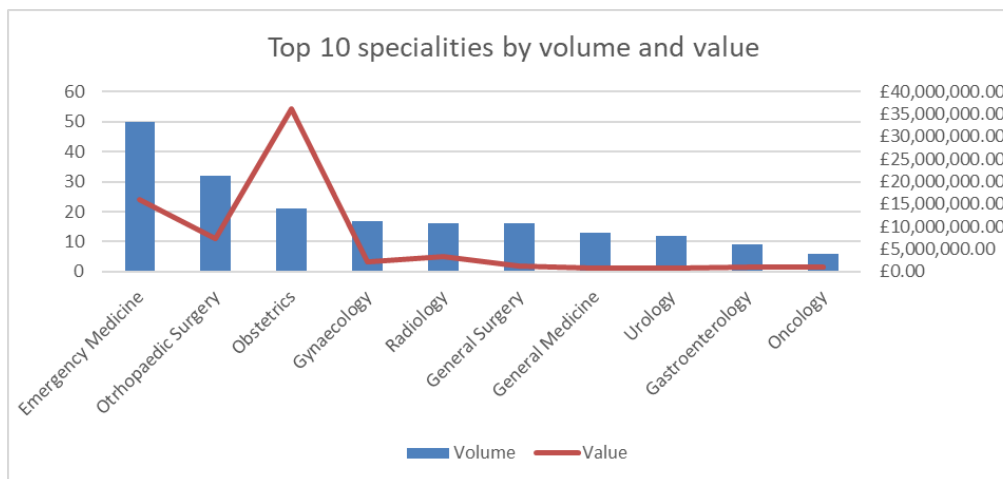
Torbay and South Devon NHS Foundation Trust scorecard shows:

High volume High value - 3 claims totalling £34,643,204

Low volume High value - 7 claims totalling £23,531,020

High volume Low value - 221 claims totalling £21,867,157

Low volume Low value - 28 claims totalling £1,760,838



Above shows the top 10 specialities at Torbay, broken down by volume and value. As can be seen whilst Emergency Medicine has seen the most significant number of claims (50) during the past 10 years this equates to just under £16 million in value of claims. This can be contrasted with Obstetrics which has 21 claims in the past 10 years equating to £36 million in value.

Legal services are now going to liaise with the care groups and arrange to discuss their individual scorecard; further analysis will then be provided to specialities based upon these conversations.

Legal Services also continue to support Trust employees called as witnesses and represent the Trust where interested person status has been granted at inquests. Since April 2025 the Trust has been asked to provide reports for 100 inquests. In comparison in 2024/25 we had been asked to provide reports in 81 inquests by this time.

Assurance and Recommendations

The committee is asked to note the following:

- A marginal increase of 0.3% in incident reporting activity across the Trust
- 14 StEIS reportable PSIs recorded including 6 never events were reported in the period under review
- The Trust has now fully implemented PSIRF
- Both safety incident and claims data will be used to inform the review of the Trust patient safety incident response plan in Quarter 4.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1.0 Incident overview	satisfactory	same
2.0 Claims overview	Satisfactory	same

QAC Committee

Research & Development (R&D)

Annual Report 24/25

Date of meeting	Date report produced
17 November 2025	October 2025

Author(s)		Report approved by	
Name and title:	Dr Fiona Roberts R&D Director	Name and title:	Dr Kate Lissett / Dr Liz Thomas Chief Medical Officer/ Deputy CMO
Phone:	01803 656635	Date:	6 November 2025
Email:	fiona.roberts34@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 an annual account of Trust Research and Development (R&D) activity and performance in 2024/25.

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

None

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

Trust Research & Development (R&D) Group – October 2025

Key recommendations and actions requested

The Committee are asked to CONSIDER the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Committee take satisfactory assurance that the Trust R&D annual 24/25 activity and performance is undertaken in accordance with NIHR performance and operating frameworks and national legislation. This is based on audits, monitoring and data reporting against national key objectives and regulations, noting the risks identified and the work being undertaken to mitigate these. Further assurance should be taken from monthly reporting to the Trust R&D Group.

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 offering and delivering research studies and opportunities to our local population as part of improving the health and wealth of the nation and Government targets and ambitions. This also contributes to the Trusts CQC well led measures.

Being a research active Trust gives opportunities and access to our local population and staff to novel and the latest treatments and technologies, providing high quality, safer evidence-based care and practices. There is strong and increasing evidence that research active trusts have improved outcomes whether a patient is in a trial or not. We aspire to put research where it belongs: at the heart of the patient care we provide at TSDFT. This is fundamental in supporting local people to live well.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	<i>Through research the organisation ensures it is providing at least the latest standard of care but also provides access to new, novel treatments and technologies. Research active sites also tend to be early adopters of new treatments which improves both evidence base practice and excellence in care as well as improving patient experience and choice.</i>
Quality of services provided	<i>Research offers protocol driven and evidence-based care and practice. Staff are kept up to date, external QA and monitoring ensure high quality best practice, improved standards e.g. documentation.</i>

Sustainable and efficient use of resources

Research improves outcomes, safer care (protocol driven), workforce (retention, recruitment, wellbeing job satisfaction). Can income generate and offers savings / cost avoidance (e.g. reduced cost of drugs, radiotherapy fractions). Research provides direct and indirect benefits and value.

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Protocol driven care (safer) and evidence-based practice through participation in research. Research trials improve access and opportunities to patients to latest technologies and new treatments locally. Improves patient outcomes and experiences.
Performance	Research performance is not currently linked to Trust performance metrics but new metrics likely to come into effect from 26/27. Research performance is linked to our ability to tender and successfully bid for new research studies and get repeat business. Also linked directly to levels of R&D funding.
People and Culture	Research helps with recruitment and retention, staff satisfaction and well-being. Research should be embedded and part of our core business, ethos and culture.
Finance	Research can income generate and can offer value and benefits directly and indirectly through savings or cost avoidance – e.g. drug savings, reduced radiotherapy fractions, purchase of equipment, funded posts.

Risk: Risk ID (as appropriate)	
Risk	Risk ID
Lack of space in Horizon centre to accommodate R&D staff.	3740
Failure of an MHRA GCP Statutory inspection. Not inspection ready. Lack of research governance capacity and capability following loss of post and unable to absorb workloads within remaining staffing compliment.	4324

External Standards affected by this report and associated risks

Care Quality Commission – well led domain
UK Policy Framework for Health and Social Care Research

UK Medicines for use in Clinical Trials regulations
Health and Care Act 2022
NHS Constitution
NIHR Performance and Operating Framework
NHS England and the NHS contract (commercial research)
UK Clinical Research Strategy, Saving Lives
Lord O'Shaughnessy Government review and recommendations
10 Year Health Plan 2025

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.

Research & Development (R&D) Annual Report 24/25

Introduction and background

This report provides a summary on the past year's (2024/25) research activity and performance; demonstrating how we are meeting the needs of our local population, Government and National Institute for Health and Care Research (NIHR) policy and performance frameworks. The report draws on a range of evidence, including activity and performance data, from the national and regional NIHR. The report highlights the breadth of service we offer and the achievements, opportunities, developments and impacts, and a summary regarding governance and finances, as part of our R&D service function and delivery.

The NHS benefits greatly from delivering research directly, with mortality lower in research active hospitals, breakthroughs enabling earlier diagnosis, earlier adoption, more effective treatments and improved system design, all of which improve patient care, experiences and health outcomes. Also supporting and enhancing both safety and high-quality care, alongside improved workforce satisfaction, recruitment and retention. Research successes bring much needed new external income and income generating opportunities and other benefits and value, not only for R&D, but also to our clinical services, the Trust and wider system overall.

The annual report offers an insight into how research studies feed into our wider role of promoting and enabling good health and wellbeing and an important part of the Government's new 10-year Health plan and a cornerstone of the national plans to improve health and wealth of the nation. In addition, the report highlights the key challenges, risks and priorities for 25/26.

Research is about supporting the NHS to deliver the treatments of tomorrow. It is seen as a key enabler to 'transformational change' to provide the evidence base to address our current and future multi-dimensional health and care challenges of today and tomorrow and to create better health & wealth for the NHS and UK.

There is increased Government attention, focus and prioritisation on research with a key strategic ambition to increase the diversity, scale and pace of research in the NHS and to support the NHS and wider health and care system in driving a revolution in research, life sciences, med tech and data, aiming to:

- Strengthen the UK clinical trial network and UK PLC
- Supports better patient outcomes
- Bolster the life sciences innovation and investment environment.
- Accelerating the delivery of the health and growth missions - underpinning the new 10-year health plan and the 3 shifts / priorities:
 1. More care in the community (from hospital to community)
 2. Investment in digital technologies (from analogue to digital)
 3. A bigger focus on prevention (from sickness to prevention).

This will involve the introduction of new KPIs, research contracts and funding models. Alongside new investment and funding opportunities and as a Trust we need to be ready to maximise these opportunities.

The report highlights many of the achievements and excellent work undertaken at TSDFT despite the very difficult NHS environment. We have built an excellent reputation over many years in clinical trials 'punching above our weight' for the size of organisation.

We are well placed to build on our many achievements, excellent performance and reputation but R&D is a fragile service. We cannot be complacent, and we need to work together to address some of the key limitations, risks and challenges:

- a. Workplace (space): R&D has outgrown the Horizon Centre and Jubilee Research Unit (JRU - dedicated research clinical outpatient facility). We urgently need to identify more space and need help navigating this within the Trusts estates use and planning.
- b. Workforce - recruitment (vacancy panel) delays, job planning issues, succession planning, all contribute to the lack of resilience and creating too many single points of failure. These are limiting activity, performance and growth and a risk to our research competitiveness (as research works in a globally competitive market). Using external income generated and increasing R&Ds programme of engagement and visibility with care groups; we hope to address some of these issues, improving communication channels to support more mutually beneficial working relationships.
- c. Urgent need for dedicated research governance capacity within R&D as the Trust is at increasing risk of failing an MHRA regulatory inspection. Also, the lack of resilience and a need to review the R&D senior structure as no longer fit for purpose. R&D propose to use external trials income to fund key new posts to address the shortfalls.
- d. Ethos and culture - R&D is often still seen as an optional luxury and extra and struggles to be accepted as part of core Trust business. Development of a new research strategy to link to the Trusts new strategy and building on the engagement work with the care groups is ongoing to help address this.

These limitations to our infrastructure (staffing, resources and space) if not addressed; will hamper the growth and expansion in clinical trials delivery the Government expect as part of the new 10-year health plan and O'Shaughnessy Review (increasing commercial trials in the UK and regaining the UKs global ranking). This will impact on future funding available, the scale, pace, and diversity of research the Trust can offer to our local population.

Assurance and Recommendations

The Committee are asked to CONSIDER the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Full report	satisfactory	No change



Research and Development (R&D) Annual Board Report 2024/25

Executive Summary:

1. This paper presents the Torbay and South Devon NHS Foundation Trusts (TSDFT) Research and Development (R&D) Activity, Performance and Governance Report for 2024-25.
2. The benefits of research in the NHS, for patients, staff, the NHS, and the UK economy, are recognised by the Care Quality Commission (CQC), professional bodies, NHSE and industry. Embedding and integrating R&D into core Trust business has been a key objective for many years and reinforced in the new 10 Year Health Plan.
3. Through improved engagement with care groups and introduction of new research metrics this will help to strengthen awareness, culture and ethos as R&D is often still seen as an optional extra and struggles to be accepted as part of core Trust business.
4. Research is about supporting the NHS to deliver the treatments of tomorrow. It is seen as a key enabler to 'transformational change' to provide the evidence base to address our current and future multi-dimensional health and care challenges. The NHS benefits greatly from delivering research directly, with mortality lower in research active hospitals, breakthroughs enabling earlier diagnosis, earlier adopters, more effective treatments and improved system design, all of which improve patient care, experiences and health outcomes, supporting and enhancing both safety and high-quality care.
5. Research provides expanded opportunities for the development of Trust staff, such as becoming investigators, offer research associate awards, alongside improved workforce satisfaction, recruitment and retention. The NHS also benefits financially from delivering research.
6. TSDFT has a growing commercial portfolio not only in cancer but across other specialities including the ward of our 1st commercial study in ICU. This aligns well with the Governments expectations for Trusts to double commercial activity and double again ([Commercial clinical trials in the UK: the Lord O'Shaughnessy review - GOV.UK](#)).
7. These successes bring much needed new external income and income generating opportunities to benefit not only R&D, but also our clinical services, the Trust and wider system overall. 24/25 was a record year for TSDFT regarding commercial income generation especially in oncology.
8. The NIHR [Annual Report 2024/25 | NIHR](#) showed that for every £1 NIHR invested into research there was a societal benefit of £13. Equally research brings other direct and indirect values and benefits such as improved staff recruitment and retention, cost avoidance or drug savings or reduced radiotherapy fractions for example.
9. TSDFT has an excellent reputation for participating in large multicentre national and internaional clinical trials. Although overall TSDFT saw reduced numbers screened and recruited in 24/25 compared to 23/24; and a reduction in the number of studies recruited into; mirroring similar trends regionally and nationally. R&D saw an increase in gross value of trials activity (£1.4M) and growth in the portfolio of active studies in some new areas of activity supported during 24/25.
10. When benchmarked against the next 10 similar size organisations in England; TSDFT slipped from 2nd in class compared to 23/24 for total recruitment; but

- remained 1st in class for commercial recruitment and 1st for number of studies recruited into for the 2nd consecutive year.
11. 2024/25 saw an improvement in our Time to Target performance for commercial research and met the non commercial Time to Target metric for the 2nd successive year.
 12. Oncology continue to perform well and has seen significant successes; building on good performances and developing a strong organisational reputation:
 - a. TSDFT was one of six Trusts nationally to open the UKs first cancer vaccine study and the only recruiting site in the South West region chosen as a treating site as part of NHSE's new initiative the Cancer Vaccine Launch Pad (CVLP).
 - b. Our Cancer vaccine performance means that TSDFT is providing just as much access, if not more than some of the larger acute Trusts across the UK, helping to address the inequity usually felt by patients in rural and coastal communities.
 - c. TSDFT was awarded £817K NIHR Capital Infrastructure Funding for new radiotherapy (RT) equipment for the benefit of all Trust RT patients. However, during 25/26 we are currently unable to open RT trials due to service capacity and replacing the RTQA system and consequently, in 25/26 we have slipped from being a large recruiter to radiotherapy trials to currently unable to recruit to any.
 13. The report highlights many of the achievements and excellent work undertaken at TSDFT despite the very difficult NHS environment. We have built an excellent reputation over many years in clinical trials 'punching above our weight' for the size of organisation. But success is a double-edged sword and to build on these successes we need to work together to address some of the key limitations and challenges highlighted in this report.
 14. **Key Limitations and Challenges include:**
 - a. **Space** – R&D has outgrown the Horizon Centre and JRU, the dedicated research clinical outpatient facility - which will impact on our performance, delivery and growth expected. The need to be co located near to the clinical services on the main site is imperative but as a clinical service limits hybrid / remote working models. We urgently need to identify more space and need help navigating this within the Trusts estates use and planning.
 - b. **Recruitment (vacancy panel) delays**, despite external funding has affected our ability to set up studies in a timely manner and performance. This has necessitated over reliance on an even smaller number of staff and has increased staff health and wellbeing concerns which is not sustainable.
 - c. **Regulatory compliance and the need to strengthen research governance.** Research is a highly regulated activity. Our core Research Management and Governance team functions need strengthening as a matter of priority to underpin the growth in the complexity, number of clinical trials and to be MHRA Inspection ready. Dedicated time and capacity is needed and essential to give both sponsors and regulators the assurance and confidence in TSDFT as a research site.
 - d. **Too many single points of failure and lack of resilience** - due to a lack of staff in key roles / functions; with reliance on too few people. These failings must be addressed urgently during 25/26 to help

- mitigate our increasing risk of regulatory non-compliances, succession planning and remaining research active.
- e. **Investigator staff time in job plans**, succession planning and seeing research as part of care group planning. Attracting new staff and sustainability of this model remains an ongoing issue.
 - f. **Need for robust, regular and reliable activity and finance data.** R&D recognises we need to strengthen these areas to create a more sustainable approach and model.
 - g. **Remaining research competitive** – regionally and nationally due to challenges as above.
15. TSDFT is well placed to build on our many achievements, excellent performance and reputation but it is a fragile service, and we cannot be complacent. Limitations to our infrastructure (staffing, resources and space) will impact our research competitiveness and hamper the growth and expansion in clinical trials delivery the Government expect as part of the new 10-year health plan and O'Shaughnessy Review. **Government investment will only be prioritised for the Trusts that can prove they can support the NHS to deliver the treatments of tomorrow.**

Recommendation: The Trust Board is asked to receive this report and note the content.

1.0 Scope and Purpose

The purpose of this report is to provide the Board of Directors with an annual account of Trust Research and Development (R&D) activity, performance and governance, covering the period of 1st April 2024 to 31st March 2025.

2.0 Introduction and Background:

- There is strong evidence showing a clear link between being a research active organisation and better patient outcomes and higher-quality care. As a result, research has featured in the Care Quality Commission (CQC) Well Led inspections since 2018. This is also recognised by professional bodies such as the Royal College of Physicians, biomedical charities like the Wellcome Trust and NHS England, alongside other benefits of embedding clinical research within the NHS, including staff morale, recruitment and retention, and economic prosperity. The value of industry clinical trials to the UK economy, the NHS and the UK's research and development base is presented in a recent report for the Association of the British Pharmaceutical Industry (ABPI). [The value of industry clinical trials to the UK.](#)
- Through active participation in research our clinical staff stay abreast of the latest possible treatments, we expand the opportunities available to develop our colleagues and we empower and engage the people we care for. Our mission is to embed clinical research as part of core business.
- R&D is part of the Corporate Services Care Group, providing both a clinical and support service function to all clinical services and specialities across the organisation. R&D reports into the Trust R&D Group and into QAC as part of the Trust governance reporting framework.
- The R&D Department is responsible for approving, supporting, facilitating and overseeing all research activity in the organisation in accordance with relevant regulations; based in the Horizon Centre with dedicated clinical outpatient research space (Jubilee Research Unit - JRU) within Crowthorne on the main Torbay Hospital site.
- The R&D Department comprises circa 60 WTEs staff; from various professional groups; with specialist research training, skills, expertise and knowledge to support, facilitate and deliver research studies and regulatory affairs; split into the following core teams:
 - o NIHR Clinical Trials Delivery teams: comprising speciality teams in cardiovascular (cardiology / diabetes), haematology, oncology and ophthalmology, with the Horizon team as a generic team supporting flexibly the other specialties.
 - o Research Management and Leadership
 - o Governance, Sponsorship and Quality (N.B. no dedicated staffing – this is tacked on and absorbed by the Head of R&D and Assistant Manager – identified as a significant risk that urgently needs addressing).
 - o Research Finance, Information (Business Intelligence) and Contracting
 - o R&D A&C support
 - o Dedicated research staff within supporting service departments e.g. pharmacy, labs and radiology.

- Our primary research business (>95%) involves recruiting into national and international multi centre commercial and non-commercial studies as part of the National Institute for Health and Care Research: Clinical Research Network (NIHR CRN) portfolio. These studies are externally led studies also known as hosted research and include drug, non-drug, medical devices, qualitative and quantitative studies. R&D supports a small level of own account Trust led research activity, mostly funded by the Torbay Medical Research Fund (TMRF), a local independent charity. Additionally, R&D supports staff and external researchers involved with projects as part of educational studies (e.g. Masters and PhDs).

3.0: Strategic Partnerships and Collaboration for Enhanced Benefit, Value and Impact.

Aligned with the NHS Long Term Plan and the new 10-year Health plan; collaboration not competition is central to tackling healthcare challenges, improving patient outcomes, and driving research excellence. To realise our vision, we must leverage strong, strategic partnerships that transcend organisational boundaries, unlocking new opportunities for innovation, resource-sharing, and expertise exchange.

- **National Institute for Health and Care Research (NIHR) - South West Peninsula Research Delivery Network (RDN); formerly the Clinical Research Network (CRN): -**
 - The NIHR is the research arm of DHSC and is committed to enhancing the health and wealth of the nation through research, with the overall aim of embedding research into clinical practice. Working with health and care organisations and the NHS to improve the environment for health and care research in England.
 - The Trust is commissioned to undertake research through the NIHR; on behalf of DHSC and remains separate from NHSE commissioning of clinical services; contracted and funded separately to support NIHR clinical trials delivery in line with relevant national R&D strategies, policies, the NHS contract, NIHR RDN (CRN) contract and the NIHR Performance and Operating Framework.
From October 1st, 2024 - the NIHR delivery networks were restructured, reducing from 15 regional Clinical Research Networks (CRNs) to 12 new Regional Research Delivery Networks (RDNs) across England. Our footprint remained the same covering Cornwall, Isles of Scilly, Devon and Somerset.
- **Life Sciences Industry:** Increasing commercial trials in the UK is a key Government priority. The Trust is a preferred site with several commercial companies: part of the IQVIA Peninsula Prime Site initiative, Pfizer, PPD, Novo Nordisk (Cardiology trials). Additionally, as part of the Government Priority Research Programme and 10-year contract with Moderna and BioNTech SE (vaccines trials) TSDFT is part of the new NHSE's Cancer Vaccine Launch Pad (CVLP). These important relationships present greater opportunities, giving preferred access and selection to commercial trial portfolios. Our commitment to increasing commercial research activity means that R&D is a vital source of

externally generated income for the Trust and provides other value and benefits and is an important alternative way to fund posts, equipment and training. We recruited 161 participants to 19 commercial trials and were the best in class when benchmarked against the next 10 similar sized Trusts for commercial recruitment in 24/25.

- **Academic partners** include locally the University of Plymouth: SW Clinical Schools Programme and the University of Exeter: Both are key partners and essential to supporting workforce development, including pre, doctoral and postdoctoral fellowships and a key component to the Trust's Nursing, Midwives, Allied Health Professionals (NMAMP) research strategy.
- **Other NHS partners** and regional collaborations to create further access to research training, development and delivery opportunities for our local staff and populations.
- **Torbay Medical Research Fund (TMRF):** A local independent charity. Researchers can apply for grants to support their own account research studies. These are usually smaller scale pilot or feasibility studies to be used to feed into the development of larger NIHR eligible grants. The TMRF are also a key funder of several pre doctoral and doctoral fellowships. A hugely successful scheme and a partnership between the TMRF, Trust and academic partners; providing a great opportunity to TSDFT staff to develop their clinical academic research journey.

4.0: Activity and Performance:

Performance Summary: Please see Appendix 1 for more in depth details, data and graphical presentations.

Clinical research performance, especially for commercial studies, is the focus of a new cross-sector UK Clinical Research Delivery (UKCRD) Programme co-led by the Department of Health and Social Care (DHSC) and NHS England (NHSE). Research is conducted in a globally competitive market. Sponsors want to place studies at the minimal number of sites and will choose sites that can consistently show fast set up and consistent time to target performance. Poor performance makes it difficult to win new and repeat business (studies) and is directly linked to our income generation (actual and potential) and sustainability.

The UK Government is keen to grow commercial research and address the decline in the UK's performance and hence attractiveness globally for clinical trials delivery. Consequently, NIHR (DHSC) KPIs have been set for sites. Any delays to start up and sites not delivery to time and target due to workforce, workplace, operational and financial challenges and pressures; often means studies are closed before we can open, sponsors withdraw studies from sites or even the UK. Excellent performance and delivery are critical to attracting both new and repeat business which in turn is imperative to sustainable income and improved outcomes.

New metrics will be introduced for NHS trusts in 2025-26 and improvements will be needed to meet national targets. Trusts failing to meet targets are at risk of reduced income from the NIHR and industry.

TSDFT's 24/25 performance highlights include:

- Time to target (T2T) target= 80% - was met for both closed commercial (80%) and non-commercial studies (83%).

- NIHR Study Set up times: (target = 40 days from site selected to confirmation). TSDFT 24/25 medium set up time = 18 days and we were top performers regionally with 78% of studies set up within 40 days.
- Date Site Selected to First Participant recruited (target = 70 days): TSDFT cumulative medium = 93 days (national medium performance = 92 days).

Summary activity statistics:

The table below summarises the key measures RAG rated to show relative to 23/24.

Key Measures	23/24 FY	24/25 FY
Total NIHR Recruitment ⁽¹⁾	3,026	2,127
Commercial Recruitment (including non NIHR) ⁽²⁾	350 (12%)	161 (8%)
Total Studies Recruited into (number of Specialties)	81 (n=24)	73 (N=21)
Total numbers screened by teams	5,164	2,487
ABF points (Complexity weighting NIHR non-commercial studies only)	5,586.5	5,259
New studies approved (number of commercial)	51 (n=14)	49 (n=13)
Total Number of studies open to recruitment at year end 31.03.25 (number of commercial)	84 (n=15)	145 (n= 21)
Total EOIs received	420	405
Total positive EOIs	98 (23%)	113 (28%)
Total Amendments Processed	281	283

1. One non-commercial study (PROTECT) accounts for over 50% of the recruits which is a self-referral dementia study.
2. One commercial observational study bolstered commercial recruitment figures in 23/24 closed at the end of December 2023, explaining the reduction in commercial recruitment in 24/25

Recruitment:

- TSDFT saw reduced numbers screened and recruited in 24/25 compared to 23/24; and a reduction in the number of studies recruited into; mirroring similar trends regionally and nationally.
- When benchmarked against the next 10 similar size organisations in England (proxy measure based on OPD attendance); TSDFT slipped from 2nd in class compared to 23/24 for total recruitment; but remained 1st in class for commercial recruitment and 1st for number of studies recruited into for the 2nd consecutive year (source NIHR ODP platform data).

Studies:

- Overall the number of new studies approved and opened was similar to last year and across a spread of specialties. Whilst showing some diversity of our portfolio we are still very acute (hospital) centric with improvements needed to

meet improved equality, inclusion and diversity agendas and increasing research in wider settings. The portfolio availability of suitable studies is a key limiting factor currently.



24/25 Key Highlights, achievements and accolades:

Research can play a pivotal role in many dimensions in how we improve our services both locally and regionally for the benefit of our population:

Cancer Vaccine Research

- TSDFT is one of the top sites for Cancer Vaccine research in the UK and we are the South West treating site for the cancer vaccine launchpad (CVLP) which is a new way to treat patients on cancer vaccine trials nationally.
- As part of the [CVLP](#); TSDFT was the lead treating site and the only site in the South West to offer a personalised vaccine to patients with bowel cancer: BNT122-01 via BioNTech (open) – Colorectal personalised Vaccine (Dr Lo PI) – 40 patients screened, 2 patients eligible for the vaccine, 1 patient received the vaccine. We became the first site within the SW to administer a personalised cancer vaccine and featured on BBC Spotlight.
- Other cancer vaccine studies include:
 - Modify via Scancell (open) – An off the shelf vaccine for Renal and H&N cancers – (Dr Dyke PI) – 5 patients recruited.
 - V940-005 via Moderna/MSD (open) – Muscle invasive Bladder Cancer vaccine – (Dr Lydon PI) -3 patients recruited with a further 3 in the pipeline which will double our recruitment and places TSDFT close to the top of recruitment across the UK.
- As part of these successes, Torbay has been approached to set up and deliver 2 new vaccine studies, which will make TSDFT the leading UK site: -
 - Interpath via Moderna/MSD (In set up) – non-muscle invasive personalised cancer vaccine - (Dr Lydon PI). Due to open in September 2025.
 - Ahead Merit via BioNTech (In set up) – H&N off the shelf vaccine – (Dr Chambers PI). Due to open in September 2025. This will also be part of the CVLP and the Trust will again be the lead site regionally.
- Dr Nangi Lo, Consultant Medical Oncologist won a national award, 'Rising Star in Cancer Vaccine Research' after her work on the BNT122-01 study and delivering vaccine research at a smaller sized acute Trust.
- Cancer vaccine performance - TSDFT are providing just as much access, if not more than some of the larger acute Trusts and bigger sites across the UK. Something our team can be really proud of as we address the inequity usually felt by patients in rural and coastal communities.
- These trials have only been possible due to the excellent hard work from our support departments (Pharmacy/Labs/Radiology), clinical research team and consultant body. This was especially impressive as a lot of hospitals shied away from handling cancer vaccines due to being badged as Advanced Therapy Investigational Medicinal Products (ATIMPs). Our successes and growing reputation are opening many other opportunities to expand our work in this area – with potential lung, prostate and melanoma vaccine trials on the Horizon to further build on the opportunities for our patients.

Other highlights:

- TSDFT was the first site in the UK to recruit a participant into the XRAY VISION study comparing treatments for patients with head and neck cancer.
- Joint top recruiter on the Haem Commercial Observational Study Reality WW, a real-world haematology study for patients with chronic lymphocytic leukaemia.
- One of the top UK recruiting sites for 12 Oncology studies including: - Krascendo, V940-005, OSCAR, Rezilient, Artemis Pro, Codebreak, SOHO - 02, Paloma 2, WayfindR, Pacific 9, BNT122 and Correct.
- There are a growing number of specialities becoming involved in commercial research and in 24/25, the Intensive Care unit team were successfully chosen to open their first ever commercial study.
- One of the fastest recruiting sites into studies across a number of specialities including orthopaedics and breast care.
- Top UK recruiting site for the ACCLAIM study looking at reducing lipoprotein in blood and reducing the incidence of heart attack and stroke.
- The only site in the South West taking part in the Chariot MS study exploring disease modifying therapies in slowing the progression of Multiple Sclerosis, which also featured on BBC Spotlight.
- We have also taken part in research looking at early detection of disease, admission avoidance and using artificial intelligence to help streamline our services.
- Podiatrist Justine Tansley won The Research Student of the Year at the 2025 'Flexitol Tomorrow's Podiatry Awards'.
- We were selected as a preferred partner by Novo Nordisk giving us earlier access to cardiovascular studies

5.0: Workforce Development:

During 2024/25 - Several staff held regional network research roles:

- NIHR SWP RDN (CRN) Regional Clinical Speciality or sub speciality Leads:
 - o Dr Kirsten Mackay: - Musculoskeletal portfolio (CRN until Sept 2024):
 - o Dr Agne Straukeine - Multiple Sclerosis portfolio (CRN until Sept 2024):
 - o Dr Louise Medley, Lung Cancer portfolio (CRN until Sept 2024):
 - o Dr Louse Anning, Respiratory portfolio (RDN from October 2024):
- Dr Richard Collings, Podiatrist: NIHR and Council for Allied Health, Professions Research (CAHPR) Champion:
- Dr Fiona Roberts, R&D Director: Regional HRA Champion and part of the UKRD leadership group

Developing the investigators and staff of the future:

- R&D continue to build our local academic capability through various training schemes in partnership with higher education institutions, Health Education England (HEE), NIHR RDN (CRN), and the Torbay Medical Research Fund (TMRF).
- In 2024/25 the TMRF again awarded funding for one pre-doc and one doctoral fellowship building on the previous awards since 2019/20 since the scheme started.
- R&D successfully applied for one CRN Research Associateship and two CRN-funded Chief Nursing Research Fellowships, joining a growing number of research-active clinical staff.

- A further five of our clinical colleagues completed the NIHR Associate Principal Investigator training programme; gaining invaluable learning and the practical skills associated with leading clinical research delivery.
- In response to England's Chief Nursing Officer's nursing research strategy and allied health professionals national research strategy, we developed a new research strategy for nursing, midwifery and allied health professionals (NMAHPs) which was launched in May 2024 and followed by a conference in September 2024.
- As part of this strategy R&D has overseen the launch of a new research NMAHP competency framework to support NMAHPs to be confident utilising research and evidence-based practice; working closely with the University of Plymouth Clinical Schools Programme to identify how we can build on this platform to support further in the future.
- UoP Torbay Clinical School is part of a regional SW clinical school model with a senior member of academic staff linked to an NHS Trust working closely with Trust Chief Nurses and Research Lead NMAHPs to grow and develop NMAHP researchers.
- New - NIHR INSIGHT South West Peninsula fully funded master's studentships in health and social care research in partnership with the University of Plymouth and University of Exeter:
 - o Master of Clinical Research, MCLinRes, University of Plymouth
 - o Masters in Leading Clinical Research Delivery, MScLCRD, University of Exeter
 - o Master's in health research Methods, MScHRM University of Exeter

Whilst we can create opportunities, the lack of time and capacity and lack of recognition in job plans remains a significant issue still for staff supporting and undertaking research usually in their own time. An issue not just at TSDFT but mirrored across the UK. When engaged clinicians have dedicated time to work with committed R&D staff, this has a life changing impact on patient care and supports workforce recruitment and retention. We aspire to put research where it belongs: at the heart of the patient care we provide at TSDFT. We are keen to explore new ways how R&D can be more integrated and aligned to activity and service delivery by care groups. How to improve cultural expectations around supporting research activity as core business. To help improve our awareness and visibility; R&D is keen to introduce new care Group reports highlighting activity and performance (research metrics) to aid conversations, planning and delivery of research.

6.0: Visibility, engagement and raising the profile of research

In Q4 2024/25 R&D introduced new uniforms for R&D clinical staff in response to feedback and following extensive consultation with both R&D staff and the Trusts Uniform Committee. This has helped improve the visibility and identity to stand out and differentiate from non-R&D clinical staff, preventing any confusion and improving safety in clinical areas. Having our own research uniform is part of wider profile-raising initiatives such as promoting research as part of national campaigns and increasing our links with the Communications team.

During 2024/25 we established a new Trust R&D Group (Committee) which meets monthly to provide better oversight, support and decision making to support the senior research leadership team and support work towards a better fit into the Trust

needs, assurance and reporting frameworks; not just the external R&D NIHR and regulatory processes and systems.

Additionally, we were tasked with developing a new Trust Research Strategy to compliment the new Trust NMAHP research strategy launched in 2024. The research strategy was drafted but then placed on hold following changes at Board level and deferred into 2025/26. This will be refreshed and submitted for approval in 25/26 following the approval and publication of the refreshed Trust Strategy to ensure alignment.

Other work helping to focus a spotlight on research to improve visibility, awareness and understanding includes:

- Starting to engage with senior managers, care group directors and clinical service leads; showcasing how research can benefit their service to help raise the profile of research and influence embedding research more into services and practice, working together to look at how to best use the proceeds from commercial trials income within their services for staff, equipment, training for mutual benefit. Helping to build more collaborative and symbiotic relationships.
- Part of the new Trust Corporate induction programme.
- International Clinical Trials Day – celebrated each year around May 20th includes a stand in the main entrance and using various promotional videos: [watch our research and development department's promotional video](#), showcasing the work we do to advance care through research.
- #Red4Research – Celebrated in June each year as part of a national community, which aims to get as many people as possible wearing red to demonstrate their support and appreciation for all those participating, undertaking and supporting research. It is an opportunity to showcase and celebrate the phenomenal work and value of R&D.

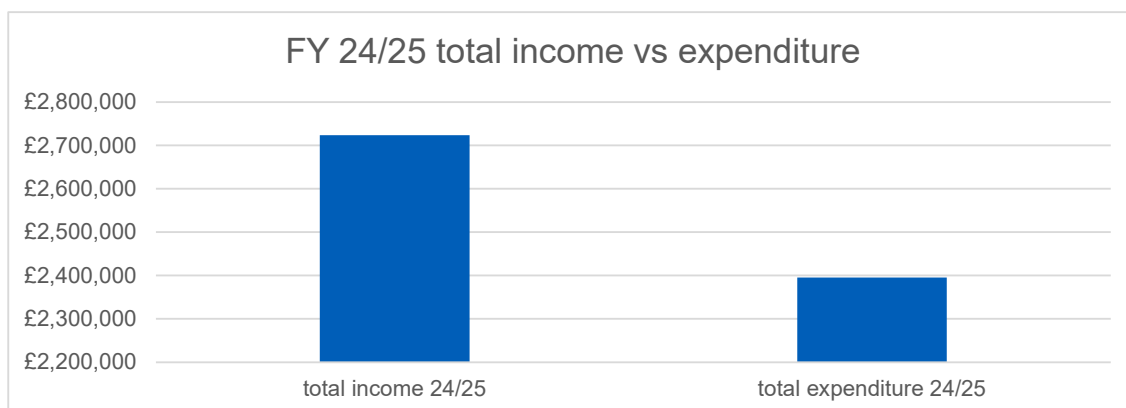
7.0: R&D Financial Sustainability and Impact

Good and effective financial management is a critical enabler of high-quality research and is a key part of effective delivery of research in the NHS. Research funding can be highly specialised, involving hybrid models of per annum funding (block contracts) and payment by results trials contracts. Consequently, it is important to recognise that some aspects of this are niche to research and require specialist knowledge, compared to overall NHS financial management and should follow NHSE's guidance on financial management of research income including the ability to roll over trial's income across financial years.

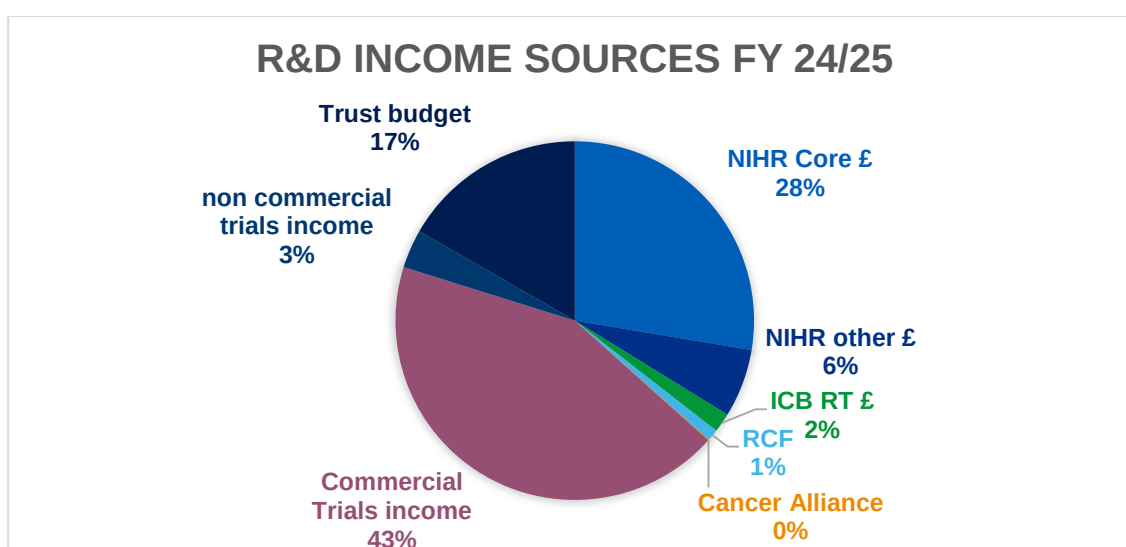
Research & Development (R&D) has a small but essential budget contribution from the Trust, otherwise research is primarily self-financing through external funding sources. Additionally, R&D is one of the few income generating services bringing both financial and other value and benefits to the organisation and wider system.

Income and Expenditure

For the 2024-25 financial year, R&D's total gross annual income and expenditure is shown below, ending the year with a £329K 'surplus'. Please note that R&D operates on the principles of using trials income to 'earn in advance', so should not be seen as a true surplus - as this goes towards covering the costs of R&D in the next financial year to mitigate financial risk to the Trust.



R&Ds 24/25 primary sources of income are summarised in below:



N.B Excludes specific research grants & NIHR Capital grant

- Trust budget:** Whilst R&D is primarily externally funded, and can income generate there is a critical level of operational costs such as central core staff and expertise needed to underpin R&D activity, services and functions that is unfunded by the NIHR and trials income. These are considered a Trust responsibility e.g. research sponsorship, leadership, management, governance and some A&C support. The Trust budget contributes towards funding these essential areas; without which it would be impossible to undertake research safely and to regulatory compliances. The investment into R&D is essential and we believe we provide a good return generating significant benefits and much needed external income and funding opportunities as detailed in this report.
- National Institute for Health and Care Research (NIHR):** The NIHR, funded by the Department of Health and Social Care (DHSC), is a key source of support for research infrastructure across England, with core RDN funding allocated to facilitate and support delivery of NIHR studies, especially NIHR non-commercial studies. RDN funding has remained steady state since the pandemic; but a new funding model will be introduced from 26/27; alongside new metrics and a performance and operating framework; issued as part of the new RRDN contracts.
- Life Sciences Industry (Commercial Clinical Trials):** Industry-sponsored trials provide vital financial sustainability, bridging the funding gap between NIHR

allocations, academic non-commercial trials funding and operational costs. These partnerships ensure continued investment in research while enhancing patient access to innovative treatments.

- **Academic Research (Non-Commercial Clinical Trials):** These trials explore clinically significant hypotheses that influence patient care pathways but often receive minimal funding and the NIHR non-commercial portfolio is a key influencer to maintaining NIHR RDN funding. Having a balanced portfolio i.e. balancing academic and commercial trials is essential to maintaining financial sustainability while driving meaningful clinical advancements.
- **NHSE/ICB Radiotherapy Trials (RT) funding** - £58K awarded in 24/25 to regional RT centres to support growth in RT trials. This has been awarded recurrently since 2018 following a successful business case.
- **DHSC Research Capability Funding (RCF):** TSDFT receives funding awarded based on recruitment into NIHR studies but does not qualify for grant based RCF; due to the lack of successful NIHR-recognised eligible grant applications and awards.
- **Research Grant Awards:** Competitive grant funding - to increase own account Trust sponsored / led research studies. This activity is very minimal at TSDFT and growth in this sector remains an aspiration currently; but is an untapped income stream for clinical academic research. Success rates in England are approximately 15%, underscoring the need for strategic, high-quality applications and for access to a critical mass of R&D expertise, skills and knowledge which is currently lacking in the R&D structure.

Other Strategic Funding:

R&D has successfully secured significant additional funding to support strategic research initiatives and broader Trust services, further reinforcing its role as contributing to greater financial stability and value-generating entity within the NHS.

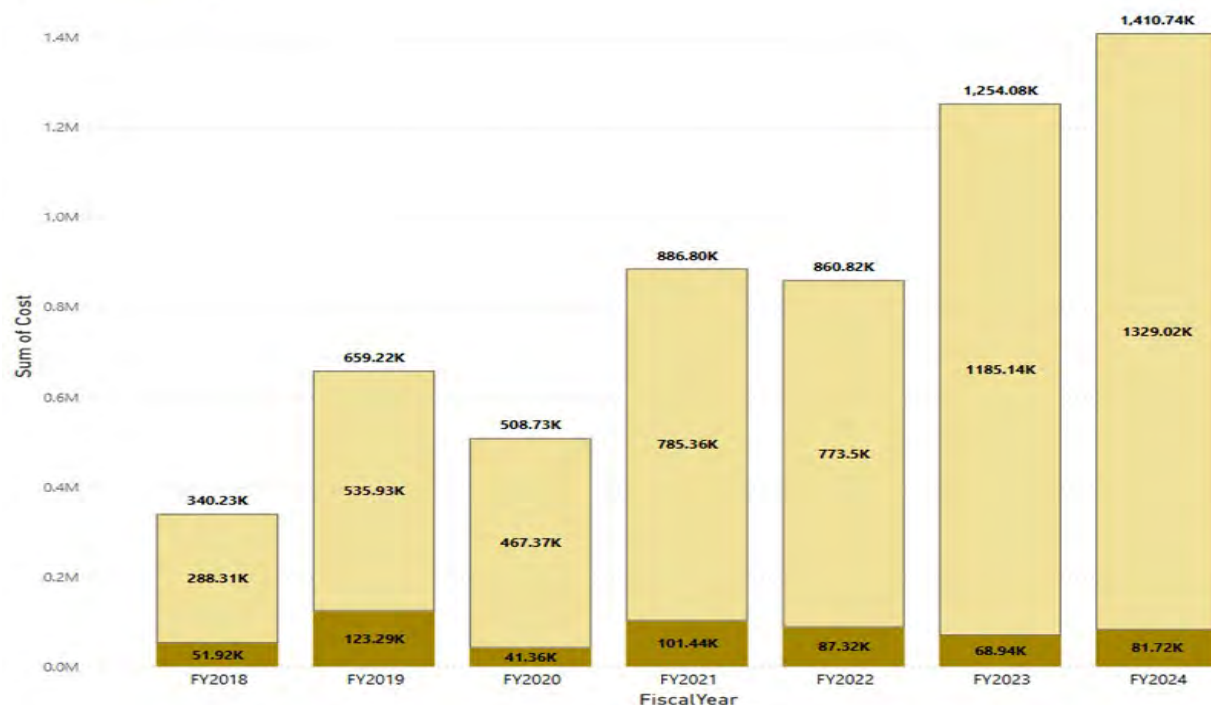
- **NIHR Capital Investment Call (up to £1.5M):** R&D in collaboration with radiotherapy and medical physics made a successful bid to the NIHR research infrastructure and capital funding stream and awarded £817K to procure essential Surface Guided Radiotherapy (SGRT) equipment and other much needed RT equipment, supporting the installation costs (~£35k) through radiotherapy commercial trials income to benefit both trial and non-trial patients. SGRT will improve safety, RT Quality Assurances and supports more efficient and effective working thus improving productivity and throughput (circa 5-10% improvement).
- **NIHR Contingency /Other Funding:** A further £208K was successfully secured from the CRN / RDN during 24/25 covering various activities and projects e.g. Research Associates, Chief Nurse Research Fellows, capacity building in supporting services e.g. pharmacy labs, radiology, communications, community posts and network medical speciality leads PAs.
- **Cancer Alliance Funding:** Cancer Alliance awarded regional Trusts some time limited funding towards Consultant Job Plans during previous years and completing early in 24/25.

Value of Clinical Trials Activity by financial year:

The graph below shows the gross value of research trials activity per annum, which demonstrates this is increasing and strongly linked to increasing our commercial trials portfolios. 2024/25 was a record year for commercial income generation especially in oncology.

GROSS VALUE OF ACTIVITY BY FY

Commercial ● False ○ True



A robust cost recovery process with close tracking is essential. This work was strengthened in 24/25 to help maximise payments and reduce backlogs to improve both R&D and the Trusts financial position. Further work is needed to build on the progress made to date.

Trials income is on a payment by results basis, per patient per visit and payable only after the sponsor has undertaken source document verification (SDV) and study monitoring, where activity is evidenced, queries dealt with and agreed between the Sponsor's systems and the Trust systems. At this point the Trust can invoice. It is not uncommon that this process can take up to 6 months and therefore cost recovery of trials income following activity has at least a 6-month lag time from work done to payment. This is recognised nationally, and Trusts need to manage activity and income differently to that of patient care budgets as per NHSE's guidance on the financial management of clinical trials. Hence activity in one year does not always mean payment necessarily in the same financial year and that R&D need to be able to carry forward income across financial years through the lifetime of contracts which span across several financial years.

Financial benefits, value and impacts:

The NIHR [Annual Report 2024/25 | NIHR](#) showed: 'NIHR research is a powerful engine for economic growth, supporting thousands of high-value jobs across our life sciences sector and attracting crucial investment into the UK as well as delivering better health care. For every £1 invested by the government, NIHR research delivers a return of over £13 in economic benefit to the nation. This demonstrates the profound dual dividend of investing in NIHR research: healthier lives and a stronger economy'. This rational can apply locally too.



For every £1 invested in NIHR research...

society receives more than £13 of benefits

R&D continues to drive significant savings e.g. drugs budgets, RT fraction reductions etc; through its successful clinical trials activity, reinforcing the broader financial, workforce and clinical benefits of research engagement. The current national proxy measure shows that the NHS earns an average of £9,000 per patient enrolled in a commercial drug clinical trial, generating a national income of £355 million annually. Cost savings of £5,800 per patient in drug expenditures, leading to £28.6 million in national savings in 2018/19.



Ref: [Impact and Value of the NIHR Clinical Research Network 2019 \(infographic summarising key findings\) | NIHR, KPMG report.](#)

Income generation: A record 24/25 financial year for commercial income generation especially in oncology. Our growing commercial Trials successes and portfolios brings much needed new external income and income generating opportunities to benefit not only R&D, but also clinical services and the Trust and wider system overall. Some examples below of how this income has been used and adds value include:

Supports funded posts:

- R&D appointed a 2nd research SACT (chemotherapy) nurse, fully funded from external trials income; administering SACT chemotherapy on RDGU; for both research and non-research patients following the success of the 1st SACT post. During 24/25 our 1st SACT nurse administered treatment on 544 occasions: 318 were non-trial patients and 226 were trial treatments. These posts ensure R&D can deliver the cancer trials activity working collaboratively with the RGDU staff as well as supporting operational service activity too, providing mutual benefit, much needed operational expertise, support to RDGU and cost savings for the Trust.
- R&D supports dedicated and blended posts in pharmacy, labs and radiology.
- Oncology trials income supported a clinical fellow in cancer services (split between research and the service).
- Commercial trials income is used to support several research PAs in Consultant Job Plans e.g. in oncology, cardiology, ophthalmology and a new development in 24/25 included: 2x PA's funded for our consultant radiologists. During 24/25 they reported on 188 research patient scans. These patients would need to be scanned regardless of whether they were on a trial, giving a direct saving for the Trust.
- Radiology commercial trials income was used to give some sessional support to radiologists to help kick start a new portfolio involving the Breast Care Surgeons. A research naïve speciality which helped to set up and open 4 studies with more studies including commercial in the pipeline. In addition to expanding and creating a new research portfolio in a new speciality. The studies offer Trust savings e.g. the SMALL Trial: A Phase III, randomised, multi-centre trial addressing overtreatment of small screen-detected breast cancer by comparing standard surgery versus minimally invasive vacuum-assisted excision. Whilst there is a need for some additional radiology time; it saves surgical and theatre time (a patient not requiring a wide local excision and sentinel node biopsy saving circa £2000 for the procedure); in addition to other the savings e.g. as no isotope injection required or wires etc.

Supports workforce development and training:

- £10k agreed to fund training and education for Radiotherapy staff.
- £20K agreed contribution from the cardiology research trials income towards cardiology department staff training and development.

Supports purchase of equipment:

- RGDU treatment room refurbishment: Funded through the Oncology Trials income to provide an improved environment for staff and patients. The room has been painted, our research logo added and purchased new equipment e.g. a saddle stool and treatment chairs. The treatment room is used for both trial and non-trial patients:
- IT equipment, software licenses, trolleys, fridges, temperature probes etc

Financial other:

R&D is one of the few activities that can help to strengthen the Trusts financial future through research delivery and excellence. R&D remains primarily externally funded bringing in new funding and offers savings (e.g. drug savings, reduction in RT fractions etc), benefits and value across many aspects of our business and therefore is a strategically vital component of the Trust.

R&D made contributions to the 24/25 CIP directly (£300K) as well CIP in kind through efficiencies and other benefits as demonstrated with examples in this report and a few example case studies below:

Case Study 1: PACE-NODES study in Prostate cancer. This study compared 37 fractions (SoC) vs 5 fractions (intervention); a saving of 32 fractions per patient with the potential to save 200+ treatment visits during the trial. The study recruited 8 patients.

Case Study 2: CirrhoCare study in Liver Disease (Gastroenterology): A real-world, randomised controlled study, to determine the clinical and cost-effectiveness of CirrhoCare digital home monitoring and management in patients with decompensated cirrhosis. The study is investigating whether CirrhoCare a remote management system leads to a reduction in hospital intervention from new-liver related complications. Additionally supporting proactive community care for cirrhosis, helping to prioritise and personalise care to an individual patient's needs and disease. A novel and digital approach to allow early detection of signs of complications and rapid triaging of patients who need early direct clinical review, at a time when this is a limited resource. This has the potential for cost savings through reduced need for readmission following discharge and more efficient and streamlined outpatient direct contacts. The kits and training are provided through the trial to help manage this new pathway; fully protocolised to ensure safety. To date 5 patients have been recruited, and the study is ongoing.

Through diversified funding streams, strategic investment in infrastructure, space and workforce, and a commitment to balancing commercial and academic research, R&D is positioned as a key driver of innovation, improved financial resilience, and enhanced patient care. By continuously securing funding, optimising financial efficiency, and maximising the economic impact of research, TSDFTs R&D service can play an increasingly important role in shaping the future of our healthcare delivery.

9.0: Digital: Information and Communications:

R&D Finance Processes: Throughout 24/25 we have been working to improve several R&D finance processes including cost recovery, invoicing, automating data transfers from the national costing tool into our local R&D management system EDGE, reducing manual processing, and the use of multiple spreadsheets. This is still a work in progress but through automated tools, Power BI and SharePoint we are starting to improve data quality and data accuracy, aiming to generate more timely and robust data, create stronger audit systems, which can then enable better scalability, better resource management through reduced manual workloads, releasing staff capacity to take on increase activity in response to increased demand and growth in commercial trials. This is priority work for 25/26.

Together with expanding the Business Intelligence team, the use of technological advancements is helping to reduce the backlog in invoicing that had built up due to staffing shortages. But sustaining this improvement is imperative to both R&Ds and the Trust financial position. As part of our commitment to improve transparency and use of research income we have started to expand the roll out of Specialty /

investigator bank statements across all budget lines. Again, this is a work in progress and remains an iterative and evolving process.

During 25/26 we are keen to identify processes that can be further automated to save even more time. With better data to use data analytics to help find inefficiencies and focus improvements. Help to streamlined income allocations by developing better methods for handling trials and non-trials income. Continue to develop 'BI' dashboards to monitor real-time performance, enable stronger stakeholder engagement by making processes more transparent and responsive to both the organisation and R&D needs.

With the expansion in medical technology trials and implementation of EPIC we will look to expand the number of digital studies we can undertake, looking at digital solutions / AI technologies as part of the Analogue to Digital' agenda.

10.0: Research Governance and Assurance

Research Governance oversees all Research and Development (R&D) studies and ensures the highest standards of quality assurance across R&D. Research governance refers to the framework to manage the research process from end to end, to ensure that research is undertaken in a safe, appropriate and ethical manner, in accordance with national guidance and applicable laws to ensure that maximum benefit is derived from research for public and patients.

It also provides assurances and responsible for quality management systems and processes. Compliance provides public assurance that the rights, safety and wellbeing of participants are respected and protected, and that the data generated are credible and accurate. Compliance with the legislation is overseen nationally by the Health Research Authority (HRA) which also oversees NHS ethics; and the Medicines Healthcare Regulatory Authority (MHRA) for Clinical Trials involving Investigational Medicinal Products (CTIMPs) and medical devices. A summary of the governance frameworks governing research is available in Appendix 2.

As part of governance, research should have policies, systems and SOPs forming part of the evidence base of an overarching Quality Management System. Additionally, it involves study risk assessments, audits, monitoring and has oversight of staff, studies, systems, practices and processes. Research Governance underpins the R&D office, service and functions, research delivery and it is central to underpinning the Trusts ability to be CQC and MHRA inspection ready and regulatory compliant. Stringent governance is vital to safeguard both patients and reputation and essential to remaining a research active organisation. Strong Governance is essential to give assurance and confidence to sponsors to award studies to the Trust.

With the increase in activity, the improvement in performance and increased complexity of studies undertaken e.g. vaccines; this places the Trust at greater risk of an MHRA inspection. The increase in demand has outstripped current capacity in this sector.

Consequently, we need to strengthen R&D governance; increasing the capacity and capability, skills and expertise needed to provide dedicated and ongoing focused attention to this critical area. We have identified this is a significant risk area. We have tried to absorb this increasing workload with a smaller team for a few years, but

it has become very clear this is not possible. R&D must strengthen staffing and support in this critical area as a matter of priority to remain research compliant and active.

Incident Data for 2024/25

Serious GCP Breaches	0
Incidents (research or otherwise)	17
Complaints	0
MHRA regulatory inspection (triggered or statutory)	0

(As recorded on the EDGE research management system)

Where applicable details are also reported on DATIX, in line with Trust policy. Each incident is reviewed and CAPA plans put in place. Incidents are reviewed and discussed by the senior management team demonstrating our proactive approach to maintaining high standards of research integrity.

11.0. Key Limitations, Challenges and risks:

The Government are expecting NHS Trusts to expand and diversify their research offer at scale and pace as part of the 10-year plan. Our key challenges to not only maintaining activity and performance but to build on our excellent reputation to grow research, to offer more of the benefits from R&D and help us remain research competitive and research active, include:

1. **Space** – Our demand has outstripped our capacity and infrastructure. We now have an imbalance regarding the space available to conduct the level of activity and accommodate the workforce needed to deliver - the type and level of support, infrastructure, oversight and governance needed. We have more business than we can accommodate and reluctantly we are turning down trials.
 - a. We have outgrown the Horizon Centre and despite maximising desk space, increased hotdesking, working from home models but as primarily a clinical team we are limited with these options to create more space within our current footprint and what's within our 'gift'. We have had little success to date negotiating with education extra space within the Horizon Centre and we are struggling to ensure staff can do their jobs as effectively and efficiently as possible. We urgently need to identify more space and need help navigating this within the Trusts estates use and planning.
 - b. We have outgrown the JRU clinical outpatient facility. To give the flexibility and predictability assurances to the sponsors especially commercial trials we must be able to plan in research clinics. The increased activity now means this is proving more difficult which will start to impact on our performance and delivery of studies.
 - c. Due to the clinical nature of our business, it is imperative R&D are closely located to clinical teams and services and therefore the main base remaining on the acute site is essential.

2. **Recruitment (vacancy panel) delays**, despite external funding has affected our ability to set up studies in a timely manner and impacted our performance. This has necessitated over reliance on an even smaller number of staff and has increased staff health and wellbeing concerns which is not sustainable.
3. **Regulatory compliance and the need to strengthen research governance.** Research is a highly regulated activity. Our core Research Management and Governance team functions need strengthening as a matter of priority to underpin the growth in the complexity, number of clinical trials and to be MHRA Inspection ready. Essential to give both sponsors and regulators the assurance and confidence in TSDFT as a research site.
4. **Too many single points of failure and lack of resilience** - due to a lack of staff in key roles / functions (links to point above) with reliance on too few people. These failings must be addressed urgently during 25/26 to help mitigate our increasing risk of regulatory non-compliances, succession planning and remaining research active. R&D are reviewing its structure and propose to establish new key posts funded through external trials income to help address this and help mitigate risks.
5. **Investigator staff time in job plans, succession planning** – we are still reliant on the good will of investigators and their passion and commitment to support and deliver research often in their own time which is an unsustainable model. Attracting new staff is essential and through better engagement working with care groups and use of trials income to help support better job planning.
6. **Need for robust, regular and reliable activity and finance data.** R&D recognised we need to strengthen these areas to create a more sustainable approach and model.
7. **Ethos and culture - How can R&D better help the Trust?** We are operating in very challenging environments but through improving our ethos, culture, awareness and visibility of research - instead of seeing research as an optional luxury for the few, often de prioritised, needs to change to how to better engage and embed research into everyday core Trust and care group business as usual.

12.0: Forward Plan for 2025/26 include:

- Develop and implementation of a new Trust Research Strategy aligned to the new Trust Strategy.
- Review the Departmental structure and workforce – as it no longer fit for purpose regarding the services, functions, resilience needed, and growth expected? An urgent review is needed, and recommendations will be submitted to the Trust for consideration.
- To continue to lobby for more space as demand has outstripped current capacity. R&D has outgrown the Horizon Centre and JRU to accommodate the expansion and growth in research demanded by the Government.
- Strengthen research governance – process, systems and workforce. Take action to address this priority area, identified an urgent need to increase staffing to provide the necessary skills, expertise, capacity and capability underpinning R&D, to strengthen safety, quality, responding to growth in R&D over the past few years and expected growth as per national ambitions and policy. To ensure regulatory compliance, MHRA Inspection readiness and ongoing sustainability.
- Improve visibility, engagement, information, awareness and communications with care groups, through new reports and dashboards.
- Improve clinical research performance – especially for commercial studies. This is the focus of a new cross-sector UK Clinical Research Delivery (UKCRD)

Programme co-led by the Department of Health and Social Care (DHSC) and NHS England (NHSE). New metrics will be introduced for NHS trusts in 2025-26 and improvements will be needed to meet national targets. Trusts failing to meet targets are at risk of reduced income from the NIHR and industry.

- Introduce improved reports relating to finance, activity and performance to enable the R&D leadership group to oversee R&D more effectively.
- New NIHR Capital funding bid - work up projects that can be put forward for the next round of funding (up to £1.5M) to support research infrastructure capacity and capability.
- Work with the EPR team in preparation for EPIC and as part of one Devon with UHP and RDUH R&D.
- Explore further digital projects to improve and streamline R&D processes, improve capacity and efficiency. Recognising the significant potential of digital and AI tools to transform many of our teams' most time-consuming and/or repetitive activities, including those related to trial set-up and management.
- Workforce development: Review and implement improved training and education and explore the potential to expand research fellowships and associates' programmes.
- Explore greater collaborative working models regionally with the NIHR RDN and partner organisations to improve access to and diversity of our research portfolio.
- Improve visibility and transparency of finances, value and benefits of research. To make it easier to access and use income generated through research to invest and enable staff and services to better support research and operational capacity and performance.
- Improve visibility, engagement, information, awareness and communications through both website and intranet site developments.
- Continue work associated with relevant national and regional policies, changes and updates (HRA, MHRA, NIHR, DHSC, NHSE)
- Update policies and SOPs and review training needs in response to the new UK Clinical Trials Regulations – complete overhaul and biggest shake up since 2004. The new law was passed by parliament and will come into effect from 28th April 2026.
- Alongside DHSC, NHSE, NIHR we will need to be ready to respond, plan and implement remaining recommendations from the Lord O'Shaughnessy report on commercial clinical trials and the demands and expectations under the new 10 Year Health Plan centred around the 3 shifts and priorities:
 - o More care in the community (from hospital to community)
 - o Investment in digital technologies (from analogue to digital)
 - o A bigger focus on prevention (from sickness to prevention).

National policy and priorities

- Research is seen a key tool for addressing the health and care challenges of today and tomorrow and to create better health & wealth for the NHS and UK.
- Consequently, there is increased Government attention, focus and prioritisation on research with a key strategic ambition to increase the diversity, scale and pace of research in the NHS and to support the NHS and wider health and care system in driving a revolution in research, life sciences, med tech and data, aiming to:
 - Strengthen the UK clinical trial network and UK PLC
 - Supports better patient outcomes
 - Bolster the life sciences innovation and investment environment.

- Accelerating the delivery of the health and growth missions - underpinning the new 10-year health plan and the 3 shifts / priorities:
 1. More care in the community (from hospital to community)
 2. Investment in digital technologies (from analogue to digital)
 3. A bigger focus on prevention (from sickness to prevention).
- This will involve new investment and funding opportunities, new KPIs, new research contracts and funding models.

The new 10 Year Health Plan - Unprecedented boost for clinical trials

We welcome clinical trials being prioritised in the 10 Year Health Plan. Everything we do in healthcare should be grounded in high quality science and evidence that is representative of the people we treat. The best way of achieving that is to ensure NHS patients are included in clinical trials. It's also important that we translate our learnings into tangible results for patients.

Patients will receive the most cutting-edge treatments years earlier than planned under the government's 10 Year Health Plan, which will speed up, accelerate and expand clinical trials, so the UK becomes a hotbed of innovation. Millions will take part in clinical trials under the 10 Year Health Plan, transforming patient care with groundbreaking treatments, while driving growth. This includes unparalleled access to trials via the NHS App, and greater transparency with public reporting of trusts to show who is and is not delivering on trials, with funding prioritised for best performers. **Government investment will only be prioritised for the trusts that can prove they can support the NHS to deliver the treatments of tomorrow.**

All NHS trusts and organisations will need to submit data on the number of trials being conducted and the amount of progress being made, rebuilding the country's global status as the epicentre of research. This is a plan for change aiming to turbocharge clinical research to regain UK's clout on the world stage and deliver the most ambitious reduction in trial set-up times in British history.

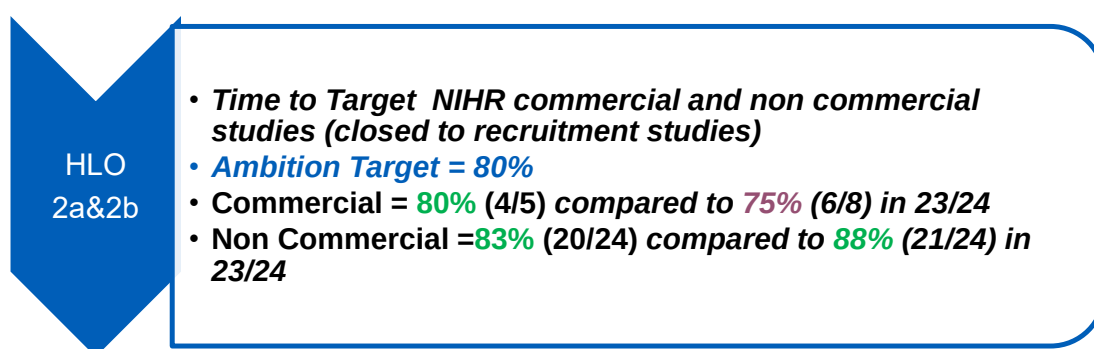
It comes as NIHR launches a UK-wide recruitment drive for clinical trials - the biggest ever health research campaign - to get as many people involved in research as possible. Adults across the UK are being urged to register, with underrepresented groups including young people, Black people and people of South Asian heritage particularly encouraged to sign up, at bepartofresearch.uk.

Appendix 1: Activity and performance data

Research is conducted in a globally competitive market. Sponsors want to place studies at the minimal number of sites and will choose sites that can consistently show quick set up and time to target performance. The UK Government are keen to grow commercial research; consequently, these are key NIHR (DHSC) KPIs for sites. Any delays to start up and sites not delivery to time and target due to workforce, operational and financial challenges and pressures; often means studies are closed before we can open, sponsors withdraw studies from sites or even the UK. Poor performance makes it difficult to win new and repeat business (studies) and is directly linked to our income generation (actual and potential) and sustainability.

Performance:

NIHR High Level Objective (HLO): Time to Target (T2T): looking at whether a study reached its recruitment target when it closes to recruitment



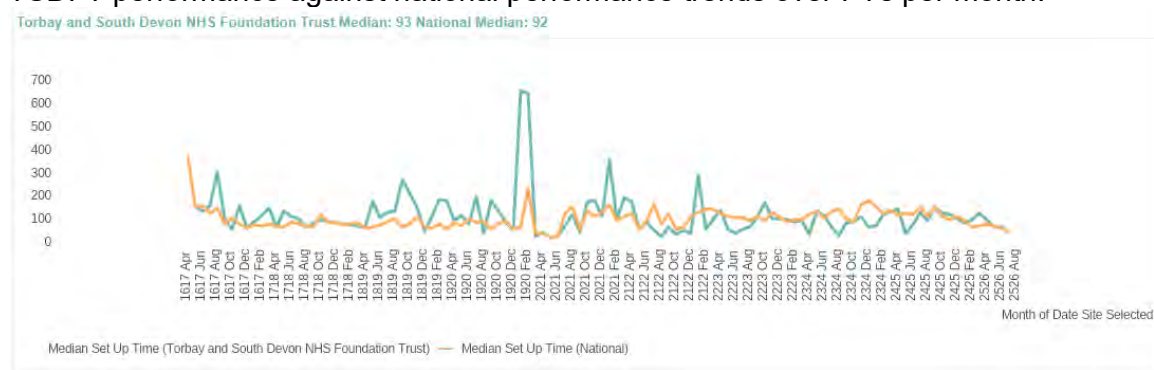
NIHR Study Set up times: (target = 40 days from site selected to confirmation)

24/25: TSDFT medium set up time = 18 days and we were top performers regionally.

Site Selected to First Recruit		Site Selected to Confirmed		
LCRN set up median times				
↑ Trust Name	Number of arrange/ assess/ confirm events	Median No of days	Number of arrange/ assess/ confirm events <=40 days	% within 40 days
Cornwall Partnership NHS Foun...	11	77	4	36%
Devon Partnership NHS Trust	13	40	7	54%
NIHR RDN: South West Peninsula	7	0	5	71%
Non-NHS Activity In South West ...	3	84	1	33%
Royal Cornwall Hospitals NHS Tr...	41	98	10	24%
Royal Devon University Healthca...	72	26	50	69%
Somerset NHS Foundation Trust	37	49	16	43%
Torbay and South Devon NHS F...	37	18	29	78%
University Hospitals Plymouth N...	80	57	28	35%

(source: NIHR ODP platform)

NIHR Date Site Selected to First Participant recruited (target = 70 days)
TSDFT meduim = 93 days (national meduim = 92 days). The graph below shows TSDFT performance against national performance trends over FYs per month.

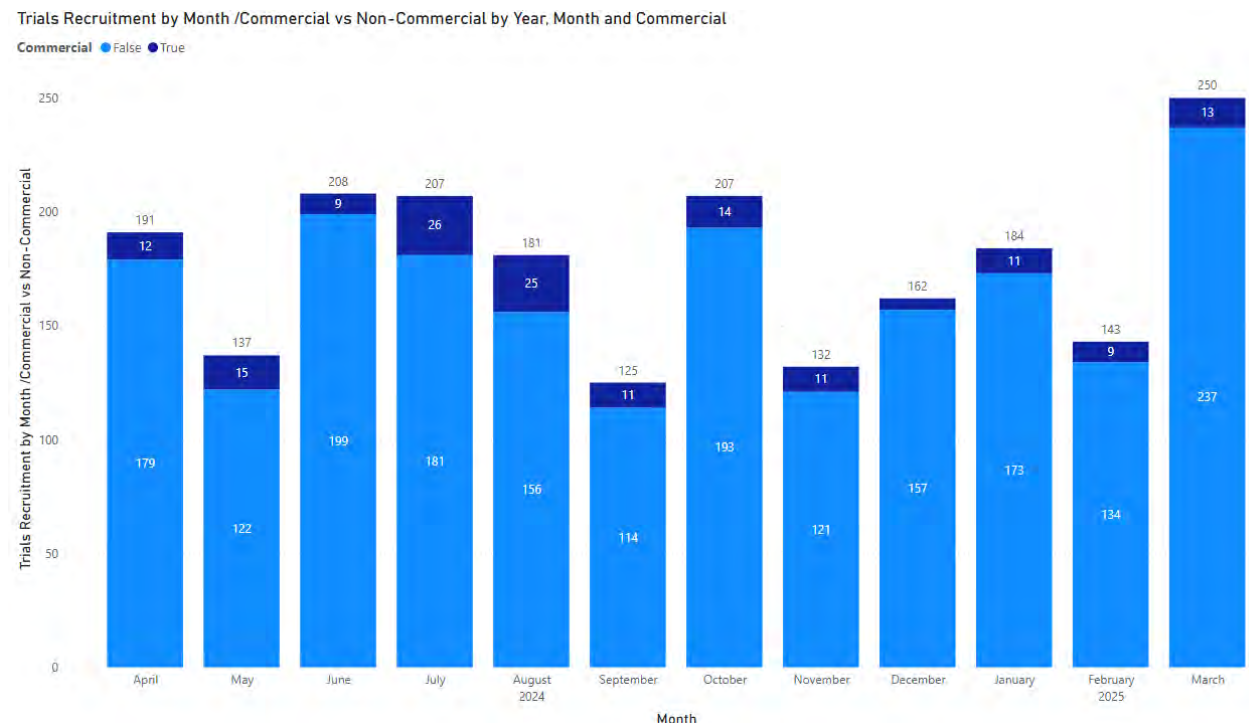


(source: NIHR ODP platform)

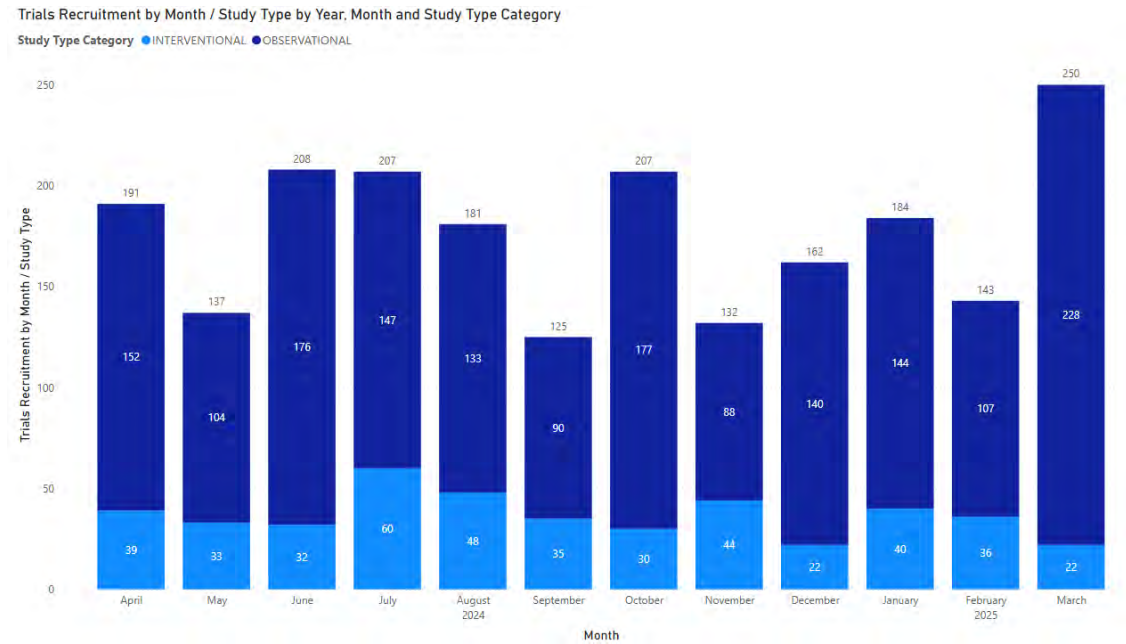
N.B. This metric is due to change from 25/26

Activity

Recruitment: Below summarises our NIHR 24/25 recruitment trends per month:

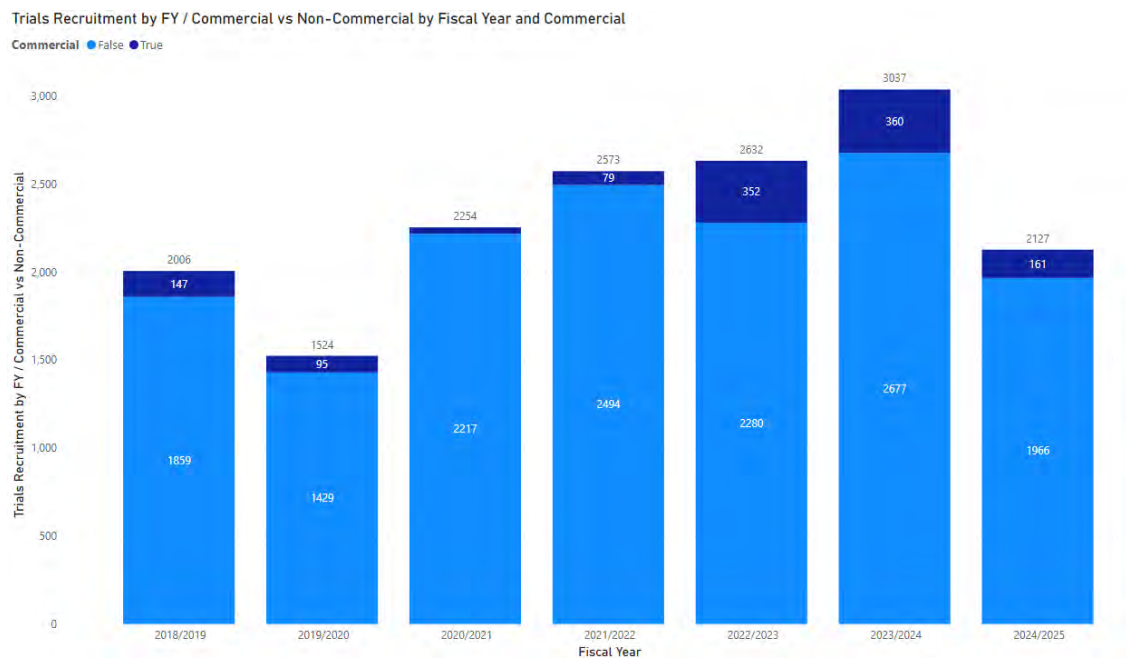


- Total per month recruitment - split Interventional vs observational recruits



Total recruitment trends per FY since 2018/19 (pre pandemic year):

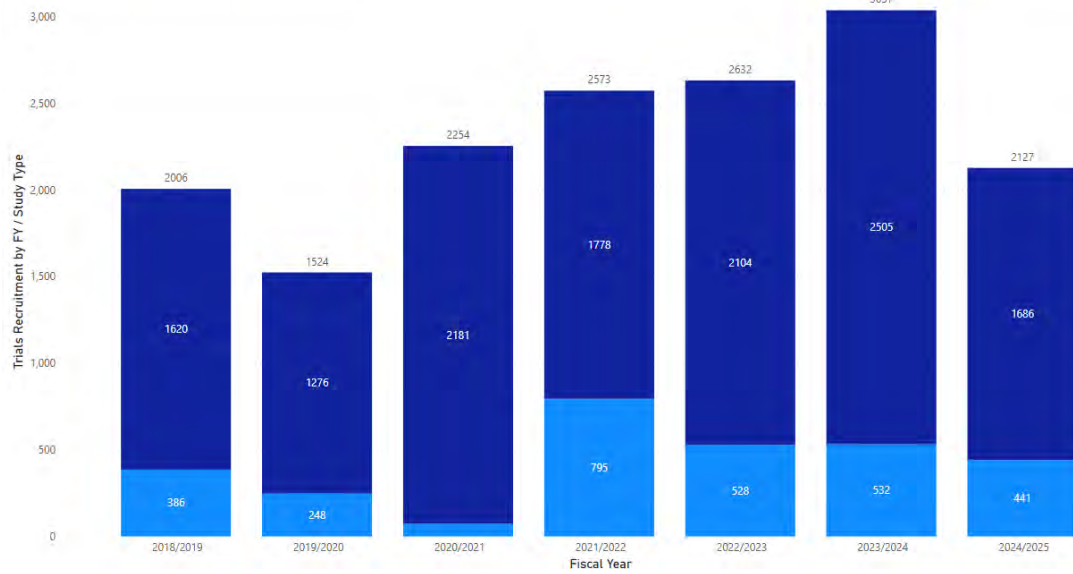
- Total per annum showing split - Commercial vs non-commercial recruits



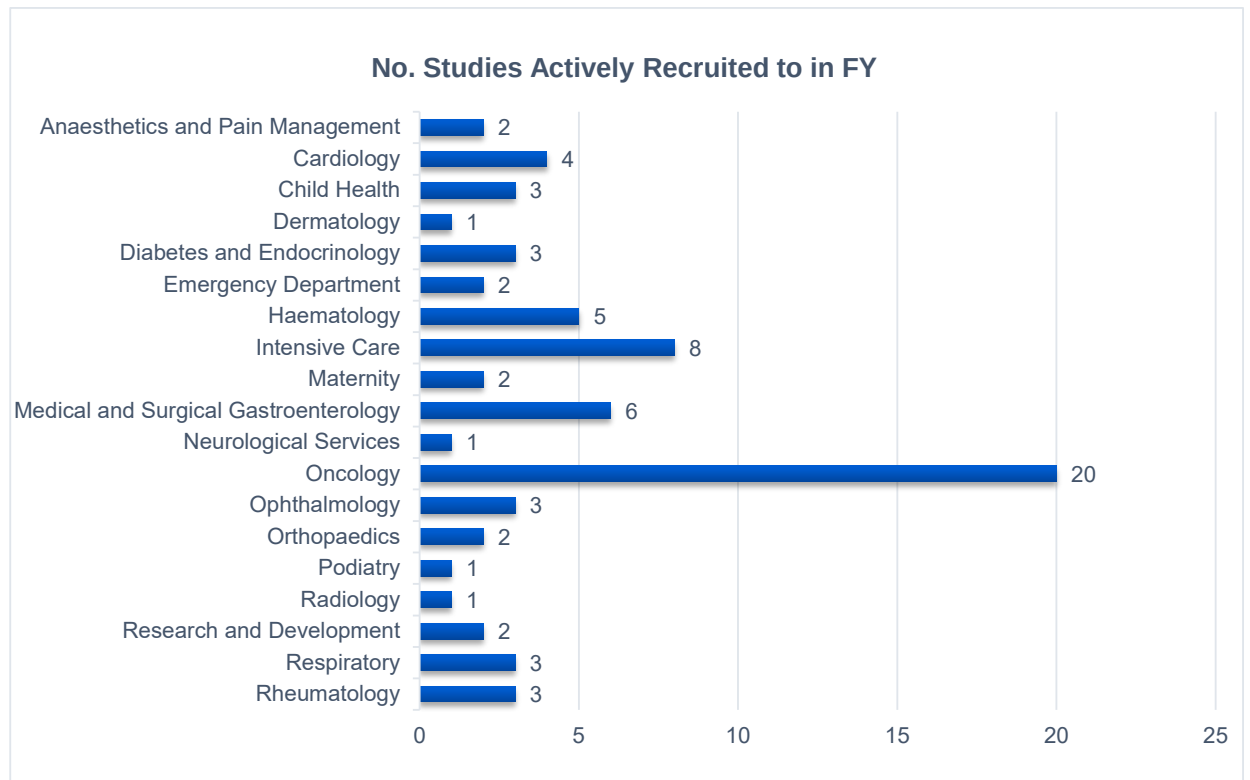
- Total per annum showing split Interventional vs observational recruits

Trials Recruitment by FY / Study Type by Fiscal Year and Study Type Category

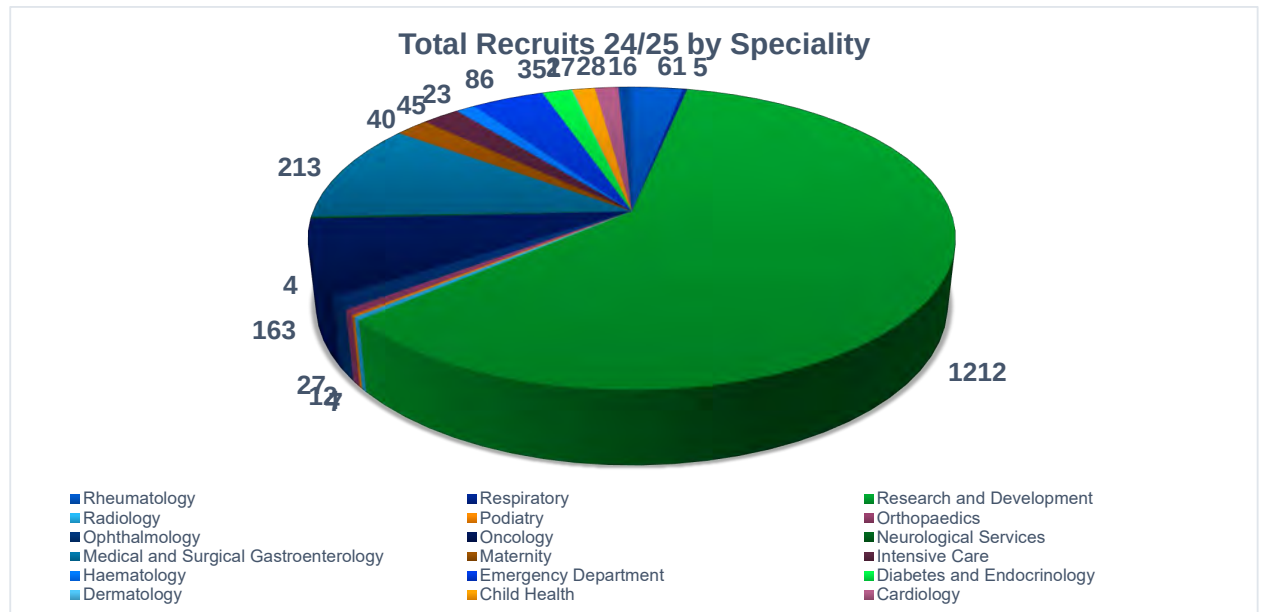
Study Type Category ● INTERVENTIONAL ● OBSERVATIONAL



Recruitment: A breakdown showing the number of studies recruited into by speciality in 24/25:

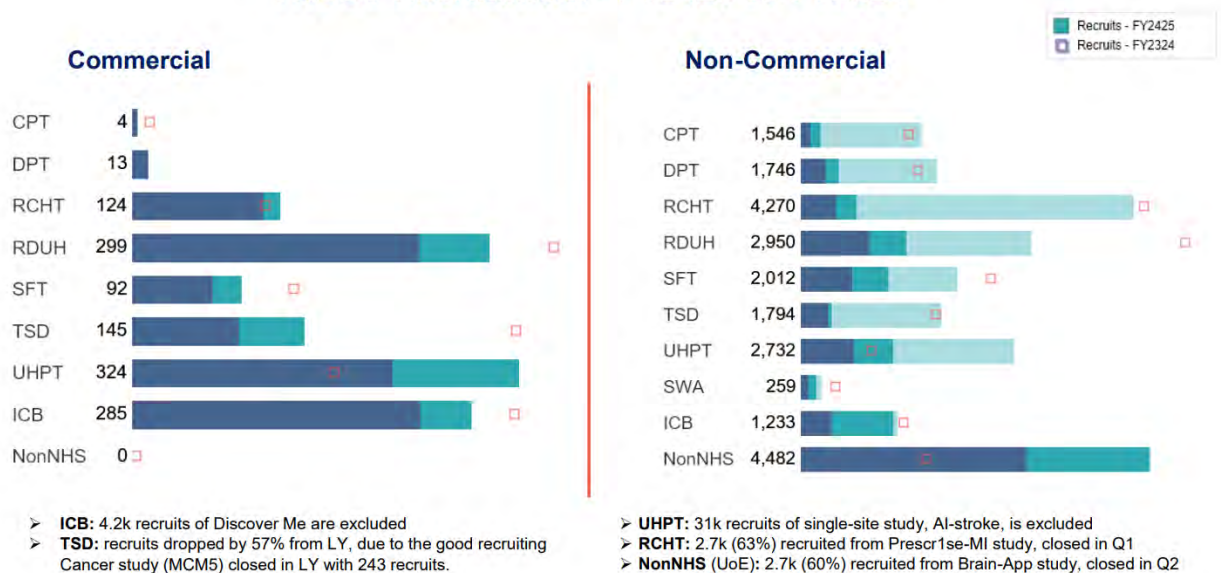


Recruitment: Graph summarises recruitment per speciality during 2024/25:



Regional and National Benchmarking:

TRUST Recruitment - FY2425 vs FY2324



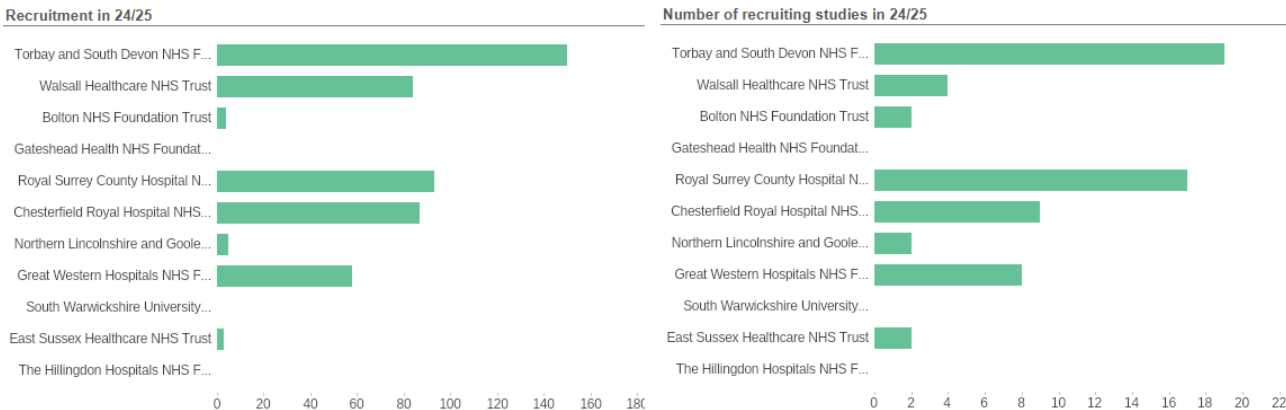
Source: provisional RDN Annual performance report 24/25 (data cut 02/05/25)

National benchmarking against other Trusts of a similar size (source NIHR ODP platform).

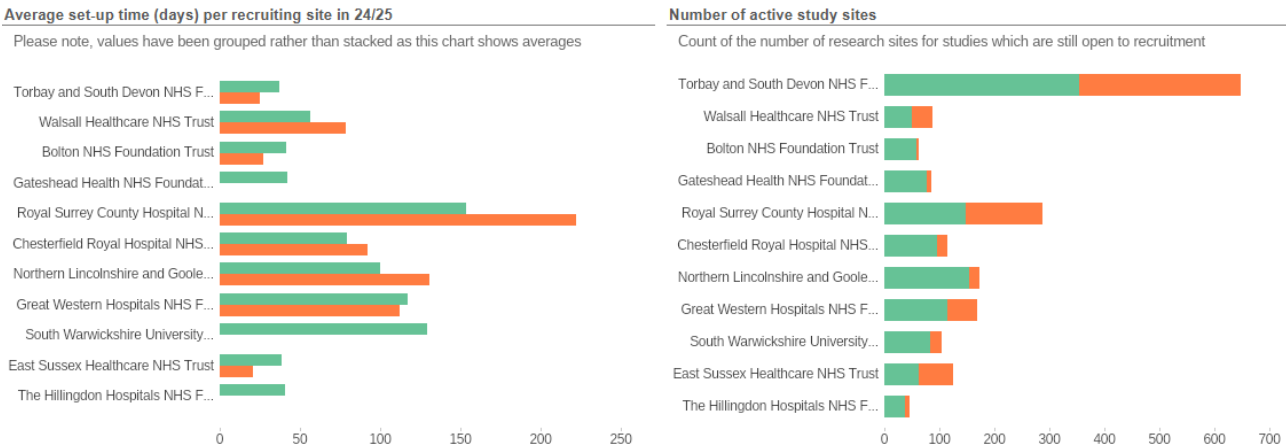
An alternative measure is shown below where Torbay is benchmarked against the next nearest 10 similar sized organisations; based on population outpatient attendances. Torbay slipped from 2nd best in class for total recruitment but best in class for commercial recruitment and 1st for number of studies recruited into for the 2nd consecutive year.



Commercial recruitment 24/25



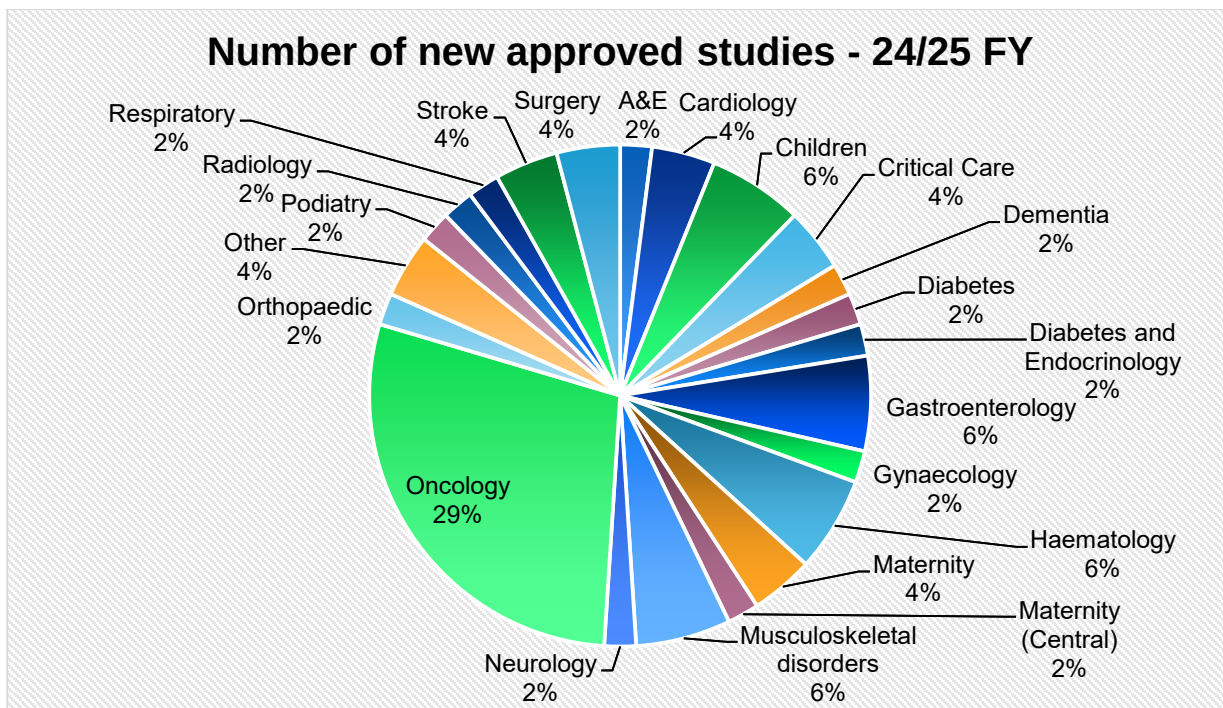
Study set up times



Research activity compared to 10 organisations in the same category (acute, care, CCG etc). Attendances (trusts) or population (CCGs) is used as a proxy for measuring similarity. The charts show the most similar organisation at the top with similarity decreasing down the chart

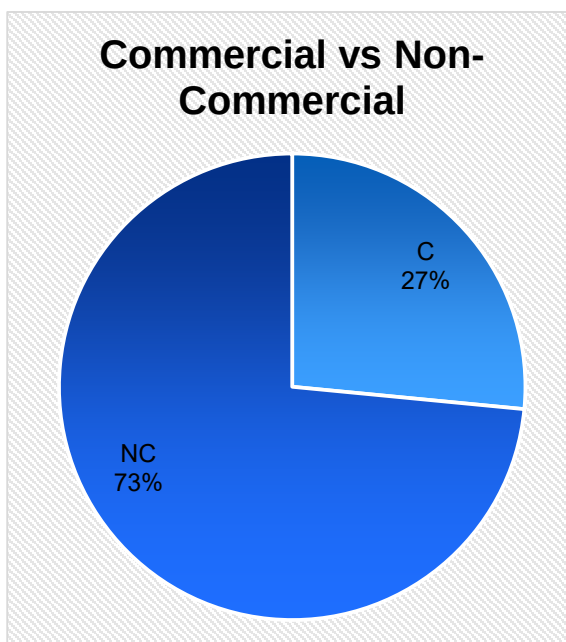
Studies:

A total of 49 studies were approved during 2024-25. Below the graph shows the new approved studies by speciality:

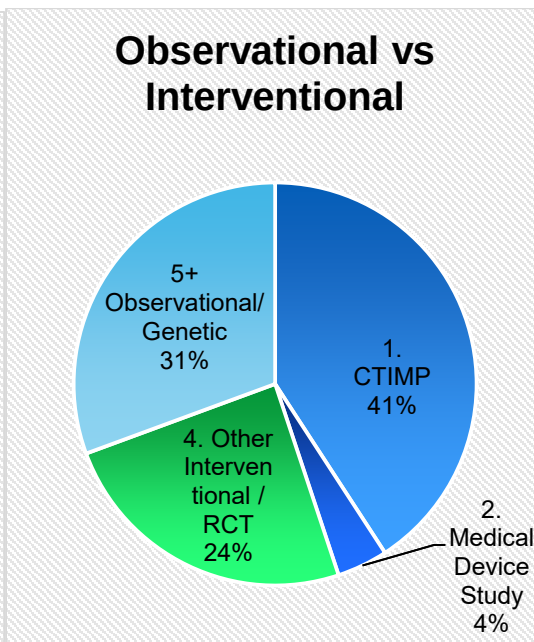


New studies approved:

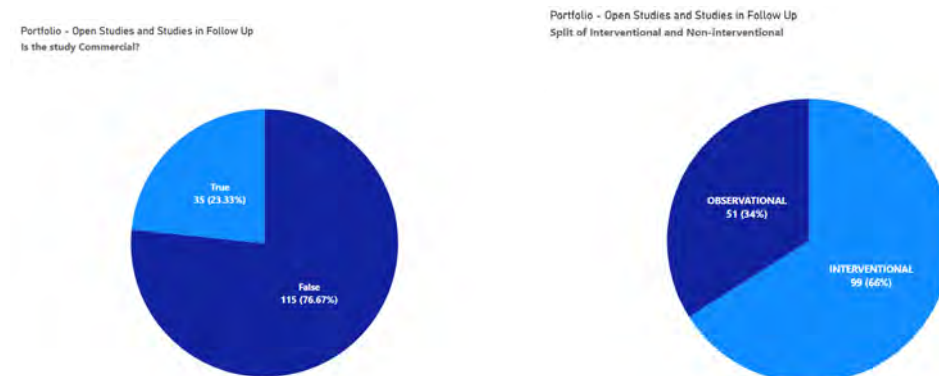
Commercial vs non-commercial:



Study type

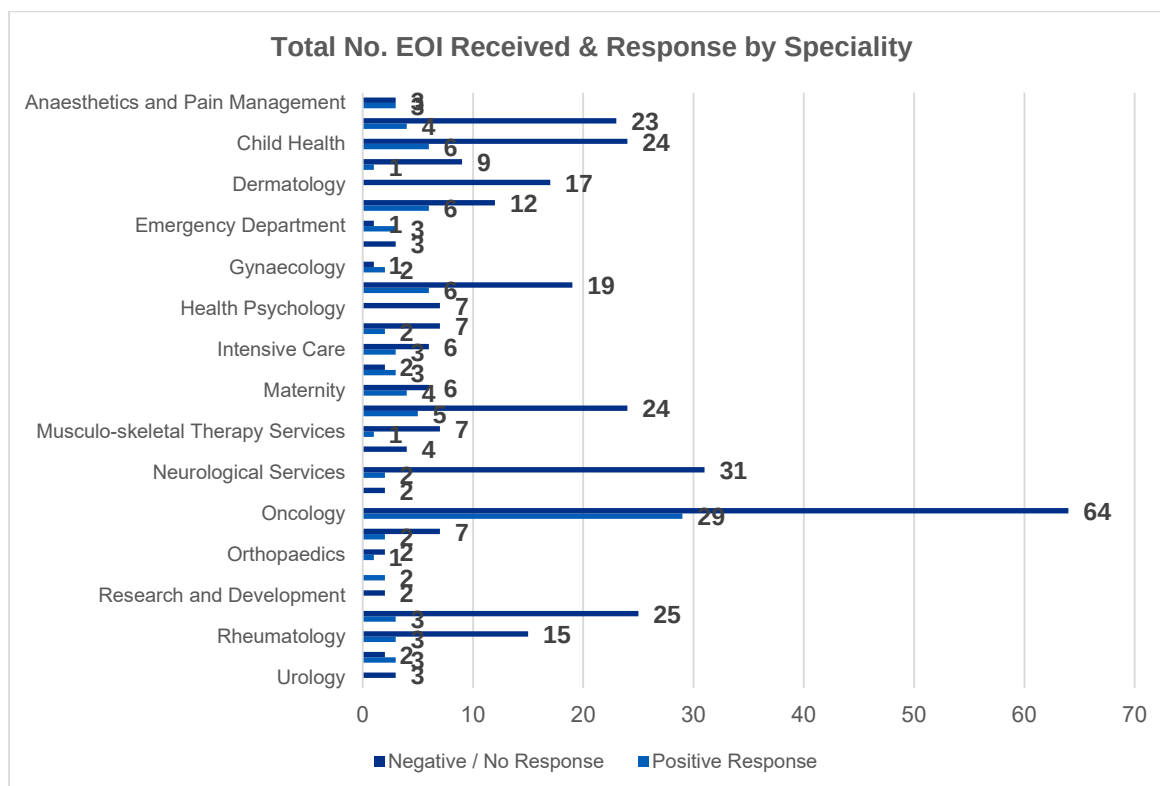


Total studies active (open and in follow up) as of 31.03.25 Commercial vs non-commercial: Study type

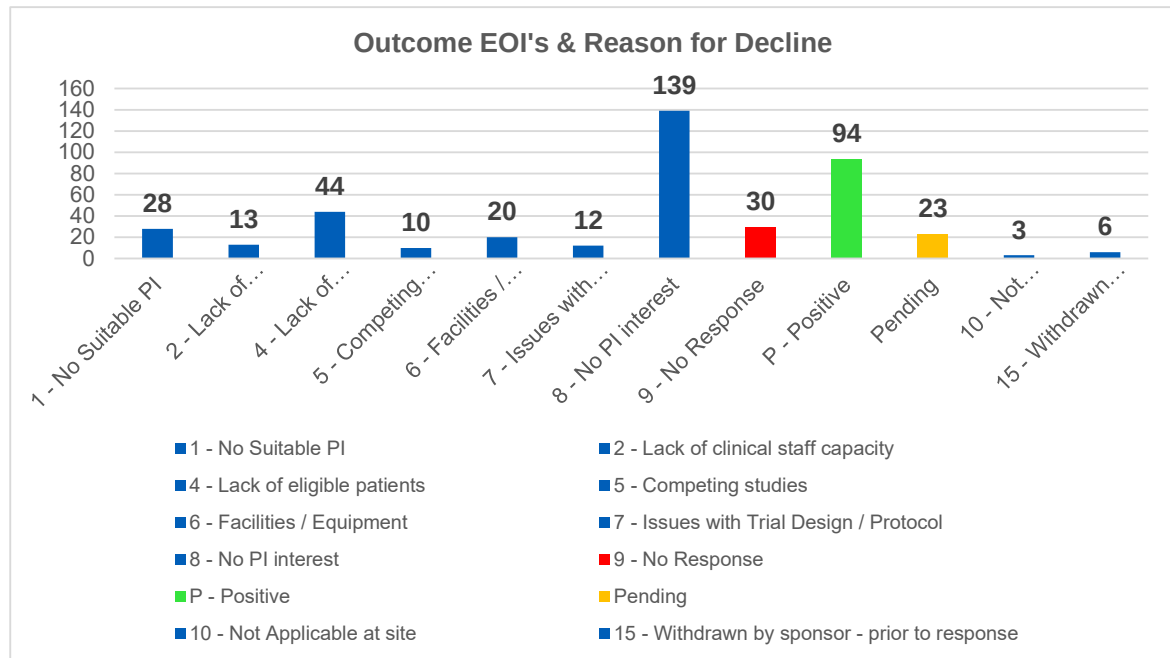


Expressions of Interest (EOIs)

- New potential business is measured through **Expressions of Interest (EOIs)** - our pipeline of potential future studies. The graph below shows the breakdown per speciality.



- During 24/25 we had 405 EOIs processed compared to 402 in 23/24 but our positive response rate increased from 23% to 28%. The graph below details a breakdown of reasons for negative responses.



- The EOI data shows there is a plentiful pipeline, but we are still declining studies primarily due to workforce and capacity issues. There is scope to do more; but we need the organisation and workforce to be in a better operational position to enable this and the infrastructure to underpin further growth. These factors all sit outside of R&Ds gift.

Appendix 2: Research Governance and Assurances:

Background

Research governance refers to the framework to manage the research process from end to end, to ensure that research is undertaken in a safe, appropriate and ethical manner, in accordance with national guidance and applicable laws to ensure that maximum benefit is derived from research for public and patients.

Compliance with the legislation is overseen nationally by the Health Research Authority. This includes:

- **UK Policy Framework for Health and Social Care 2017** - The UK policy framework sets out principles of good practice in the management and conduct of health and social care research that take account of legal requirements and other standards.
- **Good Clinical Practice (GCP)** – GCP is a set of internationally recognised ethical and scientific quality requirements for designing, conducting, recording and reporting research that involves human participation. Compliance provides public assurance that the rights, safety and wellbeing of participants are respected and protected, and that the data generated are credible and accurate.
- **EU Directives** - The EU Clinical Trials Directive (EUCTD –2001/20/EC) sets out how clinical trials investigating the safety or efficacy of a medicinal product in humans must be conducted. It includes medicinal trials with healthy volunteers and small scale or pilot studies. The Good Clinical Practice (GCP) Directive (2005/28/EC) supplements the EUCTD, strengthening the legal basis for requiring member states to comply with the principles and guidelines of good clinical practice. After leaving the EU the UK implemented the EUCTD (which become an EU Regulation on 31 January 2022), into domestic legislation.
- **Medicines for Human Use (Clinical Trials) Regulations** - The EUCTD was implemented into UK law in May 2004, as the Medicines for Human Use (Clinical Trials) Regulations 2004, and has since been amended (2006a, 2006b, 2008). Following the completion of a consultation for legislative changes for clinical trials, published in March 2023, new UK clinical trial regulations were signed into law on 11 April 2025. The new regulations are set to take full effect on 28 April 2026, after a 1-year implementation period. They aim to streamline approvals, enhance patient safety, and accelerate access to innovative treatments.
- **Human Tissue Act** - The Human Tissue Act 2004 repealed and replaced the Human Tissue Act 1961, the Anatomy Act 1984 and the Human Organ Transplants Act 1989 as they related to England and Wales, and the corresponding orders in Northern Ireland. The Human Tissue Authority regulates the removal, storage, use and disposal of human bodies, organs and tissue.
- **Declaration of Helsinki** - The Declaration of Helsinki was developed by the World Medical Association as 'a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data' (Para 1, Declaration of Helsinki).
- **General Data Protection Regulation (GDPR)** - Most clinical research requires the processing and/or storage of personal and sensitive information. The General Data Protection Regulation (GDPR) legislates for the control and protection of personal information relating to living individuals including both facts and opinions about the individual.
- **Mental Capacity Act** - Research studies involving adults aged 16 or over who lack capacity must comply with the Mental Capacity Act 2005. This includes persons with dementia, learning disabilities, mental health problems, stroke or head injuries who may lack capacity to make certain decisions, including

consenting to participate in a research study. The act does not apply to studies falling under the Clinical Trials Regulations (CTIMPs).

- **Trust R&D policies:** – Locally, clinical research is governed by R&D policies underpinned by a suite of Standard Operating Procedures (SOPs) within R&D governance. Policies and SOPs are updated in response to national and local developments. R&D Governance is responsible for a wide variety of activities, which are summarised below.

Oversight of Compliance and Safety

- **GCP Monitoring** – The purpose of monitoring is to ensure that the safety of participants is assured; that the trial results will be credible and accurate and that the trial is conducted in accordance with the protocol and regulatory frameworks. Many non-commercial sponsors and all commercial sponsors undertake regular monitoring of studies either remotely or on site issuing a monitoring report after each visit. These reports should be reviewed by the R&D management team to follow up actions and look for any trends or themes developing. Due to a lack of staffing and capacity this oversight has been patchy, and more robust management is needed. However, Sponsors have not escalated any specific concerns to senior R&D Management.
- **Formal auditing of compliance.** An audit is part of implementing quality assurance. It is independent and separate from routine monitoring or quality control functions. The purpose of an audit is to evaluate a system(s) or trial conduct and compliance with the protocol, SOPs, Good Clinical Practice (GCP), and the applicable regulatory requirements. Where TSDFT is hosting research with an external Sponsor, such trials should be audited by the R&D Governance team selected through a risk-based approach. Due to the lack of capacity, no audits were completed by the R&D Governance team during 2024-25.
- **Compliance checks.** R&D internally aims to routinely undertake assessment of compliance with various aspects of clinical research; primarily focussing on informed consent, delegation logs and safety reporting and following up CAPA plans. These briefer checks are of great value for oversight of compliance and as they are less resource intensive than formal audit, a greater number of studies can be covered. especially where studies are not covered by external monitoring by sponsors. Again, due to staffing and workload pressures this has not routinely been undertaken.
- **Safety Reporting.** The Trust has a responsibility for ensuring that safety reporting processes are appropriate and compliant. The appropriate level of oversight is established by a risk assessment prior to the granting of Trust R&D Approval. The research protocols detail the process for safety reporting. Trial patients on interventional studies are flagged on the trust systems. Each morning a report is pulled to check any trial patient admissions, and the team follow up and if applicable report as per protocol and GCP requirements to the study sponsors. Checks other than those by external monitoring has not been undertaken.
- **Risk Assessments:** A detailed risk assessment is undertaken for each study submitted for approvals at TSDFT, which help inform our audit schedules and ensure ongoing compliance.
- **Training and Development:** Research Governance ensures that bespoke training is delivered to meet the specific needs of each study, as well as in

response to updates in regulations or guidelines. Additionally, all research staff complete mandatory Good Clinical Practice (GCP) training provided by the National Institute for Health and Care Research (NIHR) prior to the commencement of any study. R&D keep a record of training and certificates, CVs as well as providing training in response to incidents / CAPAs.

- **Advice and Classification:** There are times when it is not clear if a project should be classified as a research study, audit or service evaluation or whether a study needs NHS ethics etc. R&D are regularly conducted by staff to review and give an opinion aligned to the HRA policies and decision tools.

Appendix 3: The value and benefits of research: Examples of research good news stories / commendations / impacts and outcomes:

Our staff and patients at TSDFT have helped to inform the emerging evidence base, make changes to practice etc through their participation in research. Below are examples giving a flavour of the work and various impacts and outcome from Torbay's involvement in research activity.

Anaesthetics:

	The POPPY study: Patient-reported outcomes, postoperative pain and pain relief after day case surgery (POPPY): methodology for a prospective, multicentre observational study* TSDFT PI: Dr Andrew Gunatilleke, Consultant Anaesthetist
Developing the evidence and associated service models to support older people living with frailty to manage their pain and to reduce its impact on their lives: a mixed method, co-design study Publication Date: 2025 Journal: Anaesthesia 80(1), pp. 38–47 Abstract: Access or request full text: https://libkey.io/10.1111/anae.16460 Patient-reported outcomes, postoperative pain and pain relief after day case surgery (POPPY): methodology for a prospective, multicentre observational study* In the UK, approximately 70% of surgical procedures are undertaken as day-cases. Little information exists about recovery from day-case surgery, yet international data highlights patients are at risk of developing significant longer-term health problems including chronic post-surgical pain and persistent postoperative opioid use. The Patient-reported Outcomes, Postoperative Pain and pain relief after daY case surgery (POPPY) study was a national prospective multicentre observational study, measuring short- and longer-term patient-reported outcomes, postoperative pain and pain relief after day-case surgery. This was a collaborative project led by resident anaesthetists under the Research and Audit Federation of Trainees umbrella. Adult day-case surgical patients were recruited on the day of surgery. Baseline data including patient characteristics; procedure details; pre-operative analgesic use; pre-existing pain; and quality of life scores were recorded. Patients were followed up through automated short message service messages. Short-term (postoperative days 1, 3 and 7) outcomes included: quality of recovery; pain severity; impact of pain on function; and analgesic use. Longer-term outcomes (postoperative day 97) included: quality of life; analgesic use; incidence of chronic post-surgical pain; and incidence persistent postoperative opioid use. Additional outcomes were completed by those patients with chronic post- surgical pain and persistent postoperative opioid use, with 30 patients recruited to a qualitative semi- structured interview study exploring postoperative expectations, recovery, postoperative pain and opioid use. An embedded pilot study at four sites recruited 129 patients. Responses to the automated short message service were gained from 129 patients (100%) at day 1; 116 (89.9%) at day 3; 108 (83.7%) at day 7; and 77 (59.7%) at day 97 postoperatively. The pilot enabled refinement of the methods and processes before the national roll out. This paper outlines the methods for the POPPY study, the largest UK multicentre prospective observational study considering short- and longer-term outcomes following day-case surgery.	

Breast Surgery:

	ENDONET study: Randomised controlled trial evaluating effectiveness of neoadjuvant endocrine treatment in post-menopausal women TSDFT PI: Ms Louise Merker, Consultant Breast Surgeon TSDFT recruits: =11
Fastest team to recruit to target in the ENDONET Study. Also, first study by PI Louise Merker. TSDFT was congratulated on becoming the fastest team to reach 5 participants and on track to be the top recruiter in Q3/Q4 2024/25.	

Breast Surgery:

Mammo-50 study: Mammographic surveillance in breast cancer patients aged 50 years and over: a randomised controlled trial TSDFT PI: Mr Fared Memon, Consultant Breast Surgeon TSDFT recruits: =64
Annual versus less frequent mammographic surveillance in people with breast cancer aged 50 years and older in the UK (Mammo-50): a multicentre, randomised, phase 3, non-inferiority trial Summary Background The frequency of mammographic surveillance for women after diagnosis of breast cancer varies globally. The aim of this study was to evaluate whether less than annual mammography was non-inferior in terms of breast cancer-specific survival in women aged 50 years or older. Between April 2014, and Sept 2018, 5235 women were randomly assigned to annual mammography (n=2618) or less frequent mammography (n=2617). With a median of 5·7 years follow-up. 5-year breast cancer-specific survival was 98·1% (95% CI 97·5–98·6) in the annual mammography group and 98·3% (97·8–98·8) in the less frequent mammography group (hazard ratio 0·92, 95% CI 0·64–1·32), demonstrating non-inferiority of less frequent mammography at the pre-specified 3% margin. Overall survival at 5 years was 94·7% (95% CI 93·8– 95·5%) and 94·5% (93·5–95·3), respectively. 224 (64·9%) of 345 breast cancer events were detected from emergency admissions or symptomatic referrals back to the hospital system, including 108 (61·7%) of 175 in the annual mammography group and 116 (68·2%) of 170 in the less frequent mammography group. Interpretation For patients aged 50 years or older and at 3 years post diagnosis, less frequent mammograms were non-inferior compared with annual mammograms for breast cancer-specific survival, recurrence-free interval, and overall survival, and should be considered for this population. Funding National Institute for Health Research Health Technology Assessment programme. Access or request full text: https://libkey.io/10.1016/S0140-6736(24)02715-6

Diabetes:

ACCLAIM study: A Phase 3, Randomized, Double-Blind, Placebo-Controlled Study to Investigate the Effect of Lepodisiran on the Reduction of Major Adverse Cardiovascular Events in Adults with Elevated Lipoprotein(a) who have Established Atherosclerotic Cardiovascular Disease or Are at Risk for a First Cardiovascular Event – ACCLAIM-Lp(a) TSDFT PI: Dr Jamie Smith, Consultant In diabetes and Endocrinology TSDFT recruits: =21	
Our research team ends 2024 on a high Congratulations to our research team which has achieved the incredible milestone of becoming the top NHS recruiting site in the UK, recruiting participants to ACCLAIM study. This study explores whether lepodisiran can reduce lipoprotein in the blood, reducing the risk of heart attack and stroke. This achievement highlights our dedication to research and reducing the risk of heart attacks and strokes as well as the amazing support from across our community.	
	
L-R: Lisa Felmeden (Senior Research Nurse), Alexis Marler (Senior Research Nurse), Dr Jamie Smith (Consultant Diabetologist and Principal Investigator), Dr Amal Khalil (Research Specialty Doctor) and Dr Aabha Sharma (Consultant Pathologist).	

Gastroenterology:

	
NED-APRIQOT Study: Automated Performance Reports to Improve Quality Outcomes Trial (APRIQOT) Using the National Endoscopy Database (NED) to evaluate endoscopy performance and reduce unwarranted variation in quality. TSDFT PI: Dr Mrk Freeny, Consultant Gastroenterologist TSDFT recruits = 17	
Nationally Automated Colonoscopy Performance Feedback Increases Polyp Detection: The NED APRIQOT Randomized Controlled Trial (NED-APRIQOT Published paper 2024.pdf): Torbay recruited 17 endoscopists into this study, looking at whether giving automated feedback to endoscopists about their procedure improved their polyp detection. This is important as Post colonoscopy colorectal cancer incidence and mortality rates are higher for endoscopists with low polyp detection rates. Although the automated feedback intervention did not increase case-mix adjusted polyp detection significantly, but polyp detection rates did improve significantly. Engaged endoscopists benefited most but improvements were not maintained postintervention, suggesting feedback should be ongoing.	

Neurology:

	PD-COMM study: A multi-centre randomised controlled trial to compare the clinical and cost effectiveness of Lee Silverman Voice Treatment versus standard NHS speech and language therapy versus control in Parkinson's Disease TSDFT PI: Rachel Hashed, Speech and Language Therapist TSDFT recruits: =10
The effect of two speech and language approaches on speech problems in people with Parkinson's disease: the PD COMM RCT Abstract: Background Speech impairments are common with Parkinson's disease (reported prevalence 68%), increasing conversational demands, reliance on family and social withdrawal. Objective(s) The PD COMM trial compared the clinical and cost-effectiveness of two speech and language therapy approaches: Lee Silverman Voice Treatment LOUD and National Health Service speech and language therapy for the treatment of speech or voice problems in people with Parkinson's disease to no speech and language therapy (control) and against each other. Participants were randomised in a 1: 1: 1 ratio to control, National Health Service speech and language therapy or Lee Silverman Voice Treatment LOUD. Conclusions People that had access to Lee Silverman Voice Treatment LOUD described a significantly greater reduction in the impact of their Parkinson's disease-related speech problems 3 months after randomisation compared to people that had no speech and language therapy. There was no evidence of a difference between National Health Service speech and language therapy and those that received no speech and language therapy. Lee Silverman Voice Treatment LOUD resulted in a significantly lower impact of voice problems compared to National Health Service speech and language therapy 3 months after randomisation which was still present after 12 months; however, Lee Silverman Voice Treatment LOUD was not found to be cost-effective. Future work Implementing Lee Silverman Voice Treatment LOUD in the National Health Service and identifying alternatives to Lee Silverman Voice Treatment LOUD for those who cannot tolerate it. Investigation of less costly alternative options for Lee Silverman Voice Treatment delivery require investigation, with economic evaluation using a preference-based outcome measure that captures improvement in communication. Study registration This study is registered as ISRCTN12421382. Funding This award was funded by the National Institute for Health and Care Research (NIHR) Health Technology Assessment programme (NIHR award ref: 10/135/02) and is published in full in Health Technology Assessment; Vol. 28, No. 58. See the NIHR Funding and Awards website for further award information. Access or request full text: https://libkey.io/10.3310/ADWP8001	

Neurology:

	CHarlotMS: ChariotMS – A national (UK), multi-centre, randomised, double-blind, placebo-controlled (1:1) phase IIb efficacy

	trial with cost-utility analysis of cladribine tablets (3.5mg/kg over two years) in people with advanced multiple sclerosis (EDSS 6.5-8.5). Is cladribine superior to placebo in protecting upper limb function? TSDFT PI: Dr Agne Steukeine, Consultant Neurologist TSDFT recruits: =4
Celebrating a milestone in MS research at Torbay The Torbay multiple sclerosis (MS) research team is proud to announce the successful over-recruitment of four progressive MS patients for the ChariotMS trial. Torbay Hospital is the only site in the South West participating in this vital research. The ChariotMS trial is exploring the potential of disease modifying treatment, Cladribine versus placebo, in slowing the progression of upper limb function for people with advanced MS. This unique groundbreaking study offers hope to those living with progressive MS, an area of care where treatment options remain limited. In the photo are Jack Quinn (Data Manager), Sophy Booth (Senior Research Nurse), Dr Richard Hosking and Dr Agne Straukiene (Consultant Neurologist and Principal Investigator) from the MS research team. The Horizon Research team, co-coordinators, and admin staff played a huge part in getting this trial up and running in a very tight deadline. The team raced against the clock, but together, they ensured that their patients had the opportunity to participate in this important trial. A huge thank you to Dr Marie Jasim (research fellow on the study) and the research admin team for all your help with setting up the study; A fabulous co-ordinated effort all round. A huge thank you and well done to the MS research team for your hard work, dedication, and unwavering commitment to their patients, and for the meaningful difference they are bringing to those living with advanced MS.	

Oncology:

	The OSCAR Trial: Omics Approaches to Urological Cancer Diagnosis TSDFT PI: Dr Anna Lydon, Consultant Clinical Oncologist TSDFT recruits = 85
	The work of our research and development teams and wider colleagues who contribute to this work is a vital part of our vision to provide high quality care and contribute to national developments and innovations. We run a range of clinical research trials, one of which is the OSCAR trial. In collaboration with the CI Prof. Luis Mur and his team at Aberystwyth University, the trial aims to develop a test that can detect urological cancers. This will support earlier diagnosis as well as

help people avoid unnecessary testing. Dr Liz Thomas, Deputy Medical Director, recently registered as one of the healthy participants in the trial.
[Watch this video about the trial and their involvement and find out more about our wider research work.](#)

Oncology:

PALOMA-2 Research Study	PALOMA-2 study: Subcutaneous amivantamab and lazertinib as first-line treatment in patients with EGFR-mutated, advanced non-small cell lung cancer (NSCLC): TSDFT PI: Dr Louise Medley, Consultant Medical Oncologist TSDFT recruits: =5
Background: Sub cut (SC) Conclusions: SC Amivantamab (ami), ami+ lazertinib (laz) showed a response rate similar to historic IV ami+laz in first-line EGFR-mutated NSCLC, with an improved safety profile that included significantly lower administration-related reactions (ARR) rates. Further, prophylactic anticoagulation can be safely implemented and reduced incidence of venous thromboembolic events (VTE).	

Oncology:

	PERSEPHONE: Duration of Trastuzumab with chemotherapy in women with early stage breast cancer: six months versus twelve. TSDFT PI: Dr Andrew Goodman, Consultant Clinical Oncologist TSDFT recruits: =41
The NIHR-funded PERSEPHONE trial found that 6 months' treatment with Herceptin (trastuzumab) for women with HER2-positive early breast cancer was as effective as 12 months' treatment. Shorter treatment led to fewer side effects and hospital visits and was linked to significant cost savings for the NHS (Published: 16 May 2024) Breast cancer treatment linked to serious side effects 	
Breast cancer is the most common type of cancer in the UK, with around 55,000 people being diagnosed every year. Up to 1 in 5 of those people have HER2-positive breast cancer. This type of cancer tends to grow faster, spread and recur more often than other types. Women with early stage HER2-positive breast cancer usually take an anti-cancer drug, known as Herceptin (trastuzumab), for 12 months after receiving	

chemotherapy. This reduces the chance of the cancer returning but it may cause dangerous side effects, such as heart failure.

In the largest trial of its kind, the NIHR awarded the [PERSEPHONE trial](#) £2.6 million to investigate whether the length of treatment, and therefore the risk of side effects, could safely be halved to only 6 months.

Halving treatment length reduces side effects

Published in [The Lancet](#), results showed that taking trastuzumab for 6 months was as effective as 12 months for many women. After both 6 and 12 months of treatment, 9 out of 10 women were still free of breast cancer 4 years later. While the outcomes were very similar, cutting the treatment to only 6 months resulted in fewer severe side effects, including heart problems, fewer hospital visits and significant cost savings of £9,537 per patient for the NHS.

"The trial would not have been possible without support from the NIHR Clinical Research Network for the 152 teams at centres throughout the UK who recruited patients". - Professor Helena Earl, lead researcher for PERSEPHONE

Professor Janet Dunn led the trial at the NIHR Clinical Trials Unit and added: "The NIHR is a great funder for these types of trials as they ultimately refine treatment for patients with the maximum patient benefit ensured."

Adding to the evidence base for clinical decision making

In light of their findings, NICE reviewed its existing [breast cancer diagnosis and management guidance](#). Although it concluded that more evidence from further research was needed before changing the guidelines, NICE is optimistic that shorter treatment could benefit some patients who had a low risk of the cancer recurring.

In 2024, PERSEPHONE was also cited in the NIHR-supported [Lancet Breast Cancer Commission \(.PDF\) \(.PDF\)](#) and contributed to the report's recommendations to tackle urgent global challenges in breast cancer. Following PERSEPHONE, the NIHR funded several awards investigating how well trastuzumab works as a treatment for early HER2 breast cancer. One such study is the £1.6 million [HER2-RADICAL](#), which is recruiting women with early HER2-positive breast cancer.

Its aim is to see whether women (who have no cancer left after receiving trastuzumab before surgery) can receive much less trastuzumab after their surgery. In doing so, the researchers hope to reduce the serious long-term side effects of treatment.

The study was funded by the [NIHR Health Technology Assessment \(HTA\) Programme](#) and published in [Health Technology Assessment](#).

More information about the study is available on the [NIHR's Funding & Awards website](#).

Oncology:

	BNT 122-01 Study: A multi-site, open-label, Phase II, randomized, controlled trial to compare the efficacy of RO7198457 versus watchful waiting in resected, Stage II (high risk) and Stage III colorectal cancer patients who are ctDNA positive following resection TSDFT PI: Dr Nangi Lo, Consultant Medical Oncologist TSDFT recruits: =40
First cancer vaccine in South West administered in Torbay and South Devon	

Featured on BBC spotlight showcasing our incredible research and oncology teams and the wonderful Stephen Brice as part of our work on a groundbreaking cancer vaccine trial. TSDFT is the only hospital in the South West, and one of only six in the country, selected to take part in the trial. Stephen is one of our patients and was the first person in the South West to receive his vaccine as part of this pioneering trial.

The trial looks at creating a personalised vaccine specific to a person's cancer, when markers have shown that there is a risk of the cancer returning. Stephen was diagnosed with bowel cancer last year and following his treatment with us, it is now hoped that this tailor-made vaccine specific to his tumour will prevent his cancer from returning. He will continue to receive doses and will be monitored over time. [Watch a video of the BBC Spotlight coverage online.](#)

(The trial is taking place at six sites across the country and is part of NHS England's collaboration with BioNTech on innovative treatments for cancer through the Cancer Vaccine Launchpad Programme (CVLP). This is just the latest of many positive initiatives and developments that our research and development teams, as well as colleagues across the organisation who support this work, are involved with.



Being involved in research provides incredible opportunities for both the people we care for; all while helping to further regional, national and international groundbreaking studies.

Orthopaedics:

	REPPORT Study: REcurrent Patellar dislocation: Personalised therapy or OpeRative Treatment? 'Patient reported outcomes, postoperative pain and pain relief after day case surgery' TSDFT PI: Mr Nate Ahearn, Consultant Orthopaedic Surgeon TSDFT recruits = 9
REPPORT study recruited its first patient within 24 hours of opening. This study is comparing surgery with physiotherapy for patients with recurrent patellar dislocation. This is the first study both for new PI Mr Nate Ahearn being supported by John Williams (physio).	

REPPORT award for research team

The REPPORT team at Warwick University are recognising the efforts of site teams across the country as part of the REPPORT awards.

We are delighted to confirm that we have received the 'quickest off the mark' award for being the fastest site to recruit to the REPPORT trial.

The REPPORT trial looks at recurrent dislocation and instability of the patella (knee cap) which can be a profoundly disabling condition. Recurrent dislocations may persist for many decades causing pain, cartilage, and soft tissue injury which can lead to long-term disability. The REPPORT trial aims to compare a physiotherapy intervention (PKT: Personalised Knee Therapy) versus surgery. Both physiotherapy and surgery are both options for treating repeated kneecap dislocations and available in the NHS, however it is not known if one is better than the other. The REPPORT trial will offer 50% of randomised patients PKT and 50% Surgery and will compare patient reported results to see if which treatment plan has the best patient outcomes.

Angela Willberry, Clinical Research Team Leader said, "We are delighted to receive this award and are so excited about this trial.

This acknowledgement is a testament to the dedication of our team and the enthusiasm of our participants. Rapid recruitment like this shows just how committed we all are to advancing knee research."



Podiatry:

Congratulations to Justine who has been shortlisted for an award – and WON

Podiatrist Justine Tansley has been shortlisted for The Research Student of the Year at the 2025 Flexitol Tomorrow's Podiatry Awards.

Justine said: "I have just started a PhD which is funded by the Torbay medical research fund. I took an eight-month career break to be the research fellow on a podiatry-led space research project which was funded by the UK Space Agency. This was so I could gain project management experience and improve my PhD application." Justine's work involved carrying out lower limb vascular assessments on test subjects (including real life astronauts) on a series of zero gravity flights. The nominators said: "Her research is required to provide definitive answers to uncertainties and provide clear guidance to support the use of specific combination treatment approaches. It's an excellent example and role model and demonstrate that with resilience, determination, and persistence it is possible to succeed."

The winners of the awards will be announced in Liverpool on 03 February 2025. The Tomorrow's Podiatry Awards are the first and only podiatry focused awards that recognise the outstanding contributions of those who enrich the student experience and the students who shine.



Quality Account Committee

Safeguarding Adults Annual report

Date of meeting	Date report produced
17 th November 2025	9 th November 2025

Author(s)		Report approved by	
Name and title:	Jon Anthony Head of Safeguarding Adults	Name and title:	Nicola McMinn Chief Nurse
Phone:	07909890476	Date:	9 th November 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

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
Safeguarding Adults (Health and Social care)	Satisfactory	No previous measure
Mental Capacity Act (Health Services)	Limited	No previous measure
Mental Capacity Act (Adult Social Care)	Satisfactory	No previous measure
Deprivation of Liberty Safeguards	Limited	No previous measure

Appendices

N/A

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

Annual safeguarding adults report for Board and QAC. Information is presented as reported as business as usual via the governance groups referenced in section 5 of this report.

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance ratings and take LIMITED and SATISFACTORY assurance as described.

It is recommended the Board take satisfactory assurance that Safeguarding adults and Adult Social Care Mental Capacity Act practice (MCA) is satisfactory and Health MCA assessment recording and Deprivation of Liberty Safeguards Supervisory Body measures provide limited assurance This is based on audit assurances given, noting 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'?

To provide assurance that all staff practice ensures that adults with needs for care and support are safeguarded against abuse or neglect 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	The report describes activity across health and social care networks to reduce health and social care inequalities and embed learning from safeguarding adults incidents.
Quality of services provided	The report highlights qualitative feedback, audit and organisational development relating to people at risk of abuse or neglect. This includes how we evidence valid consent where there is reason to doubt mental capacity.
Sustainable and efficient use of resources	The report highlights activity within regional forums and partnership Boards to utilise resources to maximum effect and achieve consistency in

safeguarding and mental capacity act practice.

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Our staff know how to recognise and respond to adult abuse concerns. Services seek valid consent in relation to decisions relating to care and support interventions.
Leadership and Governance	
Performance	Multi-agency policies and practice guidance and governance accountability through partnership and internal arrangements.
People and Culture	We support adults and /or their representatives to be safeguarded from abuse or neglect and improper treatment. Making safeguarding personal practice. Legal duties to seek valid consent and lawfully deprive people of their liberty.
Strategy and Business Intelligence	Strong partnership arrangements to enable people to live life free from the risk of or experience of abuse or neglect. Integrated health and social care arrangements to safeguard adults from abuse or neglect. Partnership and multi-disciplinary arrangements to improve safeguarding people from abuse or neglect. Co-location of health and social care colleagues to support multi-agency safeguarding arrangements.
Finance	Effective local partnership arrangements to maximise resource and efficiency.

Risk: Risk ID (as appropriate)	
Risk	Risk ID
<i>Deprivation of Liberty Safeguards</i>	3570

External Standards affected by this report and associated risks
<i>Care Act 2014</i> <i>Mental Capacity Act (MCA) 2005</i> CQC Regulation 13 (Health) Theme 3 'Ensuring Safety' (Adult Social Care) Deprivation of Liberty Safeguards Human Rights Act 1998 Equality Act 2010 Modern Slavery Act 2025 Counter Terrorism and Security Act 2015

Safeguarding Vulnerable Groups Act 2006
Domestic Abuse Act 2021

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 Adults Annual report

Introduction and background

The Safeguarding Adult Annual Report for 2024/2025 provides key information in relation to core messages, performance, legal frameworks, governance and safeguarding activity during this period.

1.1 National and Local Context

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

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

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

1. Key Risks

1.1 Deprivation of Liberty Safeguards (DoLS)

Audit South West have undertaken an Independent Audit of the Supervisory Body Deprivation of Liberty Safeguard arrangements in November 2024. The outcome of this audit gave limited assurance due to the extent of the application backlog and inability to log information on an electronic care management system. A new operating model has been implemented, and the backlog is decreasing. The recording of DoLS is a key part of the ASC care management programme due for implementation in 2026.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Deprivation of Libert Safeguards	Limited Assurance	Improving

1.2 Health Service Mental Capacity Act (MCA) Understanding and Application

Audit South West published their independent audit report in January 2025. This gave limited assurance due to the application of MCA in practice in clinical settings.

The recommendations and action plan have been overseen by the Audit committee, and all actions have been completed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Health Service Mental Capacity Act (MCA) Understanding and Application	Limited Assurance	Improving. Action plan completed. Ongoing audit required to evidence sustainable improvement.

2. Culture and Leadership

2.1 Torbay and South Devon NHS Foundation Trust (TSDFT).

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

- Protection of human rights. (Principle 1)
- Safe, high-quality care which focuses on patient experience. Respect, dignity, compassion and care are at the core of how people are treated. (Principle 3)
- Placing the individual at the heart of everything. (Principle 4)
- Working in partnership with other organisations in the interests of our population (Principle 5)
- Informed consent and the Mental Capacity Act (Rights)

2.2 Torbay Council Vision for Adult Social Care in Torbay.

Our Safeguarding / Mental Capacity Act principles directly connect with the vision for adult social care in Torbay.

- Focus on outcomes and well-being.
- Personalised, co-created and flexible care and support both for individuals and at a community level.
- Proactive and preventative action through early intervention.
- Integrated and coordinated local arrangements.
- Relationship based practice which empowers people to have choice and control over their lives.

2.3 Three examples of how we are putting these into practice include:

- Mandatory Safeguarding Adult and Mental Capacity Act (MCA) training for all staff.
- Qualitative feedback from those experiencing local safeguarding responses.
- Positive contributions to local safeguarding and MCA partnership arrangements.

3. Legislation and Guidance

3.1 The Care Act 2014

This Act sets out provision relating to the care and support for adults and carers.

Sections 42-47 of the Care Act relates specifically to Adult Safeguarding. Chapter 14 of

Care Act statutory guidance sets out how these duties should be implemented. The Care Act requires that each local authority must:

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

3.2 The Mental Capacity Act 2005 (MCA 2005)

This Act provides a statutory framework for:

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

The Act is underlined by 5 key principles –

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

3.3 Deprivation of Liberty Safeguards (DOLS)

The DOLS legal framework is covered within the Mental Capacity Act 2005.

- It sets out approving the deprivation of liberty for people who lack the capacity to consent to treatment or care, in either a hospital, care home or specified domestic settings.
- The requirements about when and how deprivation of liberty may be authorised.
- The assessment process that must be undertaken before deprivation of liberty may be authorised.

3.4 The Mental Capacity (Amendment) Act 2019 (Liberty Protection Safeguards)

Previous reports highlighted ongoing delays to the implementation of The Mental Capacity (Amendment) Act 2019.

In October 2025 the government announced it was implementing a consultation on introducing a new system process to take place in 2026.

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

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

3.6 Adult Social Care CQC Inspection

With effect from April 2023 the CQC regulated activity extended to include local authority adult social care services.

Relevant inspection of Adult Social Care services falls within 'Theme 3' 'Ensuring Safety'. Key areas of focus will be:

- Safeguarding systems, processes and practices.
- Responding to local safeguarding risks and issues.
- Responding to concerns and undertaking Section 42 Care Act enquiries.
- Making safeguarding personal.

Torbay Council ASC services are awaiting the outcome of their CQC inspection which took place in September 2025.

3.7 Other Key Statutory Frameworks

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

4 TSDFT Priorities and Delivering Improvement.

Our priorities and deliveries are identified against our legal and regulatory duties, data analysis, qualitative feedback and a broad range of activity undertaken within local partnership arrangements. Priorities and examples of how we have progressed these are set out below.

4.1 MCA / DOLS

Objectives.

1. To achieve compliance levels against agreed MCA training framework (All levels – 85%).
2. To have an MCA legally literate workforce.
3. To have accessible MCA resources available for frontline staff.

Assurance

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
MCA Health Services	Limited	Improving due to completion of audit actions.

Section	Assurance	Trend from previous report

	(Limited/Satisfactory/ Significant)	
Deprivation of Liberty Safeguards (Supervisory Body)	Limited	Improving due to implementation of new operating model. Last 3 months 14% reduction in backlog

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
MCA Practice Adult Social Care	Satisfactory	No change

4.1.1 How we are driving improvement.

- ASW Audit for DoLS published with clear action responses achieved or in progress.
- ASW MCA Audit for health services completed.
- Training compliance trajectories monitored via Mandatory Training Group.
- Refresher training framework for Level 3 MCA.
- Clinical team MCA audits
- MCA core component of monthly ASC audits plus specific annual audit.
- A new training framework for medics.
- New Supervisory Body operating model for DoLS.
- DoLS included in ASC care management system implementation project.
- Enhanced Supervisory Body signatory rota.
- Use of Independent Best Interest Assessors to support reduction in backlog.
- Revised policies and procedures to support practice application.
- TSDFT DOLS risk register score 9 regularly reviewed. Also reflected on Torbay Council risk register.

❖ **Summary of Torbay Supervisory Body applications received 24/25. 1338 (37% increase) Total.**

❖ **Total number of applications authorised 24/25. 344**

❖ **Current backlog (September 2025) 587. 14% reduction since June'25.**

❖ **Summary of Managing Authority Applications to Local Authority Supervisory Bodies (Torbay and Devon) 24/25. Total. 1579.**

4.1.2 Management of DOLS Risk

The new operating model provides increased capacity to utilise Independent Best Interest Assessors and complete a higher number of assessments each month. The impact of this is now beginning to be seen as evidenced by a 14% reduction in backlog between June and September 2025.

Risk is managed on an ongoing basis through weekly triage of applications against national ADASS guidance. The DoLS position is on the risk register (risk score 9) and monthly updates are provided through adult social care a QAC governance. The risk management arrangements are included adult social care governance reports.

4.1.3 Improvement of Mental Capacity Act Assessments Within Clinical Settings.

All audit recommendations have been completed in response to the Audit South West report. Ongoing activity has begun to evidence sustainable improvement in practice.

4.2 Domestic Abuse

4.2.1 Assurance:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Domestic Abuse	Satisfactory	No change.

4.4.2 Objectives:

1. All TSDFT staff understand their roles and responsibilities in response to DASV.
2. TSDFT supports national Pathfinder Project Specialist Health Practitioner recommendation – specialist response for patients who have experienced domestic abuse.
3. All TSDFT staff have access to support, in response to DASV.
4. TSDFT supports local strategic priorities and governance arrangements across health and social care.

TSDFT now has a Health Independent Domestic Violence Advocate embedded with health services. Their primary role is to provide specialist advice and support to patients and staff who disclose domestic abuse or are at risk of domestic abuse. The Trust has strong engagement within multi-agency arrangements including the delivery of strategic priorities.

4.2.3 How we are driving improvement.

- Adult Social Care representation at local Multi-Agency Risk Assessment Conferences (MARAC).
- Representation at Torbay MARAC Steering Group
- Member of the Torbay DASV Steering Groups (Executive and operational)
- Domestic Abuse training framework available to all staff via the HIVE.
- Screensavers and bulletins relating to domestic abuse.
- Regular electronic information drops to clinical teams.
- Bespoke DA awareness sessions delivered to different teams including medics, wards and therapists.
- Health IDVA drop-in sessions at maternity and ED wards each week.
- Patients accessing Health IDVA specialist support in acute and community hospital settings. Staff accessing specialist support.
- Quarterly Health IDVA Operational Group in partnership with ICB, Torbay Council and Torbay Domestic Abuse Services.
- New Domestic Abuse policies for people who access Trust services and staff.

❖ **Total number of patient referrals to Health IDVA (9/24-9/25) – 257**

❖ **Total Number of staff referrals to Health IDVA – (9/24-9/25) – 47**

4.3 Safeguarding Adults

4.3.1 Assurance:

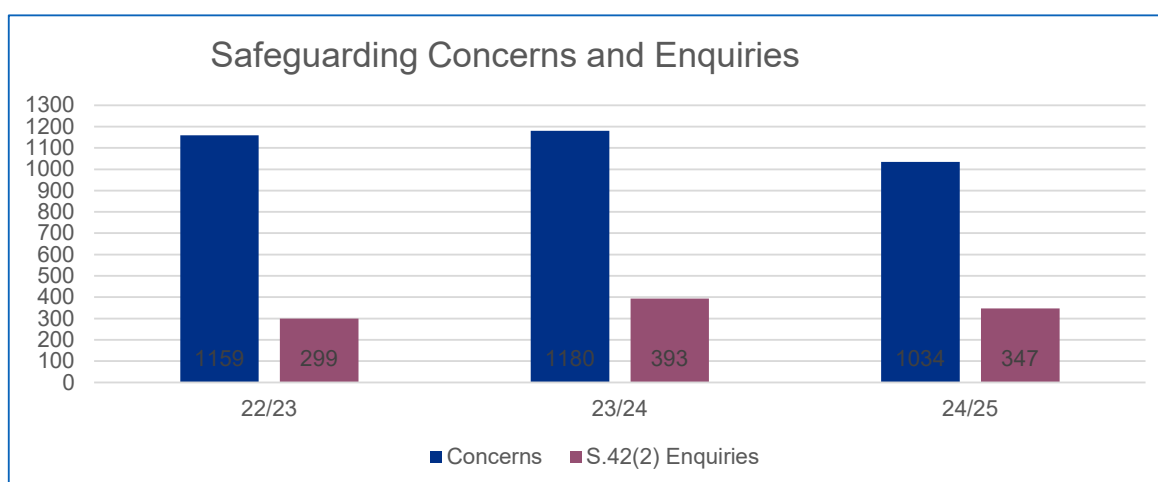
Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Safeguarding Adults	Satisfactory	No change.

4.3.2 Objectives:

- To achieve compliance levels against agreed Safeguarding training framework (All levels 85%).
- To have a Safeguarding adults legally literate workforce.
- To have accessible Safeguarding resources available for frontline staff.
- To ensure there are strong multi-disciplinary and partnership arrangements to safeguard people who draw on care and support from abuse or neglect.

4.3.3 Safeguarding Adult Data 2024-2025

Concerns and Section 42(2) Care Act 2014 Enquiries (Adult Social Care Duties)



From April 2024 to March 2025 there were 1034 safeguarding adult concerns 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 to 33.6%.

The most common types of abuse reported where neglect and acts of omission (19%), self-neglect (19%) and physical abuse (13%).

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

4.3.4 Qualitative feedback

Qualitative feedback is important in understanding people's experiences of safeguarding responses. In Torbay, we commission an independent advocacy

group to undertake discovery interviews with people or appropriate representatives who consent to giving qualitative feedback.

Qualitative Feedback Examples

- *He described the actions as 'swiftly dealt with, he stated, my son almost died, however, the outcome has been amazing so positive'. Outcomes were all achieved with a positive response. He stated that he felt fully included 'Social worker did a brilliant job' and felt fully understood and listened to.*
- *She thought the doctors, social workers and care home were all "fantastic" adding "everyone did brilliantly'.*
- *Her son felt fully included and listened to, everything was explained and we were listened to by both the care home and social services. He was completely satisfied and felt she was "much safer"*
- *They felt all outcomes were achieved, she felt it "was managed well", due to having an advocate, she did feel included and listened to, she felt supported throughout the process, there had been a lot of preparation. She was "really happy" with the end result, much safer " life changing"*

4.3.5 Management of Safeguarding Adults Level 3 Training

In September 2024 we brought our level 3 training delivery programme in house across health and social care. This has enabled targeted and delivery of level 3 training to improve overall compliance and improve quality such as focusing more on embedding learning from safeguarding adult reviews. The new training delivery began in January 2025. The compliance target is 85% and currently stands at 64%. Level 1 and level 2 training is greater than 90%.

4.3.6 Management of Completion of s.42(2) Care Act Enquiries

Live data identifies enquiries open beyond 90 days. Recently, we have increased oversight within operational teams and professional practice as part of business as usual.

4.3.7 Torbay and South Devon Safeguarding Adults Partnership (TDSAP)

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

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



TDSAP Structure

4.3.8 Partnership Priorities

TDSAP business activity plan is set against 3 strategic priorities.

The TDSAP Operational Delivery Group (ODG) which is chaired by the TSDFT Head of Safeguarding Adults, holds the business activity plan and reports on progress to TDSAP Board. The following describes each priority and gives examples on how TSDFT is supporting the delivery of each priority.

Priority 1 – Seek assurance from partners in relation to practice improvements in key risk areas.

- Making safeguarding personal embedded into safeguarding adult practice.
- Revised and conversational based training opportunities across TSDFT services.
- Participation within task and finish activity within TDSAP to improve guidance and tools for use across the system.
- Audit activity such as the MCA health audit and DoLS supervisory body audit.

Priority 2 – Seek assurance from partners that learning from SARs is embedded into practice.

- Recently submitted audit information presented to TDSAP on progress of delivery of the priority.
- ASC legal services briefing note on executive functioning.
- Dissemination of SAR practice briefings to operational teams.
- Revised face to face training includes SAR learning information and case exercises.
- Local partnership activity to support the implementation of Multi-Agency Risk Management Meeting arrangements (MARMM).

Priority 3 – Improve awareness, engagement and inclusion.

- Contribute to the planning of safeguarding adult awareness week.
- Participate in TDSAP task and finish activity relating to equality and diversity.
- ASC Equality and Diversity group.
- Safeguarding quality checker feedback.
- Ongoing activity to improve MCA compliance across services.

4.3.9 How we are driving improvement

- Compliance targets maintained for level 1 and level 2 training (i.e. if you see something say something).
- Broad range of business intelligence quantitative data relating to open Care Act s.42(2) enquiries.
- Bi-weekly and monthly data summary reports.
- Safeguarding adults quality assurance checker feedback scheme evidence people feel safer, listened to and engaged in their safeguarding response process.
- Target for consent to give qualitative feedback (>20%) achieved. 2025 average to date 32,8%.
- Contribute to all TDSAP partnership subgroups and workplan activity, including the chairing role for the Operational Delivery Group.
- Active participation in TDSAP business support arrangements.
- Contribute to ICB and ADASS safeguarding workstreams.
- Clinical safeguarding supervision sessions.
- Support ASC CQC inspection focus on 'Theme 3' ensuring safety.

4.3.10 Clinical Safeguarding Adult Supervision

The impact of a safeguarding incidents within clinical teams cannot be underestimated and it is important that we continue to prioritise offering clinical supervision to individuals or teams if requested. This not only enables teams to discuss the impact of a safeguarding incident, put reflect on what learning can be taken from such incidents.

4.4 Safeguarding Adult MCA Audit Programme

4.4.1 Assurance:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Safeguarding Adults and MCA DoLS Audits	Satisfactory	No change.

4.4.2 Objective:

- Have a clear rolling safeguarding adult and MCA audit programme with clear action plan responses.

We have a broad range of activities to support insight into safeguarding adult MCA activity. These range from activity directed and supported through internal and external governance arrangements, targeted operational audits or regular business as usual processes. Outcomes assist in providing ongoing assurance, assessment and transparency in responding accurate position updates to internal and external governance arrangements.

4.4.3 Audits undertaken to support assurance and lead improvement.

- MCA practice embedded into adult social care monthly audit programme.
- Audit South-West (ASW) MCA audit completed.
- ASW DOLS supervisory body audit completed.
- Targeted ward MCA audits completed.
- Adult social care (ASC) CQC inspection 9/25.
- Increased Community DoLS oversight within adult social care community team.
- Ongoing safeguarding adult enquiry closure panels.
- ASC oversight of live s.42 enquiries open more than 90days.
- Increased oversight of live safeguarding adult enquiries within operational teams.
- Qualitative feedback (lived experience) of safeguarding enquiry responses.
- ICB engagement and oversight of caused out TSDFT health s.42(2) enquiries.
- TDSAP engagement and feedback. E.g. TSDFT data analysis, embedding learning from safeguarding adult reviews.

Prevent

4.5.1 Assurance:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Prevent	Satisfactory	No change.

4.5.2 Objectives:

- Staff have access to training and information resources on how to identify and report Prevent concerns.

Prevent is the Government's strategy to stop people becoming terrorists or supporting terrorism, in all its forms. Prevent works at the pre criminal stage by using early intervention to encourage individuals and communities to challenge extremist and terrorist ideology and behaviour.

We are a standing member of Torbay and Devon Prevent Partnership Board. Prevent is included in our safeguarding adults training framework and supports staff in how to recognise and report Prevent concerns.

4.5.3 How we are supporting and delivering Prevent

- Contribute to the health partnership response to the counter terrorism local profile.
- Attendance at Torbay and Devon Prevent Partnership Board to inform organisational priorities.
- Monthly attendance at Torbay Channel Panel – standing member. Attendance at Devon Channel Panel when required.
- Prevent policy review.
- Prevent training framework review to ensure that training aligns to NHS Prevent training strategy.
- Close working relationship with Community Safety Partnerships.

4.6 Modern Slavery

Assurance:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Modern Slavery	Satisfactory	No change.

4.6.1 Objectives:

- Staff have access to training and information resources on how to identify and report modern slavery concerns.

Modern Slavery can happen to anyone. It happens to men, women and children from every walk of life. However, it does disproportionately effect people with pre-existing vulnerabilities that a trafficker can exploit. Poverty, limited opportunities at home, lack of education, unstable social and political conditions, economic imbalances and war are some of the key drivers that contribute to the trafficking of people.

Across the South West potential victims of slavery and trafficking have been identified on farms, in nail bars, in massage parlours, cannabis factories, car washes, care homes, takeaways/restaurants, homeless shelters, private residential homes and many more everyday places.

In TSDFT we ensure that modern slavery is a core agenda item within adult safeguarding training to enable staff to maintain awareness and know how to respond to modern slavery concerns. We also contribute to local anti-slavery partnership arrangements for the Devon and Cornwall Anti-Slavery Partnership.

4.6.1 How we are supporting the anti-slavery slavery agenda

- Member of Devon and Cornwall Anti-Slavery Partnership
- TSDFT will contribute to a planned review of local response protocol arrangements (to be scheduled).
- NHS Modern slavery short film included in mandatory staff training.
- Dedicated Modern Slavery sharepoint page.
- Close working relationship with Community Safety Partnerships.

5. Internal Quality Assurance and Governance

5.1 Assurance:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Internal governance arrangements	Satisfactory	No change.

5.2 TSDFT Integrated Safeguarding and Inclusion Group (ISIG).

This is an executive led group with a mandate to deliver safeguarding and children's statutory functions as a provider of health and social care and priorities of local safeguarding adult boards. The group also maintains oversight of other partnership

arrangements linked to themes such as exploitation, domestic abuse and sexual violence.

5.3 Adult Social Care Divisional Management Meeting (DMT)

This is a bi-weekly meeting to maintain oversight of emerging risks arising in adult social care safeguarding systems and processes.

5.4 Adult Social Care Improvement Board (ASCIB)

Senior management governance within ASC services. The purpose is to receive assurances relating to Care Act, MCA and wider statutory duties including professional practice information.

5.5 Quality Assurance Committee (QAC)

Reporting information from Adult Social Care Improvement Board is transferred by exception into the Adult Social Care QAC report.

5.6 Safeguarding Improvement Group (SIG)

Although this is not a formal governance group this plays a key role in bringing safeguarding practitioners together to reflect on how the safeguarding system is operating and take action to remedy any emerging issues. The group also plays an important role in receiving safeguarding adult review information, providing analysis of learning outcomes and disseminating information back within operational teams.

6. Other Areas of Safeguarding Activity

6.1 Criminal Exploitation

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

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

6.2 Sexual Safety in the Workplace

The Trust has signed up to the NHS Sexual Safety Charter with a commitment to deliver the ten actions set within the Charter. This activity is being led by colleagues in the TSDFT Health and Well-Being Team with an internal action plan alongside partnership activity.

6.3 Statement from NHS Devon Integrated Care Board (ICB)

NHS Devon ICB has continued to support TSDFT in fulfilling their statutory duties under the Care Act during 2024-2025. NHS Devon is a member of the Torbay Integrated Safeguarding and Inclusion Group which supports both TSDFT and NHS Devon to gain assurance of safeguarding adult processes and activity within the Trust. Professional working relationships between NHS Devon safeguarding team and TSDFT adult social care and health care teams continues to be well established with mutual respect and transparent collaboration and scrutiny.

NHS Devon continues to provide an independent health perspective to whole service safeguarding processes as well as individual enquiries where support with complex cases is appreciated. NHS Devon Safeguarding Team value the expertise and

shared vision with TSDFT Safeguarding Adult Team to foster a culture where individuals can live safely and with dignity.

6.4 Ensuring Quality of Care in Care Homes

Quality and safety oversight is retained by the TSDFT Delivery, Markets, Contracts and Quality Team (DMCQ). Oversight is also supported at Divisional Director management level within the Torbay Council Adult Social Care Commissioning Team.

The DMCQ operates to a Provider Quality Support Framework (PQSF) which includes a 4-tier system of managing provider quality concerns through escalation.

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

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

The PQSF process has proven to be an effective way of managing provider quality within the Torbay market. At the time of writing, 94% of Torbay Care Home providers are placed into BAU and Tier 1.

Quality Assurance Committee

Care Quality Commission (CQC) NHS

Adult Inpatient Survey 2024

Benchmark Report (published September 2025)

Date of meeting	Date report produced
17 November 2025	13 October 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:

Not applicable

Executive summary

The purpose of the report is to present the current CQC patient experience survey schedule and provide a detailed analysis of the results of the NHS Adult Inpatient Survey 2024 Benchmark Report. The paper describes and outlines the improvement plan arising from the NHS Adult Inpatient Survey.

The Committee should note that the Trust's results compare favourably with other trusts, with the following areas of good practice highlighted in the report:

- Patients' individual accessibility needs were considered by staff
- Staff took account of patients' individual dietary needs
- Food was accessible outside of set mealtimes
- Staff clearly explained the reason for any ward changes during the night
- Patients get answers to their questions from nurses in a way they can understand

However, there are improvements to be made, in the following areas:

- Being prevented from sleeping at night due to room temperature
- Quality of information given while on the waiting list prior to admission to hospital
- Staff discussing with patients whether they may need further health / social care services after leaving
- Before leaving hospital, patients knowing what would happen next with their care
- Noise from other patients prevents some patients from sleeping at night

Appendices

Appendix 1 – Link to the full CQC Adult Inpatient 2024 Survey report

Appendix 2 – Trust Comparative Data: TSDFT results for 2024, compared with those from 2023 and 2022

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

Feedback and Engagement Meeting 21 October 2025.

Key recommendations and actions requested

:

The Committee is asked to support the following recommendations:

- Note the schedule of CQC Patient Surveys
- Note the findings from the Adult Inpatient Survey 2024, the areas identified for improvement and the outline plan described in the report
- Note the proposed communication plan

The Committee are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

It is recommended the Committee take satisfactory assurance that this report provides assurance with 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 report provides the committee with a summary of the experience of people who use the services provided by Torbay and South Devon NHS Foundation Trust. The feedback provided to the organisation supports focused work to enable the provision of better experiences of care to those who use our services.

Improving Care Quality: By highlighting issues or areas for improvement, patients feeding back their experience helps the Trust to make changes that lead to safer, more effective treatments, better health outcomes, and positive experiences.

Empowering Patients: When patients share their experiences, they feel heard and involved in their care. This sense of empowerment can boost their confidence in managing their health and in making decisions about their health.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	The experience of our service users, patients and families is a strong indicator of their overall wellbeing
Quality of services provided	Supporting staff to provide care that promotes improved outcomes for patients

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Improved patient experience and patient safety and quality
Leadership and Governance	Not applicable
Performance	Not applicable
People and Culture	Supporting staff to provide care that promotes improved outcomes for patients
Strategy and Business Intelligence	Not applicable
Finance	Not applicable

Risk: Risk ID (as appropriate)

Risk	Risk ID
Risk score: 12	3649 Harm to Trauma Patients and Risk of Poor Patient Outcomes
Risk score: 12	3495 Risk of cancelled activity, resulting in delays in patient pathway and treatment

External Standards affected by this report and associated risks

Regulations / Care Quality Commission
 The CQC use surveys to find out what people think of the NHS healthcare services that they use.
 The results help the CQC assess NHS performance.
 They also use them for regulatory activities such as registration, monitoring ongoing compliance and reviews.

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.

Care Quality Commission (CQC) NHS Adult Inpatient Survey 2024 Benchmark Report (published September 2025)

1. Introduction

The Care Quality Commission (CQC) authorise a programme of Patient Experience Surveys to support their programme of regulation, monitoring, and inspection of NHS acute trusts in England; this programme is called the NHS Patient Survey Programme (NPSP). Survey fieldwork, undertaken through 2024/25, have a publication schedule for late 2025 and early 2026. The NPSP includes the following survey topics relevant to the Trust:

- Adult Inpatient
- Urgent and Emergency Care
- Children and Young Peoples Inpatient
- Maternity

The 2025/26 NPSP survey schedule can be seen in Table 1 below:

2024	Fieldwork	CQC Benchmark reports
Adult Inpatient 2024	closed	September 2025
Maternity 2025	April–July 2025 Closed	November 2025 tbc
Adult Inpatient 2025	Jan–Apr 2026	August 2026 tbc
Urgent & Emergency Care 2026	Apr–Jul 2026	March 2027 tbc
Children/Young Peoples IP/DC 2026	Jul–Oct 2206	March 2027 TBC

Table 1: 2025/26 NPSP survey schedule

This report provides detailed analysis and insight into the 2024 CQC Adult Inpatient Survey results for Torbay and South Devon NHS Foundation Trust (the Trust).

2. Background to the CQC Adult Inpatient Survey

2.1 The CQC benchmarking report, which sets out the Trust’s results from the 2024 Adult Inpatient Survey, was published on 9 September 2025, (see Appendix 1).

2.2 The Trust survey results provide an opportunity to gain greater insight and understanding of the experiences of people who use our adult inpatient services and provides an opportunity to reflect on this valuable feedback. This allows direction and focus on what matters to the people we care for, and to concentrate our improvement work on enhancing their experience, by taking positive action to embed change.

2.3 It is essential that the survey results are shared widely and are understood by staff working across the organisation, as the experience of those people who are inpatients intersects with a broad range of individuals, teams, wards, and services.

Everyone has a role to play in our improvement journey and the plan developed by the Communication Team is both comprehensive and inclusive, to meet this requirement.

2.4 The Trust's Feedback and Engagement Group has a wide membership, drawn both from within the organisation and from local system partners. Members of this group are accountable for overseeing delivery of the improvement plan, developed in response to the survey results. The improvement plan and actions will be regularly monitored, and progress of key targets and milestones reported to Safety and Quality Assurance Group (SQAG).

2.5 The 2024 Adult Inpatient Survey looked at the experience of 62,444 people across 131 NHS trusts, who stayed at least one night in hospital as an inpatient during November 2024 and are aged 16-years or older. Questions included in the survey follow people's journeys from admission to hospital, through their treatment and discharge. Between January and April 2025, 1,250 people at each participating NHS trust were invited to take part in the survey. The Trust received 527 responses; this equates to a 45% response rate which is higher than the average trust response rate of 41% but is a 2% decrease compared with the 2023 survey.

2.6 There were minor changes to the 2024 survey, including three new questions and changes to question wording. However, the 2024 results are comparable with data from the 2020, 2021, 2022 and 2023 surveys.

2.7 To allow for useful comparison, the CQC uses an analysis technique called the 'expected range' to determine if a trust is performing about the same, better, or worse compared with most other trusts in England. To account for the differing patient profiles between trusts, the CQC standardise the results, by applying a weight to individual patient responses to mitigate differences in demographic profile between trusts. This helps ensure that no trust will appear better or worse than another because of its patient profile and enables a fairer and more useful comparison of results across trusts.

2.8 The survey results provide comparison against all trusts (with a response rate of greater than 30) and identify: 'all NHS trusts average'; 'all NHS trusts lowest score'; and 'all NHS trusts highest score'. Responses are scored through a scale of 0-10, with 10 representing the best possible result and 0 the worst. The higher the score for each question, the better the Trust is performing. The results identify the Trust's five best and five worst questions/performance, relative to other NHS trust national averages.

3. Analysis and Discussion

4.

4.1 The demographic profile of the survey respondents reflects what is known for the population served by the Trust.

- Ethnicity – 96% white
- Sex – 49% male, 51% female
- Age – 74% aged 66yrs or older, 18% 51-65yrs of age, 5% 36-50yrs, 3% 16-35yrs
- Religion – 63% Christian, 33% no religion, 2% prefer not to say, 1% Buddhist

- Long-term Conditions – 85% have physical or mental health conditions, disabilities or illnesses lasting, or expected to last, 12 months or more

4.2A summary of Trust performance, compared to other trusts can be seen in Table 2 below, along with Trust performance measured against the Trust’s previous year’s results.

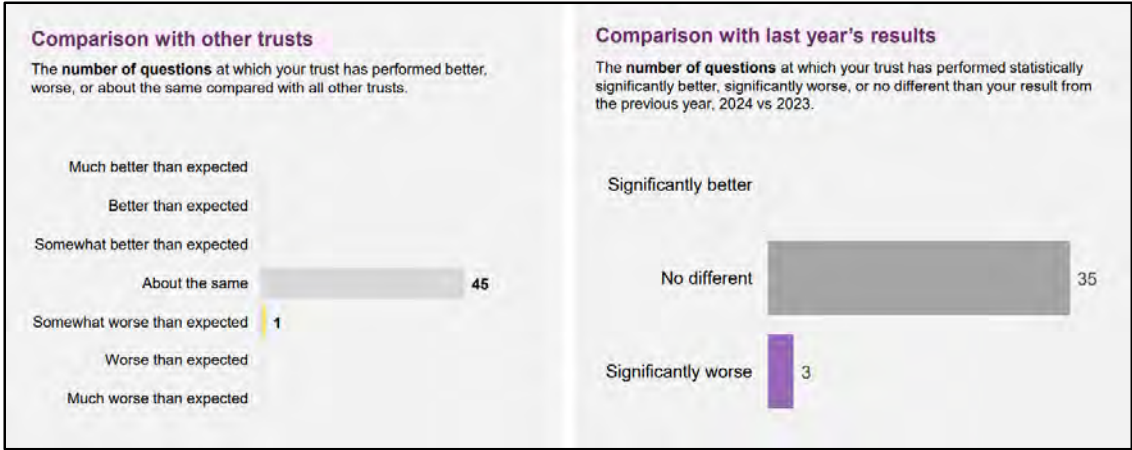


Table 2: Comparison of 2024 local results against other trusts (on the left), and 2024 results for the Trust, compared with TSDFT results from 2023 (on the right)

When compared with other trusts in England, the Trust scored “About the same” for 45 of the 50 questions asked, which is one less than in 2023. On one question the Trust performed “Somewhat worse than expected”. When the Trust is compared with its own previous performance, there was a significantly worse performance on 3 questions, compared with 2023. However, most comparisons (n=35) showed no significant difference on the previous year.

3.3 The ‘Top 5’ areas for the Trust (Table 3) fell into four domains:

- a) ‘Individual needs’ (2 questions)
- b) ‘Basic needs’ (1 question)
- c) ‘The hospital and ward’ (1 question)
- d) ‘Nurses’ (1 question)

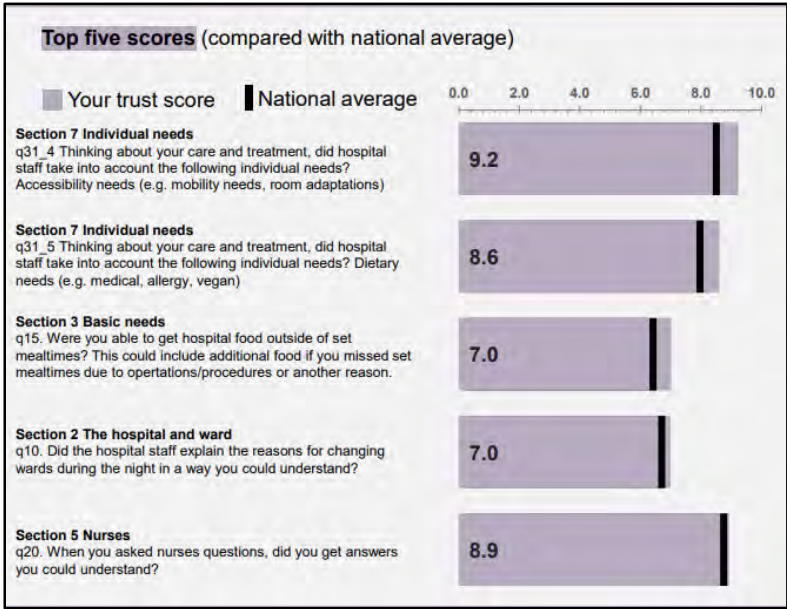


Table 3: 'Top 5' - Best performance relative to the national trust average

3.4 The 'Top 5' questions are explored further in this section.

Individual needs (section 7)

Please note, no comparative data over time is available for this section, as the questions included in section 7 are new to 2024.

Q.31 _4 Thinking about your care and treatment, did the hospital staff take into account the following individual needs? Accessibility needs (e.g. mobility needs, room adaptations)

This score is above the national average and reflects the Trust's commitment to treating patients as individuals, and the effort made by staff to provided individualised care.

Q.31 _5 Thinking about your care and treatment, did the hospital staff take into account the following individual needs? Dietary needs (e.g. medical, allergy, vegan)

This score is again above the national average and is a positive reflection on both the work of the ward-based clinical teams and that of the Trust's catering team, to facilitate and provide for a variety of dietary needs on an individual basis.

Basic needs (section 3)

Q15. Were you able to get hospital food outside of set mealtimes?

The Trust's Nutrition and Hydration Steering Group, whose aim is to ensure all patients receive the right nutritional and hydration support whilst in hospital, have continued to support staff to maintain a focus on safeguarding patients' nutritional and hydration needs. The Trust introduced an audit in 2022 with a focus on nutrition, hydration and assessment to enhance the support provided to patients.

Q15 was in the Trust's 'Top 5' results of both the 2021, 2022 and 2023 surveys. That this question is included in our best performance once again, with the same score as in 2023 (improved from 6.7 in 2022) is a testament to how embedded the nutrition and hydration needs of patients are in the daily practise of the professionals caring for them. That this practise is deep-rooted is affirmed by the responses to Q31_5 in this year's results, which further demonstrates that our staff support patients to meet their individual dietary needs.

The hospital and ward (section 2)

Q10. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

Staff work hard not to move patients overnight and this result reflects the fact that when patients are being transferred, they are well supported by clear explanation and communication. This question was also in the 2021 and 2023 'Top 5' and its inclusion, although with a lower score this year (8.1 in 2023) continues to provide assurance that the processes in place, relating to moving patients overnight, are clear and are being followed.

Nurses (section 5)

Q20. When you asked nurses questions, did you get answers you could understand?

This question has not featured in the 'Top 5' previously, but it is reassuring to see it included as it adds assurance to the results from question 10 above, regarding the quality of communication between staff and patients.

3.5 The 'Bottom 5' areas for the Trust (Table 4) fell into three domains:

- 'The hospital and ward' (2 questions)
- 'Admission to hospital' (1 question)
- 'Leaving hospital' (2 questions)

The first two domains also featured in the Trust 'Bottom 5' of the previous two reports.

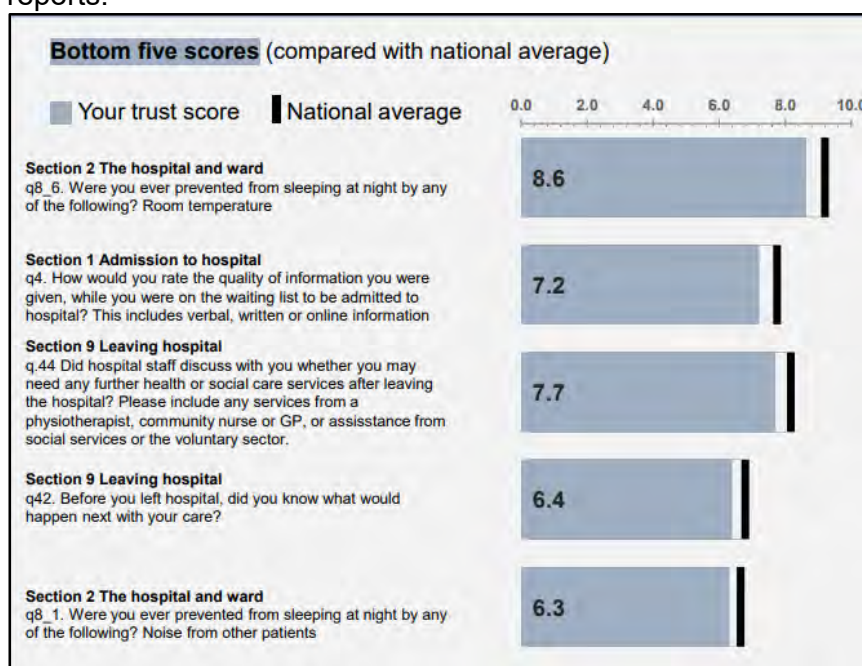


Table 4: 'Bottom 5' - Worst performance relative to the national trust average

3.6 The 'Bottom 5' questions are explored further in this section.

The hospital and ward (section 2)

Q8_1. Were you ever prevented from sleeping at night by any of the following? Noise from other patients

Q8_6. Were you ever prevented from sleeping at night by any of the following? Room temperature

This question is asked with multiple options for what may impact on the patient's ability to sleep; the options are listed below:

- Noise from other patients
- Noise from staff
- Hospital lighting
- Room temperature
- I was not prevented from sleeping

Trust results for this section were below the national average apart from c) hospital lighting. The results for a) noise from other patients, and d) room temperature, were included in the Trust 'Bottom 5'. The impact of room temperature on sleep is the response where the Trust performed 'somewhat worse than expected' when compared with all other Trusts.

Following an improvement noted in the 2023 report, the 2024 results have identified an increase in the number of factors patients reported as negatively impacting their ability to sleep while in hospital. The 2022 report identified issues relating to noise from staff, noise from other patients and hospital lighting as impacting on their ability to sleep and some of these factors remain an issue in 2024.

Improvement works previously undertaken included the use of sleep packs, dimmer lights, and soft door closures, which was thought to explain the improvement noted in 2023. Ongoing work includes observations of care and a re-launch of sleep well packs. The 'supper and settle' initiative is planned, with the SOP written, and support of a task and finish group which may further address some of the issues noted.

Hospital temperature and noise in relation to other patients may prove more challenging issues to mitigate as they depend on individual preference regards temperature, and on the diagnosis, clinical condition and capacity of the patient trying to sleep, as well as of the other patients in their vicinity.

Associate Directors of Nursing and Professional Practice will continue to collaborate with their Matrons and Ward Managers to target further improvement potentialities.

Admission to hospital (section 1)

Q4. How would you rate the quality of information you were given, while you were on the waiting list to be admitted to hospital? This includes verbal, written or online information

The Trust is committed to reducing long waits for planned care. There is a weekly referral to treatment (RTT) meeting that discusses all long wait patients and escalates issues around non-delivery. This is coupled with the monthly Planned Care Improvement Group which has governance and oversight of improving and delivering the planned care recovery programme, this includes several quality improvement streams related to the specialties under the most pressure, including Cancer standards, long waits and urgent patients.

Work was focussed on ensuring that, by the end of June 2024, no one would be waiting more than 78 weeks, which was missed in several challenged specialties such as Trauma & Orthopaedics (T&O), Ear, Nose and Throat (ENT) and Oral and Maxillofacial Surgery (OMFS) and Gynaecology. There was also the target of the end of September 2024, that no patients would wait more than 65 weeks, which again was missed predominately in those same specialities, alongside a few others with smaller numbers like Endocrine, Urology and Upper Gastro-Intestinal surgery.

The previous target of end of March 2025, where no one would be waiting longer than 52 weeks was reset to Q2 in 2025/26. A consequence of this sustained focus is that waiting times across planned care have continued to reduce. This is despite the challenges encountered because of national industrial action which have served to delay the planned recovery programme and increasing pressure from higher

referrals observed in cancer specialities and the pressure this puts on routine, long waiter in areas like ENT, Gynaecology and OMFS. This also includes challenges from non-elective care such as increased trauma and fracture clinic referrals in T&O. Together with staff sickness, vacancies and a challenging financial climate, this has led to delays in the progress of long wait recovery. NHS England have confirmed that Planned Care is no longer in the tiered monitoring measures, as our RTT as improved.

A review of current information being communicated to patients regarding waiting times, discharge, and follow-up, is underway.

Leaving hospital (section 9)

Q42. Before you left hospital, did you know what would happen next with your care?

Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Work continues to ensure that the experience of patients, at and after discharge, is understood. The Patient Discharge Group continuously monitors both the quality and quantity of information provided to patients on discharge and promptly revises this as required. The work around patients' experience of discharge continues with a sample contacted after discharge to provide contemporaneous feedback to the Trust, supporting dynamic and timely review of the discharge processes and procedures.

The findings of this survey report have been shared with Associate Directors of Nursing and Professional Practice, who will discuss the findings with their Matrons and Ward Managers, to further explore this programme of work. It will also be shared with the Patient Discharge Group.

3.7 Alongside the 'Top 5' and 'Bottom 5', the benchmark report provides details of how the Trust compares with other trusts within the same NHSE region. This section of the CQC report notes if the Trust has been identified as sitting within the regional group of trusts with the highest, or lowest scores for each section of the survey. Results can be seen in Table 5 below, where the scores from the previous two surveys, 2022 and 2023, have been included for comparison.

Trust rankings arising from the 2024 results are disappointing. Results from the 2022 survey saw the Trust achieve the highest regional ranking over three sections of the survey. While that was not replicated in 2023, the Trust achieved the highest regional ranking for one section of survey results. In these latest results, the Trust has not achieved the highest regional ranking for any section of the 2024 survey.

Further analysis shows that although only holding the highest ranking for one section in 2023, the Trust was in the top 5 for 8 of the 10 sections that were ranked (some sections are not comparable or were new, so not all 12 sections were ranked). The 2024 results place the Trust in the Top 5 for only 2 of the possible 11 sections available (one section was new in 2024).

Conversely, while in the lowest scoring group for only 2 sections in the 2023 survey, the Trust was in the lowest 5 score group for 7 of the possible 11 sections.



		Current - 2024	Previous - 2023	Previous - 2022		Current - 2024	Previous - 2023	Previous - 2022
Section	Section Title	'Highest score group' TSDFT Score & (rank)	'Highest score group' TSDFT Score & (rank)	'Highest score group' TSDFT Score & (rank)		'Lowest score group' TSDFT Score & (rank)	'Lowest score group' TSDFT Score & (rank)	'Lowest score group' TSDFT Score & (rank)
1	Admission to hospital					6.6 (=3 rd lowest)	6.2 (the lowest)	6.3 (the lowest)
2	The hospital and ward		7.8 (=2 nd)	7.8 (=2 nd)		7.3 (=3 rd lowest)		
3	Basic needs	8.2 (=3 rd)						
4	Doctors		9.0 (=1 st)	9.0 (=2 nd)		8.8 (=2 nd lowest)		
5	Nurses	Neither top nor bottom 5	8.5 (=3 rd)	8.6 (=1 st)		Neither top nor bottom 5		
6	Your care and treatment		8.3 (=3 rd)	8.4 (=2 nd)		8.3 (3 rd lowest)		
7	Individual needs	No available comparative data				No available comparative data		
8	Virtual Wards	7.2 (4 th)	7.4 (=2 nd)	N/A New - 2023				
9	Leaving hospital			7.3 (1 st)		7.0 (=4 th lowest)	6.8 (=2 nd)	
10	Kindness and compassion	Neither top nor bottom 5	9.2 (=3 rd)	N/A New - 2023		Neither top nor bottom 5		
11	Respect and dignity		9.3 (=2 nd)	9.4 (=1 st)		9.1 (=2 nd lowest)		
12	Overall experience		8.3 (=3 rd)	8.3 (=2 nd)		8.2 (=3 rd lowest)		

Table 5: Trust performance for each survey section, relative to other trusts within the same NHSE Region

3.8 The Trust's lowest ranking regional scores are section 4 'Doctors' and section 11 'Respect and dignity' which the Trust was ranked first and second highest scoring in the 2023 results. The 2024 survey places the Trust in the lowest score group for both, and these are the Trust's lowest positions this year.

The biggest change in the Trust's regionally ranked performance can be seen in section 4, 'Doctors'. Last year the Trust was ranked 1st in the region, in 2022 the position was 2nd in the highest score group. This year the Trust is ranked as the equal second lowest scoring organisation in the region. Performance for these section questions can be seen in table 6 below. As these results show, the Trust's scores for questions 17 and 19 are above the national average and for question 18, only just under the average.

The Trust's results for section 11 'Respect and dignity' are aligned to the national average but represent a decline in performance. Although close to the national averages for both sections, these results placed the Trust in the lowest, rather than highest score groups regionally. The results for question 18 also represent a statistically significant decrease for the Trust, compared with our results from both 2022 and 2023.

Section 4 'Doctors' Survey Questions	Trust performance	National average	Lowest national score	Highest national score
Q17. When you asked doctors questions, did you get answers you could understand?	8.8	8.7	8.0	9.8
Q18. Did you have confidence and trust in the doctors treating you?	8.9	9.0	8.4	9.8
Q19. When doctors spoke about your care in front of you, were you included in the conversation?	8.8	8.7	8.1	9.6
Section 11 'Respect and dignity' Survey Question	Trust performance	National average	Lowest national score	Highest national score
Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.1	9.1	8.4	9.8

Table 6: Trust performance for sections 4 and 11, relative to all other trust performance in England

3.9 The Trust's best improvement in comparative regional scores was seen in section 1, 'Admission to hospital' where, in both 2022 and 2023 the Trust was ranked as the lowest scoring organisation regionally. The 2024 results demonstrate an improved position both for this section, and for section 9, 'Leaving hospital', which was the second of the two low scoring results last year.

3.10 The closing section of the benchmark report allows the Trust to assess its own performance over time and to compare the results of the most recent survey with Trust's previous results (where the CQC has deemed the questions are comparable). Where comparable data is available, statistical significance testing is conducted against the 2022 and 2023 survey results for each relevant question.

Where a change in results is noted as 'significant', this indicates that the change is not due to random chance but is due to something particular within the Trust.

3.11 The following questions were noted to have statistically significant decreased scores in 2024:

Doctors

- Q18. Did you have confidence and trust in the doctors treating you?

The latest results for this question are noted to be a statistically significant change compared with both 2023 and 2022 results.

The hospital and ward

- Q8_6. Were you ever prevented from sleeping at night by the room temperature?
- Q10. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

These 2024 results reflect a significant decrease compared with 2023.

Basic needs

- Q16. During your time in hospital, did you get enough to drink? (significant change 2024 vs 2022).

Leaving Hospital

- Q35. To what extent did staff involve you in decisions about leaving the hospital? (significant change 2024 vs 2022).
- Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving the hospital? (significant change 2024 vs 2022).

The 2024 responses for questions 16, 35, and 44 above are not statistically significant decreases compared with those from 2023, but they do represent significant changes compared with the 2022 results.

Further details and scores for the above six questions can be found in Appendix 2.

3.12 While any decrease in scores is disappointing, it is worth noting that the Trust scores for these questions remain broadly in line with the national average. The exceptions to this are Q8_6 and Q44 both of which have significantly decreased when compared to previous Trust results, but they also feature in the Trusts 'Bottom 5' where Trust performance is compared with all other Trusts in England. Interestingly, and although also demonstrating a significant decrease compared with the Trust's 2023 survey results, Q10 also features in the Trust's 'Top 5', where it is compared with all English Trusts.

3.13 Perhaps the most pressing result for further exploration is Q18, reflecting a lack of confidence and trust in doctors. While this did not feature in the Top or Bottom 5, it represents a worsening result for the Trust regionally, and reflects statistically significant change, compared with both the 2023 and 2022 results.

5. Conclusion

4.1 The 2024 CQC Adult Inpatient Survey clearly identifies successes and areas for improvement. Headline successes include the positive recognition by patients that they are treated as individuals, with their accessibility and dietary needs being accounted for. Another key area to celebrate is that of communication with patients agreeing that staff explained why they were changing wards at night and that nurses were responsive to patient questions, answering in such a way that the patient could understand. These are important perspectives from which the Trust can take assurance and celebrate.

4.2 Headline areas for improvement cover the three sections in the 'Bottom 5': admission to hospital; the hospital and ward; and leaving hospital. The quality of communication relating to the experience of patients waiting to be admitted to hospital, and those leaving hospital, requires further improvement work and both were features of the 2023 survey. That patient sleep was impaired by room temperature, and noise from other patients is disappointingly a re-emerging theme. Further work is required to improve our understanding of the factors impacting the quality of patient sleep.

4.3 The Trust's communication team will be included in disseminating the results of the 2024 CQC Adult Inpatient Survey across the organisation. Wider plans include:

- Chief Executive Officer, Chief Nurse and Chief Medical Officer to provide headline survey results within their communication strands
- Article in ICO News sharing top lines and action being taken, with links to published reports
- Highlight top lines in Healthy Futures newsletter
- Feedback and Engagement Group to develop and monitor action plans
- Development of a Trust screensaver, sharing key findings with all staff

4.4 The results provide the Trust with real reasons to celebrate what is being done well, to understand where we are performing comparably with other trusts and where we need to focus effort and improvement work to address the deficits identified. The key focus must be to address the challenges that adult inpatients, who contributed their valuable feedback for this survey, have very clearly identified and which the Trust can, and will, improve upon. These will form part of the Care Group meetings which feed into the monthly Feedback and Engagement Group, for oversight of improvement and action plans.

6. Recommendations

The Committee is asked to support the following recommendations:

- Note the CQC NHS Patient Survey Programme schedule and proposed publication timeframes
- Note the findings from the CQC Adult Inpatient Survey 2024 and the five areas for improvement, with outline plan
- Note the proposed communication plan to disseminate the 2024 survey findings across the organisation

Assurance and Recommendations

1. Report provides overview of recommendations on areas of focus.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
3.0 Analysis and Discussion	Satisfactory	Static



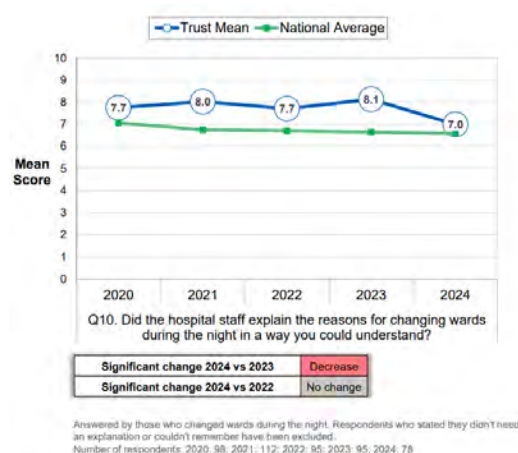
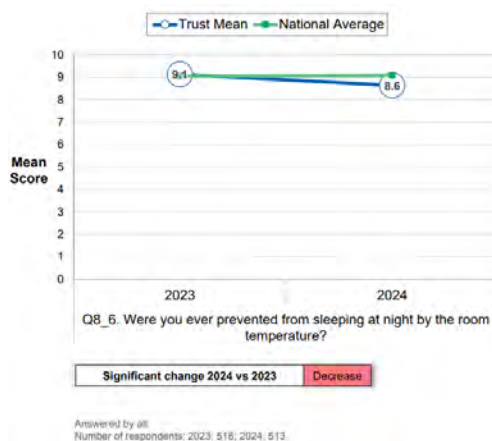
Appendix 1

Link to the CQC Adult Inpatient Survey Report 2024

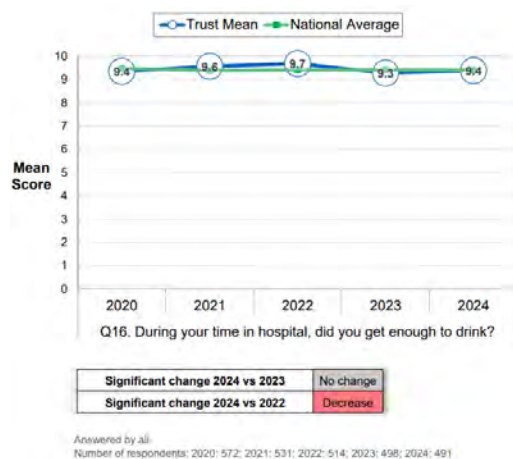
[Torbay and South Devon NHS Foundation Trust - Care Quality Commission](#)

Appendix 2 Trust Comparative Data: TSDFT results for 2024, compared with those from 2023 and 2022

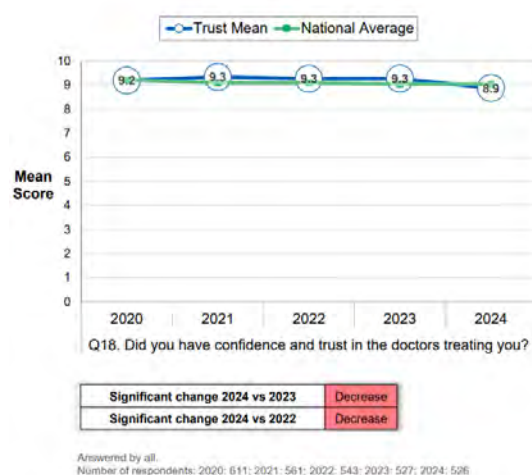
Section 2. The hospital and ward (Q8_6; Q10)



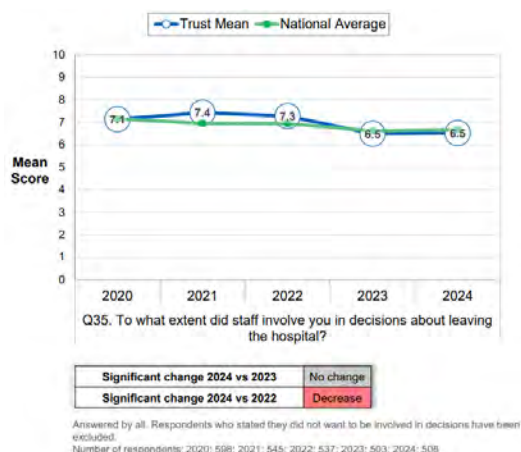
Section 3. Basic needs (Q16)



Section 4. Doctors (Q18)



Section 9. Leaving hospital (Q35; Q44)



Board of Directors

Advanced Practice Strategy

Date of meeting	Date report produced
26 th November 2025	17 th October 2025

Author(s)		Report approved by	
Name and title:	Rhoda Allison, DCAHP	Name and title:	Nicky McMinn, Chief Nursing Officer
Phone:		Date:	15 th October 2025
Email:	Rhoda.allison@nhs.net		

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

NA

Executive summary

- This is the Trust Strategy for Advanced Practice.
- It is presented for information having been previously reviewed by the Quality Assurance Committee
- This work should form a cornerstone of our approach to modernising the workforce.

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

Trust advanced practice strategy

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

Advanced practice steering group- approved
People Committee- approved

Key recommendations and actions requested

The Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed and that there is a clear plan for the development of advanced practice within the Trust.

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

Enables us to develop a more resilient and modern workforce model

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	
People and Culture	Workforce development & modernisation
Strategy and Business Intelligence	
Finance	

Risk: Risk ID (as appropriate)

Risk	Risk ID
NA	

External Standards affected by this report and associated risks

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 Foundation Trust



ADVANCED CLINICAL PRACTICE STRATEGY

2024



INTRODUCTION

Advanced practice has been recognised, in its current form in the NHS since 2017. It is defined as:

‘A level of practice characterised by a high degree of autonomy and complex decision making.... that encompasses the four pillars of clinical practice, leadership and management, education, and research.’ (NHSE, 2024).

Advanced practitioners come from a range of professional backgrounds such as nursing, allied health professionals and pharmacy. They are experienced, registered healthcare professionals educated to master’s degree level, who have developed the skills and knowledge to allow them to take on expanded roles offering advanced assessment, and care planning.

The NHS Long Term Workforce Plan (2023) has highlighted the lack of a sufficient workforce and proposes a focus on expanding advanced practice roles to meet future healthcare demand.

This paper summarises the current extent of Advanced Practice in the Trust and suggests how the development of future roles could be scoped and supported. It describes the process of training and accrediting Advanced practitioners, the governance of Advanced practice, post-qualification education and support, and further development including routes to consultant nurse, midwife and AHP roles.

It makes a number of recommendations for further work.



What is Advanced Practice

The focus of advanced practice is on developing experienced staff to offer an expanded scope of practice, underpinned by four key pillars:

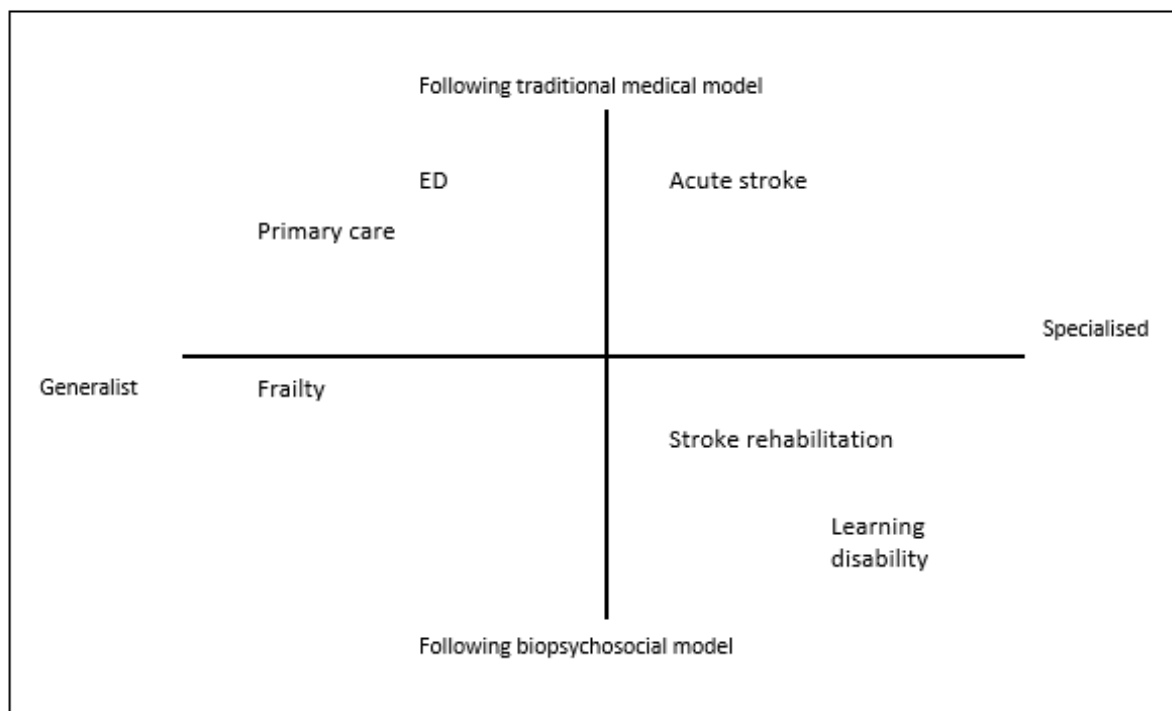
- Clinical practice - offering advanced assessment skills and support of care
- Leadership - leading new initiatives and service redesign
- Education - delivering education to a wide range of people
- Research - critically engaging in research and evaluation

However, within these pillars, there is great variety in Advanced Practice roles. NHS England Workforce, transformation, and education (NHSE WT&E) developed the graphic in Figure 1 to demonstrate the variety depending on whether roles follow more of a medical model or a social model, and the balance of generalist skills against very specialist skills.

For example, roles following a more medical model do not directly replace medical staff but can support some activity that has traditionally fallen to medical staff. This may include providing a medically based assessment, referral for imaging, care planning and prescribing of medicines. Whereas a role following a more social model is likely to incorporate advanced clinical skills using different approaches including holistic assessment.

The national expectation is that Advanced Practitioner job plans contain 80% clinical time and 20% of time for supporting professional activities (SPA).

Figure 1: WT&E graphic of Advanced Practice roles and examples of variety





Current Advanced Practice in Torbay and South Devon NHS

We currently have a number of both qualified and trainee Advanced Practitioners.

The existing roles have developed historically in response to meeting workforce challenges within discrete service areas.

Current recognised roles are present in the following areas (some departments have multiple Advanced Practice roles):

Qualified non-medical consultants	Qualified advanced practitioners	Trainee advanced practitioners
Frailty and healthcare of older people Musculoskeletal	Cancer care Emergency Department Paediatrics Stroke rehabilitation	Acute stroke Breast case unit Emergency Department Gastro-enterology Haematology Healthcare of older people Musculoskeletal therapy Ophthalmology Surgical receiving unit

These existing roles are making a current difference to patient care, predominantly improving access to care. Advanced Practice roles are also a way of retaining very experienced clinical nurses and Allied Health Professionals (AHPs), who may otherwise be lost to the NHS.



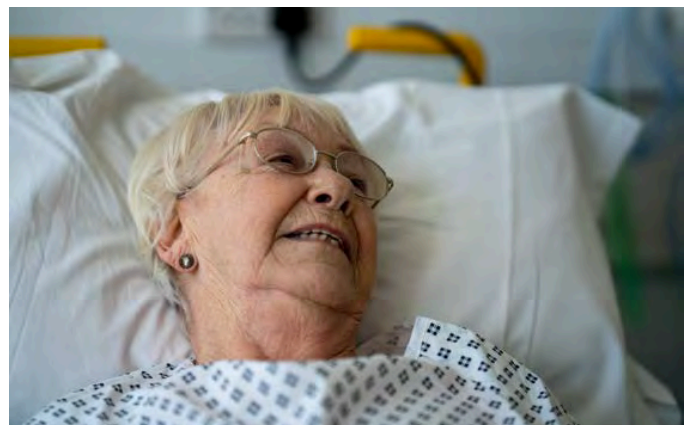
The future development of Advanced Practice in Torbay and South Devon NHS

The NHS Long Term Workforce Plan (2023) has recommended the significant expansion of Advanced Practice roles to assist with meeting future demand for healthcare.

Clearly there is potential to develop further roles to meet some of the current challenges within our organisation. Areas that may be suitable for the development of Advanced Practice roles include those with increasing service demands or above target referral to treatment waiting times, those requiring significant clinical redesign, or those with difficulty in recruiting to medical posts or with significant locum spends.

At present Devon Integrated Care Board (ICB) has identified several priority areas for development of Advanced Practice across Devon. These include:

- Critical care
- Diagnostic imaging
- Frailty, intermediate care, and virtual wards
- Learning Disabilities and autism
- Mental Health
- Musculoskeletal services
- Respiratory
- Ophthalmology
- Social care



In the absence of a Trust clinical strategy that would give additional clarity to our local priorities, we recommend that we continue to follow the ICB priority areas, whilst scoping any local medical pressures that may be supported by the development of advanced practice. This does not exclude other clinical areas from developing roles, and other priority areas may arise as our clinical strategy emerges.

Agreeing the development of roles can be complex, requiring multiple stakeholders. Devon ICB offer stakeholder workshops to facilitate discussions with stakeholders, consider workforce transformation and agree future direction. In line with the ICB priorities, we have currently booked these workshops in three clinical areas in early 2024: respiratory physiotherapy, diagnostic imaging and intermediate care.

Recommendation 1:

Provide three workshops on developing AP practice in respiratory, IC and diagnostic imaging (in line with ICB priorities) and scope local priorities.

Recommendation 2:

The Medical Workforce lead provides a summary of areas with significant medical locum spend or difficult recruitment for the Deputy Chief AHP, Deputy Chief Nurse and Deputy medical directors to agree any additional areas where Advanced Practice development is a local priority.

When service leads identify potential roles, they will need to then a) complete a business case, and b) obtain sign off that the role fulfils the requirements of advanced practice.

To progress to an offer of a master's apprenticeship for an Advanced Practice trainee, or for recognition of an existing qualification, all new Advanced Practice roles are authorised by the Deputy Chief AHP who leads on Advanced Practice. The process followed is shown in our Advanced Practice policy.

Training and recruitment of Advanced Practitioners

Historically there was not an agreed national development programme to support Advanced practice but there has been a move to credential master's programmes that lead to an Advanced Practice qualification.

Any new Advanced Practitioners now undertake this programme. This is largely through an apprenticeship completing a master's degree in Advanced Practice or for those historically employed in advanced practice roles that meet the criteria through the NHSE WT&E e-portfolio route. During this time, trainees are supported by a Coordinating Educational Supervisor as per the requirements of the apprenticeship and module specific prerequisites.

Advanced Practitioners are employed at Agenda for Change (AfC) Band 8a when they are qualified, and at Band 7 during their training. After successful completion of the training, the trainee will automatically move to the qualified Advanced Practice post without the need to reapply.

Qualified Advanced Practitioners who have trained externally, will be expected to demonstrate their competency and capability through a credentialing process. This will be reviewed by the individual's allocated clinical supervisor and line manager. This process will highlight any learning needs, to enable the person to work safely and effectively within our organisation, while recognising existing capability.

Historically members of staff may have left our employment during training or stood down their training. It is recommended that there is a stronger governance process and oversight of trainees.

Recommendation 3:

The apprenticeship lead maintains an up-to-date log of all staff undertaking Advanced Clinical Practices qualifications.

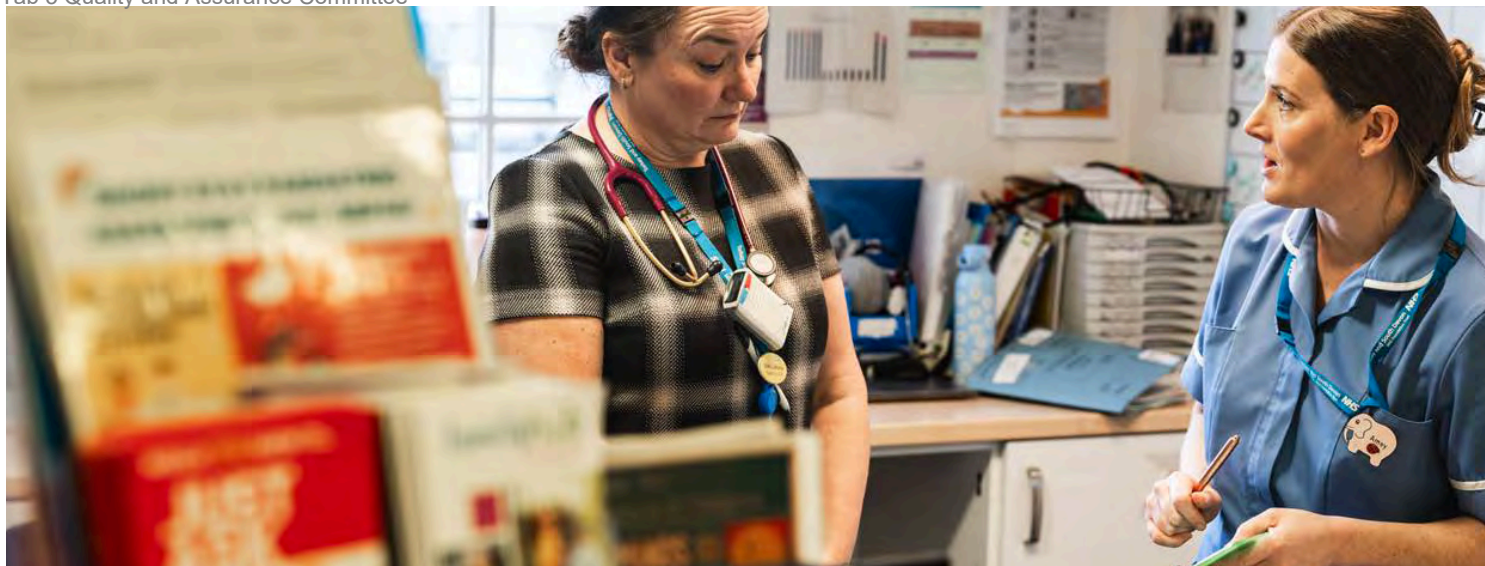
Post qualification support, supervision and accountability

Historically, there have been a range of models of support and line management of Advanced Clinical Practitioners. Moving forward, to ensure clear reporting and accountability, the Advanced Practitioner should be professionally accountable to the lead for their original profession and to the ADNPP of the relevant care group. Post qualification they will continue to receive regular supervision from a clinical supervisor.

The Advanced Practitioner will develop, with their clinical supervisor and line manager, a capability set which describes the skills required across the four pillars of the role. Support and supervision will be directed at the maintenance of this capability set.

It is the responsibility of all Advanced Practitioners to ensure that they are maintaining up to date practice across the four pillars of their practice. All Advanced Practitioners must maintain a contemporary portfolio, which contains documented evidence of working across all four pillars and provides evidence to meet the capability set.

All Advanced Practitioners will undertake an annual achievement review with their clinical supervisor and line manager. At this review the Advanced Practitioner will use their portfolio of evidence to demonstrate their ongoing capability to practice. Further detail is provided in the policy to support Advanced Practice.



Governance of Advanced Practice

NHSE WT&E make several recommendations for the governance of Advanced Practice which we are in the process of implementing.

We will maintain an up-to-date record of all staff in Advanced Practice roles, and there is clear oversight of the whereabouts of staff working in Advanced Practice. There should be clarity of Advanced Practice roles with clear uniform and statement of roles and responsibilities.

To ensure clear reporting and accountability, the Advanced Practitioner will be ultimately professionally accountable to the lead for their original profession and to the ADNPP of the relevant care group. These professional leads are expected to liaise closely with any medical or clinical supervisors, and the ADNPP is expected to maintain oversight of Advanced Practice within their portfolio.

Advanced Practitioners themselves are expected to actively participate in ongoing clinical audit of their practice as part of their commitment to evaluation, and present results of this at their annual review. Other Trust systems for review of practice via clinical audit will also apply.

Concerns around any trainee or qualified Advanced Practitioners competencies/fitness to practice would follow our organisational policies.

Recommendation 4:

The Nursing/ AHP Workforce lead will maintain an up-to-date log of each qualified ACP, their area of practice, and the arrangements for the ongoing governance of their role (including their named ADNPP).

Recommendation 5:

ADNPPs who oversee Advanced Clinical Practitioners will provide robust evidence of the governance of these roles.



Further development of Advanced Practice

Advanced practice is an expanded scope of practice, and for some staff this will be their optimum role. However, there is also opportunity to progress roles and practitioners. Examples include the development as a Consultant Practitioner (Nurse or AHP). These roles continue to cover the four pillars of practice and have been defined as having:

- 'Expertise in four domains necessary for enabling quality care from micro, to meso and macro levels of the system,
- The key skill set for systems leadership and systems transformation aided by clinical credibility in own professional field
- Clinical academic role as an embedded researcher' (NHSE 2024).

At present there is only one trainee Consultant level role within the Trust, although historically there were more.

Recommendation 6:

It is recommended that the current application of the research pillar in Advanced Practice is explored to map out current Advanced Practitioners achievements in this domain.

Recommendation 7:

Further work is required to understand the potential to develop further non-medical consultant roles, commencing in areas where there are established ACPs.



Quality Assurance Committee

Perinatal Governance and Safety Report (1 September 2025)

Date of meeting	Date report produced
17 th November 2025	10 th November 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
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 committee 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 to 9 out of 10 safety actions

Appendices

Please list any appendices to the main report

Committees 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

- 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 requirement to support participation in the Equity and anti-discrimination programme
- Note the current position of compliance against the Maternity Incentive Scheme with full compliance anticipated in March 2026
- Note the Compliance with BAPM standards for neonatal medical workforce
- Note the Birthrate Plus report recommendations of an increase in midwifery establishment of 1.11 - 3.81 WTE

Note the findings identified through the triangulation of the NHSR litigation Scorecard

The Committee 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'?

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	
Sustainable and efficient use of resources	

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	X
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

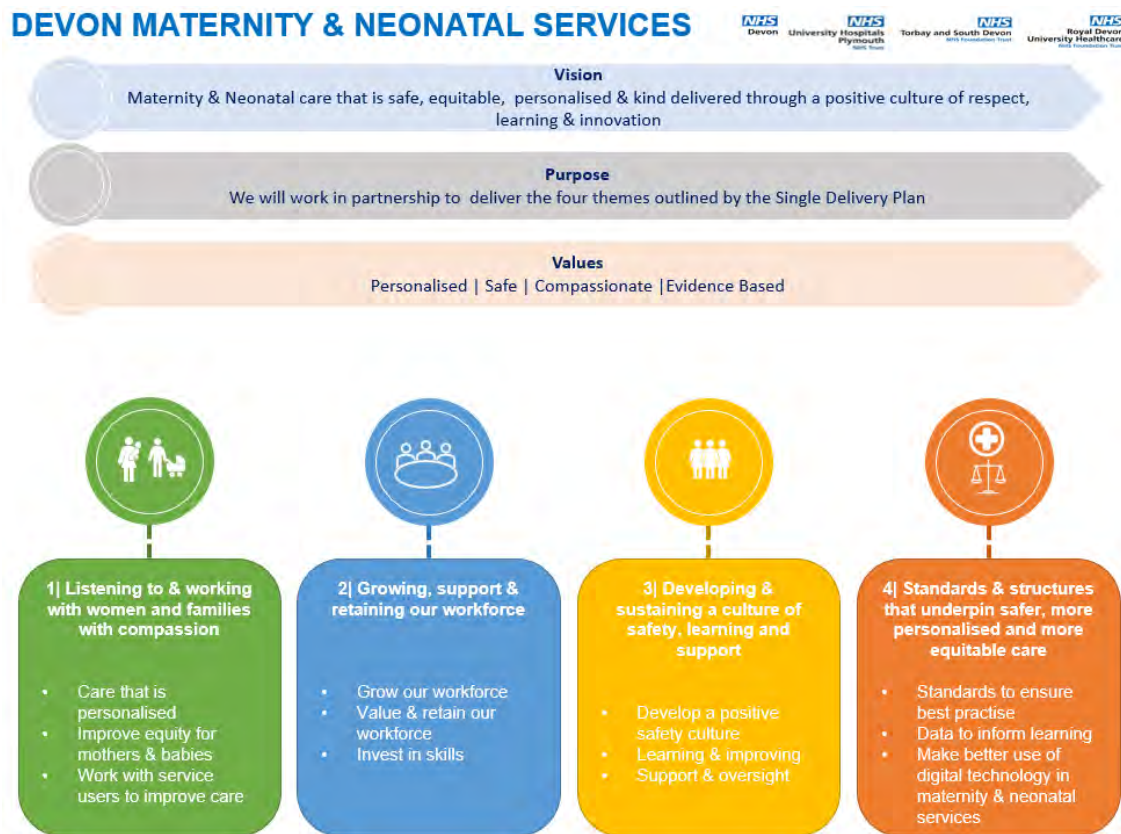
NHS England licence and regulations
National policy, guidance

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 September-October 2025

Introduction and background



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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 Oversight 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- <i>including births <27 weeks at units <Level 3 NICU</i> 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 Committee 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 committee (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. Positive comments are in relation to staff care and communication.	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 no concerns raised. Complaint was regarding outpatient care and inpatient stay across the antenatal ward, labour ward and postnatal ward.	Investigation ongoing, recommended to offer woman to meet with leadership team to discuss as feel that written response will not be satisfactory.	Complete response either following meeting or by letter dependent upon woman's wishes.	Dec 2025
3) Devon Maternity & Neonatal Voice (MNVP) projects/ additional comments	enchmarked themselves against the national standard and identified they cannot meet all the requirements for MIS without additional resources	To meet all the requirements of MIS the trust has identified the need for further MNVP resources and this has been escalated via PQSM and the ICB board and an action plan has been devised.	Additional funding has been received by the DLMNS and procurement of additional MNVP resources are in progress including a Neonatal lead. Current DMNVP are continually to attend all trust meetings as required and to review and update the current feedback mechanisms.	Audit of compliance in December 2025. Submission of MIS March 2026.
4) CQC Maternity survey 2025	Preliminary results released. Final report due Nov 2025.	Preliminary results from patient perspectives indicate an improvement for service user satisfaction	Action plan to be produced in collaboration with the DMNVP. Analysis of survey results	2025 action plan to be produced by Feb 2026. Results to be presented to Trust board and

		with the service	and free text feedback	Feedback and Engagement group

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
Safety Champion Walkaround September and October 2025	A service user shared positive feedback on continuity and clear planning following a previous pregnancy bereavement. Feedback from (MNVP) on improving engagement with vulnerable groups. Positive feedback on services; no themes of women/families not feeling heard. Kind and friendly culture reported.
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. Safety Champion Walkaround- September and October	Some midwives highlighted a supportive and a kind culture with acknowledgement of	Assurance that works to improve civility via SCORE culture	Continue focusing on culture. Consider safety champion	Ongoing

	good collaborative working between obstetric and midwifery teams Staff frustration over limited midwife posts for newly qualified midwives	survey is having some impact Uncertainty for learners in practice	attendance at MDT handover. Working with region to maximise vacancy opportunities for next year.	
2) Listening events with Maternity Improvement Advisor	Inconsistent working practices of consultant workforce when on call and some concerns re: communication styles	Maternity staff feeling frustrated around processes that impede effective working practice	Support the development of consistency and improved communication during maternity ward rounds and further support team to understand culture. Response to feedback from staff related to culture being planned. Improvement Advisors met with Clinical Lead, Deputy Medical Director and Chief Medical Officer. Obstetric Improvement Advisor to	

			continue with medical engagement. On site visit in November.	
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
September 2025	Board Safety champion- NED Maternity Safety Champion	Visit to labour ward. Met with service user and staff. Discussion focused on Quality Improvement Projects and collaborations using ATAIN/TCW model in maternity care. Also focused on relationships between midwives and doctors.
October 2025	Maternity Safety Champion. Neonatal Safety Champion. Board Safety Champions (CNO and NED)	Visit to SCBU: Explored the potential for neonatal outreach model to reduce length of stay and enable earlier discharge – better for babies and families. Discussed staffing model challenges and the need for more than one neonatal nurse for resilience.

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 multi-skilled 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.	1	
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.	7	Activity levels have been high in Sept and Oct leading to delays in the IOL process, women are counselled about this antenatally and communication around delays with women if necessary is maintained.

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	4 – not providing 1:1 care 2 – 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. Assurance can be provided that any times that the supernumerary status of the LWC is challenged are kept to a minimum and all clinical measures are taken to ensure that safety is maintained. Quick changes in acuity within a small unit overnight are difficult to manage without challenging the supernumerary status of the LWC.
Retention Issues	0	No concerns.
Obstetric cover on Labour Ward	Quarterly audits are performed on consultant attendance when called for clinical support In both Q1 and Q2 of 25/26 the consultant attended when required based on the RCOG guidance. This data has been presented at Quadrumvirate/	All gaps were filled within the existing Obstetric workforce. Long term locum cover required.

	safety champion meeting	
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	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.	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 Nov 25.
Nursing -	QIS as % of registered workforce is 58% (BAPM min 70%) New recruit will improve this in next reporting period	1.0 WTE B6 starting in early Nov 25. Further B6 vacancy did not attract any applicants that could be shortlisted and will be going back out to advert again. Ongoing workforce establishment review for consideration of structure redevelopment to ensure it meets the service needs now and in the future. Organisational change paper and process underway.
Medical staffing		Use of Practice Educator and Enhanced Neonatal Nurse Practitioner (ENNP) in clinical numbers and staff picking up additional hours and bank shifts.

	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	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 %
September 2025	76.3	92.2	85.9	96.7
October 2025	64.4*	89.4	76.6	95.1

*This information is taken from the Trust CHPPD data distributed; Maternity have concerns about the use of this information in providing an accurate representation of staffing with our integrated service.

Fill rates alternate for several reasons, these include gaps caused by sickness absence, ongoing vacancies or staff who are working in a supernumerary 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.

3.2.2 Birthrate plus report

The Birthrate plus midwifery workforce report has been finalised and received. The report evaluates midwifery staffing needs for the Maternity Services at TSDFT and covers hospital and community teams, using the Birthrate Plus® methodology (The Birthrate Plus® methodology calculates staffing based on an intrapartum case mix reflecting complexity and dependency levels. It aligns with NICE guidance and is endorsed by RCM and RCOG).

The midwifery staffing needs are calculated to include annual activity data, case mix analysis, staffing requirements, and comparisons with the current funded establishments. Whilst there has been a fall in the annual birthrate there has been an increase in case mix acuity with a shift from lower risk categories to higher risk categories, this has been driven by factors such as diabetes, mental health, high BMI, and increased induction and operative deliveries.

The finalised calculations based on a 23% uplift show a recommended total establishment of 117.18 WTE. The current funded establishment is 116.07 WTE. This demonstrates an overall deficit of 1.11 WTE.

If a 25% uplift is applied this increases the recommended total establishment to 119.88 WTE and compared with the current funded establishment of 116.07 WTE, shows an overall deficit of 3.81 WTE

3.3 Multidisciplinary Training Compliance

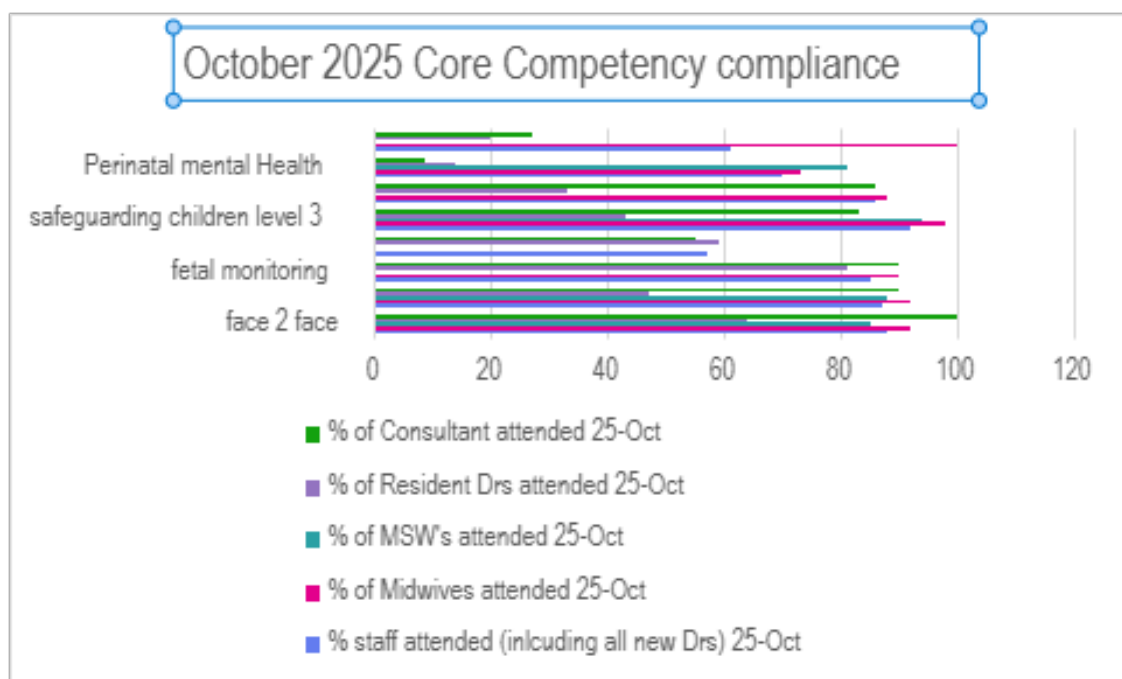
TRAINING COMPLIANCE	PROMPT	Fetal Monitoring	Safeguarding
Midwives	92%	90%	98%
Maternity Support Workers	85%	NA	94%
Obstetric Consultants/Registrars	77%	86%	59%
Anaesthetists	57%	NA	NA
<i>Actions required</i>	To continue to book all staff on training in advance and closely monitor compliance. Liaise closely with the medical team and anaesthetic consultant lead for Obstetrics to ensure staff attend within a 12-month timeframe. 3 Additional PROMPT MDT mop-up sessions have been arranged for November to improve anaesthetic compliance. If everyone who has booked attends these, we will be over 90% by	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 due to clinical demands	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 of or booking of mandatory training – including

	the end of November. Monthly meeting with the medical administrator ensures that any medical staff who have been taken off training 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. The percentages	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. Percentages include new rotation Doctors, if these were not included it would be 95% As the Education Lead is also the Fetal Monitoring Lead Midwife, and is absent at present, the Fetal monitoring lead Obstetrician has been delivering the training with the support of the practice educator to ensure ongoing compliance	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. The percentages used above include new rotation Doctors who will not be included within CNST figured but should attend training within 6 months of their start date – However this may be impacted if training is reduced/ stopped during EPIC implementation. If these Drs were not included it is 80%

	used above include new rotation Doctors who have a grace period of 6 months to complete their training. If they are excluded from the figures the Dr % is 87%		

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 program

						me 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. There were 2 babies (twins) born at 31+4 weeks gestation born at Torbay which falls outside of our commissioned service. Due to capacity pressures for level 2 and 3 cots across the South West neonatal network, a mutual clinical decision between SONAR (peninsula transport team) and local consultant paediatrician was made for babies to remain in the high dependency unit at Torbay. Exceptions are reviewed and reported on monthly to provide rationale and feedback is given to the SW Neonatal network.

4.3 Safety Improvement Plan -Maternity Safety Support Programme (MSSP)

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. NHSE have announced a change to the programme The MSSP is being replaced by the Maternity and Neonatal Improvement Support Team which support trusts to more quickly identify and resolve concerns and allow for time-limited national interventions. The team will work in partnership with regions and neonatal operational delivery networks, enabling trusts to lead and sustain their own change efforts Faster support with accelerated diagnostic processes (reducing time from identification of concerns to provision of support from months to just 4–6 weeks). The focus will be Listening to and acting on service user feedback, strengthening board-level leadership whilst enabling trusts to lead and sustain their own change efforts. This will be underpinned by both local responsibility and national support, designed to ensure safe, high-quality, and person-centred care for all families.

Current trusts on the programme will continue their improvement journey without disruption. During the autumn, meetings with all trust chief executives and regional teams will review improvement plans and agree next steps for the transition. The new improvement support team will be fully operational by 1 January 2026.

The Trust have a review and reset meeting in January 2026 when it is anticipated they will move under regional support rather than via the national team.

Suzanne Cunningham has provided monthly progress reports since June 2025. The August and September report are included in the appendix. 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) Good 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 are 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.

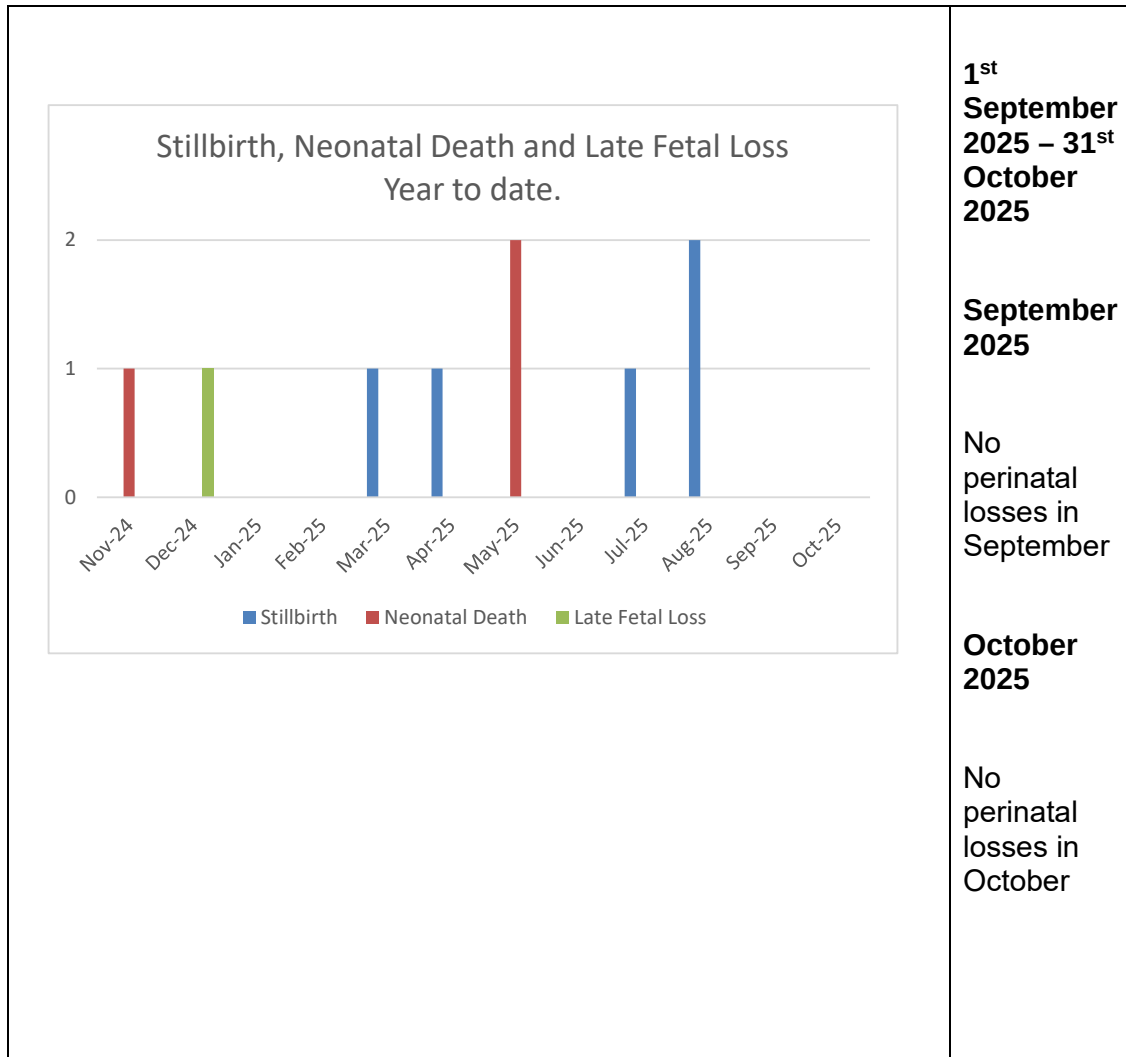
CQC MUST DO actions	Achievements	Action for Improvement
Maternity Triage	- Dedicated phone line in place. Netcall now installed and working well. - Consistent documentation process embedded in the electronic record includes a standardised risk assessment mechanism. - Allocated midwife to answer the phone 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 mid-November. - 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. - Review of datix if delays to theatre noted in practice - Progress with recruitment of ODP	- Consultation period with theatre staff planned for January to enable staffing of second team. - 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. - 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.

	(Operating Department Practitioners) / theatres staff. • Consultation period with staff planned for January to staff second team.	
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 forms part of the MNIP. • Recommendations from deep dive to include more oversight of policies and guidelines and the audit programme – Clinical Effectiveness midwife now in place. • Implement NHSE governance tool kit. •

4.5 Patient Safety

4.5.1 Perinatal Morbidity and Mortality Summary for the period



PATIENT SAFETY Incidents (PSI)	Number	Key themes/ trends/ escalations
Serious Incidents	0 in total	1st September 2025 – 31st October 2025 September 2025 – No Serious incidents were reported October 2025 – No Serious incidents were reported. *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 committee once finalised.
Moderate Incidents	3 in total	September 2025 – 3 Moderate Incidents reported 1 Moderate – 1 Moderate incident – Datix No: 28332 - Major Obstetric Haemorrhage - 2.4 litres, delay in going to theatre. 1 Moderate incident – Datix No: 28189 - Twins born at 31/40 due to Antepartum Haemorrhage – Babies born before 32 weeks gestation in level 1 unit. 1 Moderate incident - Datix No: 27709 - Due to pathological fetal monitoring, baby born at 28+5 by caesarean section – Baby born before 32 weeks gestation in level 1 unit. October 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)	2	MNSI case no: 042047 – Datix No: 23235 – A report was received following an investigation into an incident from May 2025 where a baby had been transferred to a high-level neonatal unit for cooling therapy and sadly died when they were 5 days old. The actions for the trust can be seen in table 5 below and an action plan is being produced to reflect this. Family was informed and duty of candour completed by letter containing information about the role of MNSI and online links to the patient facing information from MNSI, they did not require the information in an alternative format (i.e. in a different language etc). This case does not meet the criteria for referral to the ENS. MNSI case no: 041938 – No Datix - A report was received following an investigation into an incident from June 2025 where a baby had been stillborn at RDUH, however antenatal care was completed by Torbay Maternity Services. The actions for the trust can be seen in table 5 below and an action plan is being produced to reflect this. This case falls under the reporting requirements of RDUH for MNSI, PMRT and MIS purposes. Reports Received in Previous periods: MNSI case no: 039424 – Datix No: 19051 - One report was received from MNSI during the July - September 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 has been produced. (see table 5). The trust has held a tripartite meeting with MNSI and the family. The family were informed, duty of candour was completed by letter containing information about the role of MNSI and NHS Resolutions Early Notification Scheme and online links to the patient facing information from these bodies. They did not require the information in an alternative format (i.e. in a different language etc).and the ENS referral was made – ENS No: M24CT173/008. They have now received the final report and the babies MRI scan.
Findings of cases reviewed under PMRT. (themes only)	1	1 PMRT case was reviewed in this period. Case 3 – Datix No: 22736 - CNST SA1 (a) met, (b) met (c) met – Requirement for external panel members, met - PMRT MDT meeting was held on 25th September 2025 and completed on the 16th October 2025, Report completed on 23rd October 2025. The MDT determined that the cause of death was due to placental abruption and possible sepsis. There were care issues found when discussing the case, particularly around time taken for escalation to senior clinician and delay in delivery. An action plan has been produced to monitor completion via the action tracker meeting (See table 4 below). 3 PMRT reviews are pending. Dates due for completion: 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 28th February 2026. Will be met once PMRT MDT meeting held. Other PMRT reviews held in 2025

		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 4).

4.5.2 Patient Safety Incidents

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**

Cas e No:	Theme	Issue	Actions	Responsibl e role	By when
2	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	Complete d
3	Decision making and escalation	This mother had an operative delivery, but this was not carried out with appropriate urgency	Discussion to be held with staff members involved to reflect on the care given and identify any learning points or additional training requirements from the care given.	Supervisors of relevant staff.	30/11/2025
3	Decision making and escalation	The mother should have been asked to attend the unit after her first call to the triage line	BSOTs implementation, when full triage works are complete to help with the situational awareness of women that are high risk e.g. multiple pregnancy versus amber flags for singleton pregnancies.	Outpatient Matron	31/12/2025

3	Record Keeping	The review group felt that some aspects of the documentation in this case were lacking in detail. This is to be addressed as part of a wider project around improvements in documentation.	Continue with updates to policies around record keeping in maternity, continue with ongoing notes audits and highlight importance of documentations as part of EPIC launch. Consider documentation workshop/learning session in conjunction with litigation team?	Inpatient Matron and Clinical Governance Coordinator(s)	30/04/2026
3	Staff Debrief	It is not possible to assess from the notes whether following the resuscitation of the baby a rapid safety focused resus de-brief with the staff involved was carried out	Senior team to ensure that debriefs are held following a serious incident. Implementation of SWARM huddles as planned should help with this as it will be part of the initial actions. Continue work to progress implementation of SWARM Huddles, this should include the process of booking a debrief.	Inpatient Matron and Clinical Governance Coordinator(s)	30/04/2026
3	Equipment	The portable scanner on Labour Ward was faulty and not working properly	Scanner has now been upgraded and replaced.	Labour Ward Manager	Completed
3	Labelling Error	Due to the placentas not being correctly	Action plan produced by bereavement midwives.	Bereavement Midwives	31/12/2025

		labelled, the genetics for Deceased twin reported his sex as female, additional distress was caused to parents.	Correct labelling protocol to be updated in relevant guidelines.		
3	Record Keeping	"Sepsis Six" proforma not used. Therefore, it is difficult to determine if the requirements around this were met.	Reminders to be sent to all staff regarding use of sepsis proforma. Education midwife to provide reassurance that all midwives are up to date with Sepsis training on the HIVE. Sepsis to be a focus for PROMPT mandatory training next year. Labour ward coordinators to be reminded to highlight the use of the Sepsis proforma if Sepsis is suspected.	Inpatient Matron, Labour Ward Manager and Education Lead Midwife	31/12/2026
3	Communication	The review group found that the paediatricians would have preferred to be more prepared for a potential twin delivery.	Labour ward coordinator to be reminded to be mindful to notify paediatrics when a woman attends the unit preterm with complications in her pregnancy. Inpatient matron to highlight at next Labour	Inpatient Matron	31/12/2025

			Ward coordinators meeting.		
3	Record Keeping	The review group felt it would have been easier to determine the facts of the case if memory captures had been sought from the staff involved at the time of the event.	Governance team to ensure that memory captures are sent to staff who are involved in serious events, shortly after the event. This will help with gathering facts for the case as well as prove to be good practice for those involved in reflective practice.	Maternity and Child Health Clinical Governance Coordinators .	Ongoing

Learning from MNSI reviews (Table 5)

Table 5

MNSI Number	Safety Recommendation identified from the MNSI investigation	Action required, how will it be achieved and to whom?	How will the outcome be measured as evidence the action is complete?	Accountable Action Lead(s)	Deadline
039424	Safety Recommendation: It is recommended that the Trust ensure that when the quality of the CTG trace is poor, this is escalated and managed before an oxytocin	1. Include in MDT CTG teaching as of this active training cycle. 2. Update Intrapartum Fetal Monitoring Guideline & Induction / Augmentation Guidelines. 3. "Handover notice"	Audit of CTG Review prior to commencement of Syntocinon for induction or augmentation during November 2025. Present at	1. Fetal Monitoring Lead 2. Labour Ward Lead 3. Fetal Monitoring Lead & Fetal Monitoring Lead	1. Immediate 2. End Dec 2025 3. Immediate Q1 2026

	infusion is started	through October as a reminder to staff. Explore the inclusion or addition of a prompt within the new EPIC EPR.	perinatal in early 2026. Note this will need to be prior to the EPR work as this will not be rolled out until mid-2026.	Fetal Monitoring Lead	
039424	Safety Recommendation: It is recommended that the Trust ensure that babies undergoing resuscitation and stabilisation maintain a temperature within the normal range.	1. Proforma to be completed during resuscitation now in place on every resuscitation, this encourages monitoring of temperature. 2. Use of proforma, thermoregulation and maintenance of normothermia highlighted at every resuscitation. 3. Thermoregulation toolkit in action. Audit in progress on temperature of delivery rooms and theatre.	Ongoing audit and education to encourage maintenance of normothermia in resuscitation.	Paediatrics	Ongoing

03942 4	Safety Prompt: The investigation found that the woman had risk factors and experienced contractions during induction of labour on the antenatal ward. How are staff supported to transfer a mother with multiple risk factors promptly to labour ward for continuous CTG monitoring?	1. Include in MDT CTG teaching as of this active training cycle. Update Intrapartum Fetal Monitoring Guideline & Induction / Augmentation Guidelines.	Publication of new teaching and guidance. Formal audit not practicable as numbers will be too small.	1. Fetal Monitoring Lead Fetal Monitoring Lead & Labour Ward Lead	1. Immediate End Dec 2025
03942 4	Safety Prompt: The investigation found that an antenatal CTG interpretation tool was used to categorise a CTG after an induction of labour had started. How are staff supported to follow Trust guidance for fetal monitoring and interpretation tools used during induction of labour?	Review and update IOL guideline(s) and then disseminate via handover notice and updated MDT CTG Training.	Audit of CTG monitoring during IOL process (alongside Syntocinon audit above) during November 2025.	Fetal Monitoring Lead	End Dec 2025

03942 4	Safety Prompt: The investigation found that Trust fetal monitoring guidance was not clear to support staff caring for a mother in labour to complete and document a full assessment of a mother and baby every hour in line with national guidance. How does the Trust support staff to complete and document a full assessment of a mother and a baby and a separate in person fresh eyes review within the electronic records?	Already included within MDT CTG teaching, additional emphasis to be applied during relevant session. SystemOne based EPR acknowledged to be somewhat clumsy and difficult to use in this respect. New EPR (with better established processes and forms) to be rolled out mid- 2026. Paper stickers kept in use to aid staff in interim.	Rolling audit already in place. No issues flagged prior to this event.	Fetal Monitoring Lead Education Lead Midwife	Already Rolling
03942 4	Safety Prompt: The investigation found that Trust fetal monitoring guidance was not clear to support staff caring for a mother in labour to complete and	Review and update Intrapartum guideline(s) and then disseminate via handover notice and updated MDT CTG Training.	Audit of CTG monitoring & documentation during labour (alongside Syntocinon audit above) during November 2025.	Fetal Monitoring Lead	End Dec 2025

	document a full assessment of a mother and baby every hour in line with national guidance. How is the Trust assured the Trust fetal monitoring guideline supports staff to complete assessments of a Mother and a baby in line with national guidance?				
039424	Safety Prompt: The investigation learned that CTG monitoring was stopped and restarted on multiple occasions for woman to go to the toilet How can the Trust support staff to continuously monitor the fetal heart by CTG during labour for mothers with identified risk factors.	Update MDT CTG training to stress this importance of maintaining continuity of monitoring. Discuss with LW coordinators and managers the consideration of making wireless the default monitoring state (an approach used by a neighbouring trust).	Publication of new teaching and guidance.	Fetal Monitoring Lead	Immediate
042047	Safety Recommendation: It is recommended that the Trust	To include in the Fetal monitoring day, this birth as a case history	Slides and lesson plan	Fetal monitoring Leads	31/12/2026

	supports staff to recognise the inability to locate a baby's heart rate during labour as a potential obstetric emergency.	Share safety recommendations via the LAZER			
042047	Safety Recommendation: It is recommended that the Trust ensures that staff are supported to use the emergency bell when there is an obstetric emergency, to enable immediate review and a shared mental model for care planning.	At the annual mandatory day, during PROMPT sessions all the clinical staff are reminded of the importance of using the emergency bell to call for assistance, and not to shout outside of the room for assistance Share safety recommendations via the LAZER	LASER to be completed and to be added to the lesson plan for the PROMPT session of Mandatory training.	Education Lead Midwives and Clinical Governance Coordinator	21/12/2026
042047	Safety Recommendation: It is recommended that the Trust ensures any maintenance work undertaken within the maternity unit has a comprehensive risk assessment to	Any disruption to the delivery of care to mothers and babies has a risk assessment undertaken.	Risk Assessment completed	Ward Managers	Ongoing

	identify and mitigate risk.				
042047	Safety Recommendation: It is recommended that the Trust ensures that all staff use closed loop communication in all maternity settings and during emergency situations.	Include these important human factors in the PROMPT mandatory training. Share safety recommendations via the LAZER	LASER to be completed and to be added to the lesson plan for the PROMPT session of Mandatory training.	Education Lead Midwives and Clinical Governance Coordinator	21/12/2026
042027	Safety prompt. 1 The investigation found that a scribe was allocated during the Baby's resuscitation which meant that there was clear, comprehensive, and contemporaneous documentation of his care. • How does the Trust identify and share best practice?	Include best practice in the PROMPT mandatory training. Share recommendations via the LAZER	LASER to be completed and to be added to the lesson plan for the PROMPT session of Mandatory training.	Education Lead Midwives and Clinical Governance Coordinator	21/12/2026
042047	Safety prompt 2. The investigation found that some documentation	Continue with updates to policies around record keeping in maternity, continue with ongoing notes audits and	Policies Updates, discussion with litigation held, EPIC launched	Inpatient Matron and Clinical Governance	30/04/2026

	n of labour care is handwritten contemporaneously and uploaded to the electronic record following birth. • How is the Trust assured that the electronic record system supports contemporaneous record keeping? • Has the Trust reviewed any barriers or challenges staff face in using the electronic system to document care contemporaneously	highlight importance of documentations as part of EPIC launch. Consider documentation workshop/learning session in conjunction with litigation team?	and embedded.	Coordinators	
The following recommendations are acknowledged by the trust, and an action plan is being developed.					
041938	Safety recommendation: It is recommended that the Trust A and Trust B have a robust system to share information when a mother is receiving care from both				

	maternity hospitals				
041938	Safety prompt: The investigation found that information about the family history of a half sibling with a cardiac condition was included on the booking information and was not included within the obstetric referral completed. • How does the Trust support staff to recognise any risk factors that need referral for example a family history of a congenital cardiac condition that will increase a baby's risk for having this condition? • How does the Trust ensure that all risk factors are included within a referral form for obstetric review?				

Outstanding reports due from Coroner Table 6**Table 6**

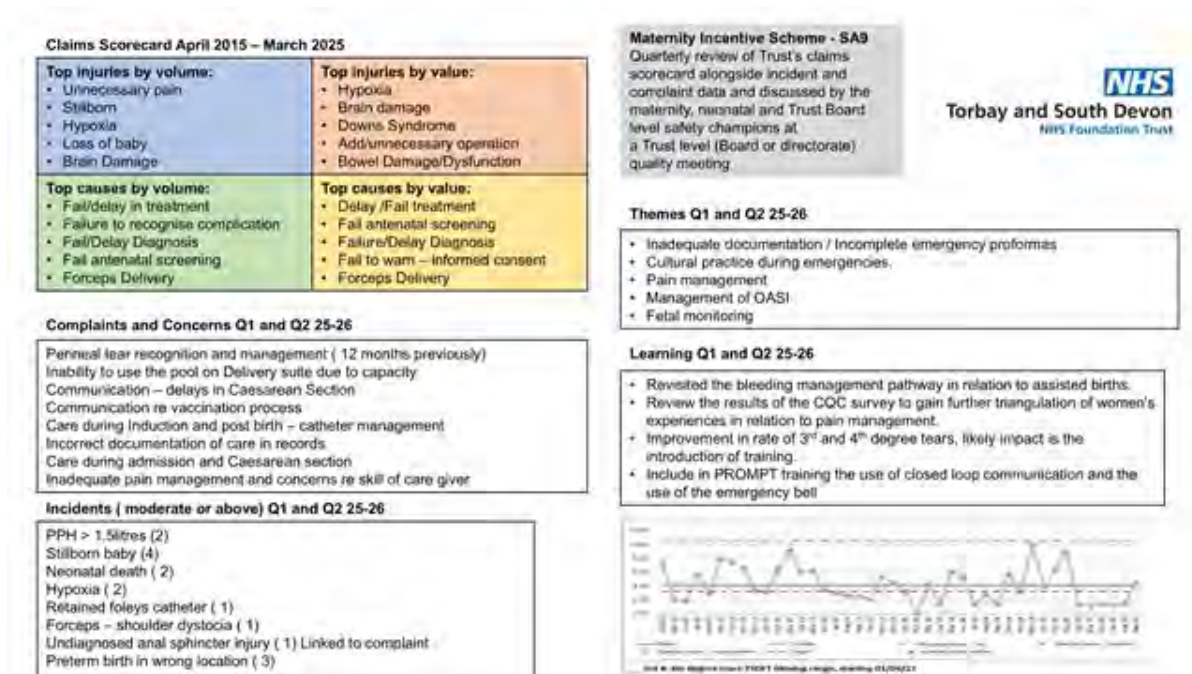
Identifier	Date Listed	Summary
Maternal Death	02.06.2025	Woman found deceased at home at 9 days postnatal. Multiagency report being finalised by ICB.
TOP for medical reasons	21.01.2025	A woman undergoing a termination of pregnancy (TOP) due to the baby having a congenital abnormality. Baby born at 22+5 weeks gestation showing signs of life. Died shortly afterwards.

Triangulation of NHS Resolution Scorecard – Quarter 1 and 2 (April – September 2025)

To facilitate learning from feedback, incidents and litigation claims a quarterly review of Trust's claims scorecard alongside incident and complaint data should be presented by the maternity, neonatal and Trust Board level safety champions at a Trust level quality meeting.

The claims scorecard below details obstetric claims received in the last ten years. The number of claims received is fifteen; of these only six remain open. Of the nine closed claims, a third did not pay any damages.

Data on rates of brain injury for Torbay have been compared to national rates, and this demonstrates that the rate is below both the national and the regional rate.



To be updated further in the next QAC report as we will have Q3 data

4.6 Saving Babies Lives Care Bundle - RAG Rating

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

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

Element	Areas of non-compliance	Actions Required
1	Recording CO levels within 3 days of a maternity booking appointment	Increase capacity for face-to-face booking appointments.
5	Changes required to Multiple birth Slight rise in preterm birth rate.	Awaiting clinical governance approval

	Change to requirement to use regional born in the right place data Thermoregulation for preterm babies	Audit of preterm birth rate in progress Continue with the PERIPrem quality improvement project.
6	Change to requirements from, continuous glucose monitoring to. closed loop monitoring	Awaiting clinical governance approval

Narrative by exception

The 2025-26 Q2 (June 25 - August 25) 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 policies and exception reporting. During this transition period, whilst our policies are updated to reflect the new requirements, there has been a drop in compliance. However, we are on track to maintain compliance with the MIS requirements due as compliance has been maintained on original elements and significant progress made towards achieving the new requirements,

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 October.

Topics addressed included

- **LMNS Leadership & Funding:** Transition in clinical leadership roles and confirmation of LMNS engagement.
- **CNST Compliance:** Safety action 8-. Anaesthetic training compliance remains below 90%, flagged as a critical risk. Advised this may require executive support via Chief Medical officer
- **Improvement Work:** Cultural improvement initiatives underway; obstetric leadership visit scheduled for November.
- **Claims & Litigation:** NHS Resolution scorecard reviewed; benchmarking of brain injury and hypoxia rates discussed.
- **NMVP Update:** Positive family feedback with improvement areas identified; equity and bereavement projects progressing; neonatal lead recruitment in progress.

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?			Currently 6 cases meet eligibility criteria, 100% have sought parental input, 100% have started review within 2 months (including all factual questions) 3 out of 6 reports published to date, for the reporting period for CNST submission, all eligible cases have had reports published within the deadlines. 3 out of 6 reviews have external member present, including all three completed reports. The remaining 3 cases are still being investigated, and the reporting period falls outside of the CNST reporting window. PMRT data included within the Perinatal Governance and Safety Report
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			CNST Scorecard shows compliance for reporting month of July
3	Can you demonstrate that you have transitional care (TC) services in place to minimise separation of parents and their babies?			Transitional Care policy in place (G2934). Data audited using ATAIN data, report available for Q1 2025/6 QI project continued from previous year with one presentation to LMNS completed. Second update to LMNS to be provided in November

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 completed to identify any staff used who are not currently working in the unit. Currently 2x long-term locums have been used, with evidence of sign off and audit (as per policy 2992) Consultant attendance to clinical situations is recorded and reported (needs to be shared with Trust Board, safety champions and LMNS) Anaesthetic workforce meets standard, with evidence provided by workforce rota Neonatal medical workforce meets BAPM standard, with evidence provided by rota, this is recorded in September Board minutes as part of Perinatal Governance & Safety Report Neonatal Nursing workforce not meeting BAPM standards recorded in September Board minutes as part of Perinatal Governance & Safety Report and the action plan is described in Maternity Staffing report. (Needs reporting to LMNS and Neonatal ODN)
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		Maternity staffing report Jan - June 2025 covers majority of actions. Birthrate + workforce report now finalised and received Needs to be included in Board minutes
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving		SBLCBv3 audit tool showing compliance as green for all 6 elements, need sign off from LMNS and copies of minutes

	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%. Mop up training due in November, escalated to anaesthetic clinical lead and Care Group Directors. Neonatal resus training should be 90% by November
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?		Perinatal Governance & Safety Report aligned to PQSM/PQOM reporting Bimonthly meetings occur with the QUAD and the safety champions including the Board level champions. Perinatal Governance & Safety Bimonthly Report presented to QAC by HOM on a bi-monthly basis.

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?		2 reportable cases within audit period to date, screenshots from MNSI portal as evidence. Trust board papers 250924 include section with findings of final MNSI reports

- **Future Oversight:** MSSP to transition to regional support under new improvement model from January 2026

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.

No signals received in September and October 2025

4.9 Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (MIS)

Year 7 commenced on 2nd April 2025. 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 have progressed the recruitment of a Perinatal Compliance post to support this work, and a conditional offer was made this week. Additional funds have also been 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.

Committee is asked to note for assurance and compliance:

- The Trust has implemented the RCOG guidance on engagement of long-term locums in full, following the appointment of long-term locums' policy (2992). Audit of compliance completed for 6-month period as per CNST guidelines, with identification of the use of two long-term locums, both of whom meet the RCOG guidance.
- Quarterly audits are performed on consultant attendance when called for clinical support. In both Q1 and Q2 of 25/26 the consultant attended when required based on the RCOG guidance. This data has been presented at Quadrumvirate (QUAD) / safety champion meeting.
- The Trust meets BAPM recommendations for the neonatal medical workforce in a tier 1 special care unit.
- Neonatal unit doesn't meet BAPM recommendations for the neonatal nursing workforce. Action plan presented to QAC in September 2025 as part of maternity staffing report.
- Trust claims scorecard has been reviewed alongside incident and complaint data and discussed at the perinatal QUAD meeting.
- Board can be assured that the Board level safety champions meet the perinatal leadership team regularly (via the QUAD meeting) and any support required from the Board is escalated via the QAC

4.9.1 Actions to improve care for women and families

NHSE wrote to all Trusts in October with an update on a package of measures to continue to enable services to strengthen care and support for all. These include:

i) **Perinatal Equity and Anti-Discrimination Programme**

The programme aims to reduce inequalities in maternity and neonatal care by addressing disparities in access, experience, and outcomes for ethnic minority groups and those from deprived communities. It also seeks to improve the working lives of staff from these groups through cultural and organisational change. Objectives are to

- Equip perinatal teams with skills and tools to tackle discrimination and inequity.
- Drive behavioural, cultural, and organisational changes to sustain improvements.
- Embed anti-discrimination principles into leadership, governance, and frontline practice.
- Support inclusive workforce development, ensuring fair opportunities and representation.

Programme Components

1. **Leadership Development**
Senior perinatal leaders will attend structured sessions focused on equity, cultural competence, and anti-discrimination strategies.
2. **Practical Tools & Training**
Resources to help teams identify and address inequities in care pathways, including health equity audits and targeted interventions.
3. **Monitoring & Accountability**
Integration of equity metrics into governance frameworks and audit plans to track progress and outcomes.

Board Actions

- Endorse participation of senior leadership in the programme.
- Ensure local maternity and neonatal improvement plans reflect equity objectives.
- Monitor delivery against KPIs and audit findings linked to equity and inclusion.

The team have already begun to address equity and inclusion in the workplace by reviewing current data with MNVP to improve engagement opportunities as well as discussing ways to enhance workforce support from the strategic people partner and EDI lead.

ii) **Submit a Perinatal Event Notification service**

To reduce the burden of reporting and administration on staff, NHSE have developed a new Submit a Perinatal Event Notification (SPEN) portal. This will replace existing legacy reporting systems. The NHS Submit a Perinatal Event Notification (SPEN) is a web-based portal designed to streamline the notifications of qualifying perinatal safety events to 3 national organisations:

- MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK) and any CDOP reporting of neonatal deaths that is made to MBRRACE-UK via the new Cascade system.
- Maternity and Newborn Safety Investigations (MNSI).
- NHS Resolution Early Notification (NHSR EN) scheme.

The Trust were registered and onboarded on the 6th October 2025 and have not had any events required to be notified

This work is essential to the roll-out of the Maternity Outcomes Signal System (MOSS) which means services can identify safety risks earlier and quickly take appropriate actions.

iii) **Maternity and Neonatal Performance Dashboard**

The Secretary of State has committed to setting strong and consistent expectations for trust chairs, chief executives, and boards, with overhauled oversight and performance frameworks and a new performance dashboard to support trusts to further understand their services. This is the first iteration of the national set of metrics and definitions that make up the performance dashboard:

Metric Definition

- Obstetric unit suspensions and external neonatal unit suspensions
- Delays to induction of labour greater than 24 hours
- Stillbirth rate
- Neonatal mortality rate
- Postpartum haemorrhage rate
- Optimal perinatal care composite measure (Proportion of babies born at less than 34 weeks receiving all relevant optimal perinatal care component measures, which include: • antenatal steroids • antenatal magnesium sulphate • birth in a centre with a NICU • deferred cord clamping • normal temperature on admission and • breastmilk feeding in the first two days of life)
- Patients experience measure: CQC maternity survey

This same set of metrics will be used to monitor performance in maternity and neonatal services in all parts of the system, supporting trusts and integrated care boards to monitor their own progress and demonstrate curiosity as to the underpinning conditions leading to the outcomes seen. The dashboard represents a balanced scorecard of operational outcome and patient experience measures. All trusts must report regularly to their boards on maternity and neonatal safety, and they will shortly be offering a model board report template for this.

The data required for these metrics is already routinely collected and the majority are publicly available.

NHSE are in the process of developing a digital solution to automate the process further and we will share this with you later in the year

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 requirement to support participation in the equity and anti-discrimination programme
- Note the finalised Birthrate Plus workforce report recommendations of a requirement for a 1.11 WTE uplift in midwifery establishment (if calculated on a 23% uplift) and a 3.81 WTE uplift in establishment (if calculated on a 25% uplift).
- Note the current position of compliance against the Maternity Incentive Scheme with full compliance anticipated in March 2026
- Note the compliance with BAPM standards for Neonatal medical workforce.

- Note the findings identified through triangulation of the NHSR litigation Scorecard

The Committee are asked to agree the recommended assurance rating noting the mitigations around assurance

Appendix 1 – Monthly Maternity Safety Support Programme Reports

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 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.		Key issues or areas of concerns 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 No escalations.		Next steps 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	

Maternity Safety Support Programme Monthly Update Report

Trust Name:	Torbay & South Devon NHS Hospitals Trust	Report Date:	August 2025
MIA(s):	Suzanne Cunningham (MW) Erum Khan (Obstetrics)	MSSP Phase:	Improvement
Progress and successes The Perinatal Improvement Plan has been drafted and shared with the Leadership Team. Leads and deputies for each workstream are confirmed. The first Board meeting is scheduled, with stakeholder engagement events planned. The Chief Nurse will chair the Perinatal Improvement Board. Safeguarding role has been job matched and now advertised Progress made with Triage estates bid – confirmation of start date due mid September. Birthrate+ data now confirmed – report due end of September		Key issues or areas of concerns Gaps in Obstetric workforce remain around remuneration & protected time for obstetric leadership roles. Division will not be seeking funding for this until 2026/27 Disruptive social media activity continues; 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. Response to feedback from staff related to culture being planned Clinical lead for Obstetrics has resigned and support for the role being advertised.	
Escalations Progress on establishing the Director of Midwifery role and creating a full time Head of Midwifery has stalled pending funding approval and process clarification.		Next steps Feedback on Director of Midwifery job description & person specification Perinatal Improvement Plan to be finalised and projects established with leads Process and timelines for assurance regarding elapsed guidelines to be established to ensure guidance is correct and timeframes for completion agreed. Support the refresh of governance systems and processes, pending the appointment of new staff. Support the development of consistency and improved communication during Maternity Ward Rounds	

Maternity Safety Support Programme Monthly Update Report

Trust Name:	Torbay & South Devon NHS Hospitals Trust	Report Date:	September 2025
MIA(s):	Suzanne Cunningham (MW) Erum Khan (Obstetrics)	MSSP Phase:	Improvement
Progress and successes		Key issues or areas of concerns	
The Perinatal Improvement Plan is progressing but still requires clinical leads to confirm actions. The purpose and planning needed is better understood and supported. The Chief Nurse will chair the Perinatal Improvement Board. Progress made around obstetric theatre workforce with next steps subject to staff consultation process. Progress made with Triage estates bid – confirmation of start date October 20th. Midwives trained Birthrate+ data now confirmed – comments have been given on draft report – final report awaited. Staff engagement continues to improve – CEO & CNO met with staff and Staff newsletter received well – 2nd edition now circulating. <u>Clinical Lead for obstetrics appointed starts mid November.</u>		Gaps in Obstetric workforce remain around remuneration & protected time for obstetric leadership roles. Division will not be seeking funding for this until 2026/27 53 clinical guidelines are out of date (end of October). Currently engagement with clinicians is challenging. Leadership Team supporting solutions related to capacity & leadership. progress limited Response to feedback from staff related to culture being planned. CEO & CNO met with staff, Trust and Regional meetings planned for support Clinical guidelines for triage	
Escalations		Next steps	
Progress on establishing the Director of Midwifery role and creating a full time Head of Midwifery has stalled pending funding approval and process clarification. Process and timelines for assurance regarding elapsed guidelines to be established to ensure guidance is correct and timeframes for completion agreed. This has stalled		Perinatal Improvement Plan to be finalised and projects established with leads Meet with Medical Director and Chief Nurse regarding culture Support the refresh of governance systems and processes. Priority to give assurance about the plan to ensure all guidelines are in date Support the development of consistency and improved communication during Maternity Ward Rounds and further support Team to understand culture Attend PMA meeting to understand staff support strategy and continue with staff engagement	

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 – 82% women seen within 15 mins	DM	September 2025	Guidelines drafted. Building extensions out to tender. On Risk Register (R)
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 (2G)
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 action agreed	Head of Midwifery	September 2026	Job matching submitted, consultation drafted
The Trust will have a MNVP in place with progress against expected measures. This will be developed as a Devon wide approach with Trust and ICB oversight and support.	MNVP and governance arrangements implemented	Quaid	January 2026	MNVP 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 PSRF is established	Review current system against MSSP Governance Toolkit & PSRF, 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 MNVPs appointed and starting work with the 3 hospitals

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.	ADD/DM	January 2026	Project Lead agreed for MNIP
The Berintra Plus Workforce Study should be completed and a workforce plan created that addresses the services acute 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 acute 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	ADD/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.	ADD/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 other support services.	Review pathway for vulnerable women, process map support available, review my model in the community, implementation of agreed plan.	DM	April 2026	UJA 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 for MNIP implemented, civility workshops, minisite of improvement Board progress	Quac	April 2026	Staff listening events completed, Maternity Meeting implemented, Civility Workshops delivered.