Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Thursday 8 January 2026

Time: 12.30 pm - 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

08/01/2026 12:30 - 14:30

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NHS
Torbay and South Devon
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM AND MS TEAMS
AT 12 NOON ON WEDNESDAY 26 NOVEMBER 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
	Mr M Greaves	Non-Executive Director
	Dr C Lissett	Chief Medical Officer
	Ms E Long	Director of Corporate Governance and Trust Secretary
	Mrs N McMinn	Chief Nursing Officer
	Ms A Jones	Deputy Chief Executive/Chief Operating Officer
	Mr P Richards	Non-Executive Director
	Mr C Saxby	Non-Executive Director
	Mr S Tapley	Chief Strategy and Planning Officer
	Mr R Williams	Non-Executive Director
In Attendance:	Mrs V Browning	Lead Governor
	Mrs L Densham	Governor
	Mrs S Fox	Corporate Governance Manager
	Mr P Foster	Director of Pharmacy (for item 137/11/25)
	Mr L Gibbon	CMR Surgical Lead
	Mrs A Hall	Member of the Public
	Mrs N Herring	Deputy Chief Nurse
	Ms S Howard	Workstream Lead – National Recovery Support Team
	Ms A Lydon	Medical Research Lead (for item 143/11/25)
	Mrs J Passmore	Frailty and Healthcare of Older People Nurse Consultant (for item 128/11/25)
	Mrs J Piper	Acting Chief People Officer
	Ms F Roberts	Research and Development Director (for item 143/11/25)
	Mr L Thomas	Governor (part)
	Mr S Wadham-Sharpe	Deputy Chief Operating Officer (part)
	Mrs A Williams	System Improvement Director
	Mr G Yardy	Governor

	WELCOME AND INTRODUCTIONS
125/11/25	The Chairman welcomed all those in attendance.
	PRELIMINARY MATTERS
126/11/25	**Apologies for Absence, Quoracy and Declarations of Interest**
	No apologies for absence were received. The Chair confirmed the meeting as quorate.
127/11/25	**Unconfirmed Minutes of the Meeting held on 24 September 2025**
	The Board received the minutes of the meeting held on 24 September 2025, circulated with the agenda pack. The action log was reviewed, and updates were received on outstanding actions.
	The Board APPROVED the Unconfirmed Minutes from the Public Board meeting held on 24 September 2025 as a true and correct record
128/11/25	**Patient Story**
	The patient story was presented by Jo Passmore, Nurse Consultant - Frailty and Healthcare of Older People.
	The story involved Yvonne, who was 79 years old when she used the Trust's services. Yvonne and her family were thanked for sharing her story.
	Yvonne had been referred to the Frailty Virtual Ward by the intermediate care team, paramedic and heart failure nurse as she required additional care and did not want to return to hospital.
	During Yvonne's previous visit to hospital she had a long stay and on the frailty score had deteriorated significantly, she had also had a negative experience where by she felt she had not been compassionately enough advised that she was now to be treated as end-of life in the provision of care.
	This loss of independence meant that she was no longer able to care for herself and was living with her daughter. This was common for people admitted in their later life, illustrating the importance of care being provided as close to home as possible. However, it also meant that she was frightened and apprehensive when visited by the Frailty team.
	The team undertook an initial review at Yvonne's home which included a full geriatric assessment; medication review; skin review; discussed risks and benefits of hospital admission; and produced an updated treatment escalation plan to allow her to stay at home. 11 different health care teams were involved in Yvonne's care.
	In respect of the patient experience, Yvonne and her daughter fed back the following: Yvonne was relieved she could stay at home; care was co-ordinated; expert decision-making was provided; a gentle and kind approach was experienced; Yvonne's fear was taken away; both Yvonne and her daughter felt listened to; and this resulted in a change in Yvonne's demeanour from frighted and anxious to calm.
	Yvonne passed away peacefully at home supported by her daughter, carers, Rowcroft Hospice and community nurses.
	Reflections on Yvonne's story
	• The extent of the co-ordination and support that had been put in place for one patient was acknowledged. Jo was asked if this level of care was provided for all patients. She replied that it was, however, not all patients wished to stay at home or could not stay at home if the right care package was not in

place for them. She added that some patients were passed to the Intermediate Care team for support, depending on the level of intervention required. Ideally, more resource and co-ordination support would ensure a better service could be provided to those that needed it. The roll out of Epic and whether this would improve delivery was discussed. It was noted that verbal handovers took place due to the nature of the work, and notes were already recorded electronically; however, they expected the administration of EPIC to improve delivery in other ways.

- Patients with dementia added a further layer of complexity to the work of the team, in particular, in respect of communication with the patient, checking if anyone held lasting power of attorney etc.
- The role of the Nurse Consultant was discussed, noting that the Trust was an outlier in only having one person in this role. It was also noted that medical colleagues did not always understand the scope of the role and that there was a need for the Trust to ensure it was fully understood and included when looking at its workforce for the future.
- The percentage of patients that were seen by the team, but had to be admitted, was queried. It was noted that for some patients hospital was the right place to be; however it was probably around 20% of patients that required an acute admission. Reasons could be that they were acutely unwell or could not manage at home.
- It was recognised that the Trust needed to look at its bed base and how it was used, given that acute beds were often used by patients who did not need one and their care could be delivered in a community setting. In was also noted that more use could be made of Intermediate Care facilities.

The Board thanked Jo Passmore for her presentation.

129/11/25 **Report from the Chairman**

The Chair briefed the Board on the following:

- Consultant interviews and appointments had been made in both Ophthalmology and Dermatology.
- The Board, in private session, had agreed a system-wide collaborative approach for the delivery of Pathology services.
- The Chair and Chief Executive had attended the Junior Doctors' SAS awards event which reflected the large contribution they made to the Trust.
- The reduction in the number of ambulances waiting outside the Emergency Department had reduced following the work to enable patients to be admitted to the department more quickly, however the quicker handovers were operationally challenging as there was a significant increase in demand during Winter but as patients were safer in the hospital this was being managed in line with the Winter Plan.
- The lack of investment in the Trust's estate continued to be of concern, the variable nature of the buildings was highlighted by a visit to the Intensive Care Unit, which was a state of the art facility, and the Breast Care Unit, which would not be fit for purpose in the longer term.

- The Chair had been involved in a number of stakeholder meetings with local authorities in respect of the local government reorganisation. It was likely the direction of travel would be understood by the spring of 2026.
- In the last month the Chair of the new Devon and Cornwall ICB cluster had visited the Trust. Opportunity was taken to showcase the Trust's Frailty Unit at Newton Abbot Hospital and the concerns in respect of the Trust's wider estate.
- The need for the Trust to work closely with its partners during the next planning round should not be over-estimated to ensure an aligned collaborative plan was presented for the system. An aspiration of the ICB cluster chair was to bring system trusts and the ICB closer together to ensure collective leadership was in place.
- Once the plan had been developed an engagement process would commence with stakeholders.

130/11/25 **Chief Executive's Report**

The Board received the Chief Executive's report, circulated with the agenda pack. The following was discussed:

- Given the scale of the financial challenge facing the Trust and wider system in 2026/27, the need for a robust plan to be in place to deliver savings at a scale not achieved before in the system was recognised.
- Thanks were recorded to all members of staff who had supported the Trust during the recent resident doctor industrial action. It was noted that more resident doctors had chosen to go on strike than previously.
- The recent Medicine for Members event was incorrectly recorded in the report as being delivered by Dr Dorey, when it had been delivered by Dr Louise Medley, who had delivered an informative and well received session.
- The proposal for the future of the Cardiology Service had not yet been received. Concern had been raised that there was activism increasing public concern in this regard when as yet there was no proposal to share. Should that change the Board would review and ensure that engagement with the local population took place.. The importance of the Trust to communicating with its population so they understood that the current cardiology service continued to be provided was noted.
- The Chief Executive had recently visited Teignmouth Hospital with the MP for Teignbridge, Martin Wrigley. A 'Meet Joe' session was held and he was challenged on the future of the hospital and how staff felt unsettled when no clear decision had been made, and when different teams were visiting the hospital looking at potential future plans. It had been agreed single leadership would be put in place, led by the Chief Operating Officer, to consider the future of the hospital and prepare a report for the Board to consider. The need for clearer communications with staff and the wider public was also acknowledged.
- Concern was raised around the time it was taking to make a decision in respect of the future of Dawlish Hospital. It was noted that the Trust was working with the ICB on this issue and in the meantime would undertake a weekly review of staffing at the hospital. The Board was reminded that NHSE had stated minor injury units (MIUs) were not considered good value and

alternative solutions for urgent care needed to be found in those communities where MIUs were currently located. Trusts with MIUs had been informed they would not be supported after the end of 2025/26 unless they were converted to Urgent Treatment Centres (UTCs). Engagement was discussed and whether the local population were made aware if Dawlish MIU was open or not, as it was closed frequently due to difficulty in staffing the unit. It was reported that social media was used and that only a small number of people used the unit; most of whom arrived by car; and with conditions that could be treated by primary care .

The Board noted the report of the Chief Executive.

131/11/25 **Resetting Recovery Support Exit Criteria**

The Board received the Resetting Recovery Support Exit Criteria report, circulated with the agenda pack.

This paper outlined the criteria on which the Trust would be assessed in terms of exiting the Recovery Support Programme (RSP). Future reports would provide a dashboard showing progress against delivery of the criteria.

Risks associated with exiting the RSP were queried. There were operational and financial risks exiting this level of oversight due to the resource that would no longer be provided, though this would be assessed by NHSE and the Trust could advocate for its requirements to continue to improve.

The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board noted the ongoing monitoring of progress against exit criteria would be included in future Chief Executive reports.

132/11/25 **Board Assurance Framework**

The Board received the Board Assurance Framework (BAF), circulated with the agenda pack. The following was discussed:

- The BAF had been revised and updated. The objectives would need to be updated once the Board had approved the revised Board sub-committee structure, due to be considered later in the meeting.
- Work would also take place to ensure it was aligned to any feedback received following the recent Insightful Board Self-Assessment.
- Risks outlined in the papers were noted and these were further described within the Committee Chairs' reports as well as the BAF. The principal strategic risks included Adult Social Care; estates; financial sustainability; and some specific quality risks.
- The Board was reminded of the work taking place to ensure readiness for the move from the web version of Datix to DCIQ which included data integrity work. Once this work was completed a paper would be presented to the Audit and Risk Committee detailing the work that had been undertaken and the benefits of moving to DCIQ.
- A query was raised around the use of risk management software and whether the Trust's risk management assurance ratings were the same as those used across the system. It was noted that Datix web was currently the Trust's risk management software. Once the Trust had moved to DCIQ it would provide more automation of the risk reporting process. In terms of assurance ratings, work had taken place to encourage the system to use the same methodology,

however this had not been successful. The Trust used the same language as that used by ASW Assurance.

- It was suggested that when presented with a number of red and amber ratings against risks, clarity should be provided around the actions being taken to improve the risks. This was agreed, noting that due to scoring many of the "red" risks were scored incorrectly and this was being addressed.

The Board received and noted the Board Assurance Framework, Organisational Risk Map and Datix Summary Report and AGREED the recommended assurance recommendations.

FOR APPROVAL

133/11/25 **Actions arising from Developmental Well Led Review – Strengthening Governance Arrangements**

The Board received the Actions arising from Developmental Well Led Review – Strengthening Governance Arrangements report, circulated with the agenda pack. The following was discussed:

- The Board was reminded that the work to strengthen the Trust's governance arrangements was in part to deliver the actions from the recent Developmental Well-Led Review.
- The report outlined the changes that were proposed to be made to both strengthen and streamline the Trust's governance framework. This included reducing the number of Board sub-committees, providing a clearer assurance role for them and clarity on those matters reserved for the Board's oversight.
- Delegated authority was sought for the Chair and Chief Executive to finalise the documentation attached to the framework.
- The new framework would be operationalised from January 2026.

The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed.

The Board took satisfactory assurance that the proposed revised governance arrangements and outline Board Development Programme satisfied 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.

The Board approved the governance proposals and documentation included in the report and delegated finalisation of these to the Chair and Chief Executive; noting that the Terms of Reference for Governor Nomination and Renumeration Committee were included for the Board's oversight and recommendation to the Council of Governors who must approve these.

FOR REVIEW

134/11/25 **Operational Performance Report**

The Board received the Operational Performance report, circulated with the agenda pack.

The first version of the new performance paper was presented, aligned to RSP exit criteria and also contained cancer and diagnostics data. Benchmarking data was provided to show where the Trust was positioned nationally against key metrics, noting that the Trust's national ranking on all referral to treatment and urgency and emergency care measures had improved compared to the same time in 2024/25.

Wider performance detail was provided in the Integrated Performance and Quality Report. The report also matched the reporting framework for finance.

Urgent and Emergency Care

- 4 hour performance had deteriorated in September to its lowest point in the reporting year. It was expected to improve by about 0.5% in October but would not meet the new trajectory. The Trust had been asked to submit refreshed trajectories for remainder of the year, based on demand increases in excess of expected levels, impact of timely handover process and ongoing limitations with the Emergency Department build. The Trust remained committed to meeting the target of 78% by year end. Current November performance was just short of 70%. All type urgent and emergency care demand growth in 2025/26 was 5.97% against a planned increase of 2%.
- 12 hour performance had met the required standard of lower than 10% of attendances in all months of 2025/26 and was a significant improvement compared to 2024/25. The vast majority of 12 hour breaches were patients who would benefit in the Trust's investment in frailty.
- The Trust implemented the 45-minute Ambulance Timely Handover Process (THP) in early October. The initial review of the impacts of the THP was that it had resulted in an increase in ambulance demand. In October conveyances were a 7% increase compared to September, 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 was forecasted to result in a significant improvement in average ambulance handover times in October, mirroring performance achieved in July and August 2025. It should be noted that the requirements of THP had resulted in increased use of escalation space at cost and there was a correlation with a worsening in 4-hour performance.
- The Trust's Winter Plan was being mobilised, and it was noted that the winter peak was now expected to be just before Christmas.

Elective Activity

- The Trust had continued to make good progress on the referral to treatment (RTT) performance measures detailed within the RSP exit criteria. The Trust had met the key performance standards for: the total size of the RTT waiting list; RTT 18-week performance; the percentage of RTT patients receiving first outpatients appointment within 18 weeks; and the percentage of the total RTT waiting list with a wait time more than 52 weeks.
- There had been a requirement to balance the amount of additional monies being spent on RTT improvements and a planned reduction, which had resulted in an improved financial forecast for planned care. This had caused a tapering-off of the improvements and while the Trust continued to meet the key measures, risks to delivery in some specialities were being closely monitored. There might be a need to consider re-starting some additional activity to ensure the 52 week position was met.
- 65 week wait performance remained a concern. A new national mandate for clearance of 65 week waiters by 21 December 2025 had been shared with Trusts. The Trust was confident of eliminating all waiters, other than admitted trauma and orthopaedic patients, and had set a forecast of 40 patients still

waiting at this date. Several actions were being undertaken with the Trauma and Orthopaedic team to maximise capacity to meet the trajectory.

- The Trust's RTT performance was currently in the top ten nationally.
- A new process had been put in place to manage the impact of recent industrial action, resulting in less activity needing to be cancelled than during previous episodes.

Cancer and Diagnostics

- Both cancer and diagnostics had been challenged, however improvements had been made in cancer performance and it was expected national standards would be met in October. An improvement programme was focussing on key pathway requirements in prostate, dermatology, breast and colorectal.
- Diagnostics had remained challenged across many modalities. September performance had shown improvements in all areas except two, with major improvements in CT and MRI. A 7% improvement on the standard was expected to be made in October due to an improvement in coding of Community Diagnostics Centre activity and other improvement work.
- The Board welcomed the revised reporting format which provided visibility of the requirement for the Trust's commissioners to pay it appropriately for the activity it undertook. In respect of ambulance handovers it was noted that the increase in demand had been experienced across the system. The Devon system needed to work with the ambulance service to consider alternatives to bringing patients to hospital where appropriate.
- The impact on patients who were waiting a long time for treatment was discussed, alongside health inequalities. It was noted that this detail would be included in the quality report. In respect of health inequalities the Board was informed that equalising of waiting lists was taking place and also each patient list had been reviewed. In some cases the reasons for long waits included the need for tandem operations and procedures taking a long time to completed.
- Concern was raised around the lack of available clinical space impacting on waiting lists. It was acknowledged that the Trust's outpatient space was currently under-utilised and work was taking place to bring oversight of the service into one place. In addition Epic would support improvements to be made to waiting times, and the use of reminders to reduce 'do not attends'. In addition, the Trust needed to ensure it adopted best practice, for example 'Getting it Right First Time' data to improve efficiency.
- Trauma and Orthopaedics had the highest number of long waiters, the factors affecting this included the age of the Trust's estate and humidity in theatres. It was noted that the Trust had received capital to replace some of its theatres.
- It was suggested it would be helpful to have sight of the data detailing routine trauma and orthopaedics cancellations and the reasons for the cancellations. It was noted that this was not always due to bed availability, but could be due to cancellation on the day by the patient or clinician. It was acknowledged these were issues that the Trust could better manage.
- The use of AI to support care provided was discussed and the Trust's AI policy was queried. The Director of Corporate Governance and Trust

Secretary provided assurance that the Trust had an AI policy in place, which was in the process of being updated to take account of the use of Microsoft Co-pilot.

- The Board considered the assurance ratings presented in the report and confirmed it was content with them.

The Board AGREED the recommended assurance rating and took limited assurance against delivery of the 4-hour performance and the 45-minute ambulance handover targets. Satisfactory assurance was provided on 12-hour performance.

Assurance was limited against delivery of the 65 weeks wait elimination standard.

Satisfactory assurance was provided on all other RTT metrics within the exit criteria, noting the risks articulated.

Assurance was limited against delivery of the cancer performance targets but noted the expected recovery in September and October.

Limited assurance was provided on diagnostic performance, with plans in place to recover the position against the 10% target.

135/11/25 **Month 7 Finance Report**

The Board received the Month 7 Finance report, circulated with the agenda pack. The following was discussed:

- The Trust was reporting a net year to date deficit of £13.8m against a planned deficit of £11.3m – this was due to the loss of deficit support funding.
- Assuming deficit support funding became available, the Trust remained on plan to deliver its end of year forecast.
- The overall risk of delivery had fallen in month from £18.9m to £17.8m.
- CIP delivery was ahead of plan, but the split between recurrent and non-recurrent was not yet satisfactory.
- An application for cash had been made and £8m of cash support was received in October. If deficit support funding was not received, a further application for cash would need to be made in December for receipt in January 2026.
- The Trust's underlying deficit position had increased from £81.8m to £99.5m, partly due to the split between recurrent and non-recurrent CIP delivery and other cost pressures. Work was ongoing to reduce this further.
- The increase in agency spend was queried. It was noted that the increased spend related to backed-dated pay and agency use in Oncology which had been deemed necessary.
- The increase in the Trust's underlying position would result in a significant issue for the Trust in 2026/27 with the Trust being impacted by adult social care debt; impact of industrial action; pay award; and continuing healthcare overspend. Work was taking place to identify mitigations to reduce the underlying position.
- The Finance and Performance Committee had discussed the report in some detail noting:

- the need to ensure CIP schemes started to deliver from the start of the financial year, with concern expressed that it was already too late for this to happen.
- Assurance in the quality of the information being reported.
- Concern around the withdrawal of deficit support funding through no fault of the Trust and the amount of work that needed to be undertaken to manage the gap presented due to the lack of funding.

The Board AGREED 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 also NOTED the following:

- **Financial performance was off plan by £2.6m year to date due to deficit support funding.**
- **Forecast outturn to the end of October was on plan, as the Trust had been advised by the Integrated Care Board to assume this full deficit support would be earned back in Quarter 4.**

136/11/25 **Our Plan for Better Care**

The Board received the Our Plan for Better Care report, circulated with the agenda pack. The report provided an update on progress against the Our Plan for Better Care workstreams. The following was noted:

- The Peninsula Acute Sustainability Programme remained red rated – the plan for joint working needed to be renewed.
- The One Devon Shared Services workstream was also rated red with work taking place to shape action plans, with the oversight group Chaired by the Chief Executive.

The assurance levels used were queried as it was difficult to understand at times; for example, if an amber rating meant work was behind plan or just not yet completed. It was noted that the delivery of the action plans for each workstream were closely scrutinised before being allocated an assurance rating. The framework attached to delivery of the One Plan provided a discipline to the process. It was noted that the programme would need to be reviewed and updated for 2026/27 in the context of medium-term financial plan and transformation requirements.

The Board AGREED the recommended assurance rating and took LIMITED assurance as to those matters reviewed. The Board also:

- **Noted the progress made during the reporting period;**
- **Acknowledged the risks to delivery and ongoing work required to improve our risk position in the core domains; and**
- **Took assurance that the improvement programme was being actively driven by the Executive Team and was beginning to impact on delivery of the organisation's key priorities.**

137/11/25 **SDH Developments Annual Report and Accounts and Operational Update**

The Board received the SDH Developments Annual Report, Accounts and an Operational Update, circulated with the agenda pack. The Board was reminded of the background to the establishment of SDH Developments, which was a wholly owned subsidiary of the Trust. The following was discussed:

- Performance metrics for 2025/26 were noted, including: dispensing activity: 8,250 items per month; dispensing value: £1.1m per month; number of home deliveries: 2,240 per month; activity increasing at 6% year on year; and SACT (Systemic Anti-Cancer Therapy) dispensing increasing at circa 12% year on year
- Key performance indicators: percentage of patients receiving medicines within 30 minutes - 59% (target 70%); percentage of patients receiving medicines within 60 minutes - 87% (target 90%); dispensing errors made - 0.02% (target < 0.04%) – there was no patient harm; and complaints received - Average 1 per month (target < 2)
- Other issues affecting the service: 30% vacancy rate which impacted on the inpatient pharmacy; SDH was reliant upon locum pharmacists; transport – Epic would support the identification of patients who needed medication to be delivered ; Epic included a new pharmacy stock control system which would be a challenge to implement; and activity was expected to increase by 20% over the next three years.
- It was noted that the only way to increase pharmacy capacity was to increase opening hours as it did not have the physical capacity to expand.
- In the future there could be opportunity to expand by working with both Exeter and Plymouth trusts.
- Assurance was sought that the necessary clinical indemnity insurance was in place for the services provided by the Pharmacy. Paul Foster confirmed that it was.

The Board thanked Paul Foster for attending the meeting and his presentation.

The Board took SATISFACTORY assurance as to those matters reviewed. The Board is also NOTED the audited financial performance of the wholly owned subsidiary of TSDFT, SDH Developments Ltd and took SATISFACTORY assurance that the annual report and financial statements for SDH Developments Ltd had been appropriately prepared.

REPORTS FROM BOARD SUB COMMITTEES, CHARITY AND SUBSIDIARIES

138/11/25 **Audit and Risk Committee**

The Committee had highlighted concern at the time it was taking to identify a system wide Chief Information Officer (CIO) and also for the Trust. Adel Jones informed the meeting that interim cover for the CIO role was being organised, and the Trust was in negotiation with an experienced colleague for a set number of days to commence as soon as possible

139/11/25 **Building a Brighter Future Committee**

The fragility of the Trust's estate was discussed and the dedication of the teams that worked to maintain it; the risks attached to the Tower Block and Teignmouth Hospital; and the level of risk being held by the Trust whilst the right course of action was considered, was also recognised.

140/11/25 **Finance and Performance Committee**

The Committee discussed the need to focus on the delivery of the CIP; noted the improved level of reporting; focus on transformation to deliver benefits; and the need for improved productivity data from NHSE.

141/11/25 **People Committee**

The Committee had noted the concerns around non-delivery of recurrent savings and the actions being taken to close the gap; NHSE multi-professional education quality visit report and partnership with the Open University.

142/11/25 **Quality and Assurance Committee**

The Committee considered the following:

- Concern around the number of patients attending the Emergency Department with primarily a mental health problem.
- Neonatal deaths and a local thematic review taking place to identify if there was any learning from the incidents.
- CQC action plan was on an improvement trajectory with two remaining 'must do' actions.
- Satisfactory assurance provided in relation to the Trust's mortality data.
- Deprivation of Liberty waits remained a risk, but the introduction of independent best interest assessors was starting to reduce the waiting list.
- The new BAF was commended, with the need for more information provided in the narrative in respect of red rated risks.

143/11/25 **Research and Development Annual Report**

The Committee received the Research and Development (R&D) Annual report, circulated with the agenda pack.

R&D had experienced a very positive, busy year. The Board was reminded of the strong evidence in terms of better patient outcomes for research-active trusts. The Board noted that gross value of R&D activity which helped to support Trust activity. The following was highlighted:

- Plans for the year ahead included the development of a new Research Strategy; improve collaborative research; continue to implement Trust Nurses, Midwives and Allied Health Professionals research strategy; plan for Epic implementation; and respond to updated UK Clinical Trials regulations.
- Operational challenges included lack of space to expand; drop off of ability to recruit to some studies; recruitment delays; need for strengthened resource; and resilience – current single points of failure in the team.
- A query was raised around how well networked R&D teams were across the peninsula and equity of patients joining trials. It was noted that identifying suitable patients for trials currently relied on local networks and individual relationships. I was hoped that in the future an app would be set up which contained details of live trials for all teams to access.
- The Trust had areas of excellence in R&D and digital and they both needed to be integrated into the Trust's strategy. It was noted that the R&D strategy could be accelerated so that it was published at the same time as the Trust's overarching strategy.
- It was suggested work needed to take place to better integrate research, digital innovations and education to provide a combined offer and that the Trust's strategy needed to provide a clear narrative on this offer.
- It was suggested an area that would benefit from research was that around local care partnerships, however there needed to be studies available to participate in, in this area. The role of the Researcher in Residence was also

discussed, noting the Trust no longer had the role in place. It was agreed this would be further discussed outside of the meeting. **Action: AJ/FR**

The Board thanked both Fiona Roberts and Anna Lydon for attending the meeting and their presentation.

FOR INFORMATION

144/11/25 **Legal/Regulatory Report**

The Board received the Legal/Regulatory report, circulated with the agenda pack.

CLOSING MATTERS

145/11/25 **Any Other Business and Review of Meeting**

The following was discussed:

BirthRate + (BR) report: The service received its final BR establishment report in October. This recommended a small uplift of between 1.1 and 3.8 WTE midwives depending on the headcount uplift that was agreed. At the present time this meant the funded establishment would not reflect the recommended BR workforce requirement.

The Director of Midwifery would prepare a briefing for the Executive Committee as well as this uplift requirement being included in the 2026/27 business planning process. It was anticipated that the agreement for the required funded establishment would be achieved in early 2026/27.

146/11/25 **Board Assurance Framework (matters for review or escalation)**

The Board reviewed the discussion that had taken place in the meeting and considered any matters that required review. It was agreed both mental health and maternity risks required further review. **Action: NM/AJ**

Devon Partnership Trust had established meetings to discuss how better to care for patients with primarily mental health issues that presented at the Emergency Department. These meetings would ensure the Trust better understood the risks of caring for those patients.

The Board had also discussed the risks attached to the Trust's estate and that this would be the subject of a deep dive at the Private Board meeting being held in December.

147/11/25 **Board Workplan**

The Board received and noted the Board Workplan.

148/11/25 **Date and Time of Next Meeting:**

The next Board meeting in public is scheduled to take place at 12.30 pm on Wednesday 7 January 2026.

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.

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. **November Update**: the policy had been submitted.	**Closed**
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. **November Update:** a visit had been undertaken to McCullum ward and issues discussed at QAC.	**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. **November Update:** discussed at November Private Board meeting.	**Closed**

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 was be reported through QAC 17/11/25. Recommend closure.	**Closed**
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.	**Closed**
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.	**Closed**
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**	**November Update:** feedback provided. In addition, locally, the report was referred to using the investigation's full title.	**Closed**
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. **November Update:** completed.	**Closed**
112/09/25	**Integrated Performance and Quality Report** – provide data on the numbers of Torbay and South Devon no criteria to reside patients.	**ST**	**November Update:** completed.	**Closed**
113/09/25	**Our Plan for Better Care** – October report to contain detail of the plans to build organisational capacity.	**ST**	**November Update:** completed.	**Closed**
121/09/25	**Board Assurance Framework** – heat map to be provided in future reports.	**EL**		**Open**

143/11/25	**Research and Development Annual Report** – consider how to further research local care partnerships and the role of the Researcher in Residence.	**AJ/FR**	**January Update** – Email sent to Fiona Roberts and Simon Tapley to develop a proposed way forward. Propose close action.	**Open**
146/11/25	**Review of Board Assurance Framework** – update risks in respect of maternity and Emergency Department (relating to the care of patients that presented with primarily mental health issues)	**NM/AJ**	**January Update** – BAF updated.	**Closed**

Torbay and South Devon NHS Foundation Trust

Board of Directors

Chief Executive's report

Date of meeting	Date report produced
08.01.2026	30.12.2025

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:**	31.12.2025
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.

Appendices
Recovery Support Programme (RSP) self-assessment

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 strategy?
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

Risks lodged on Datix:	
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

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 the pride people feel in the services they provide and the ideas they have for how their services could be improved or enhanced. There is often a disconnect between messages I may hear on my visits and the feedback staff give us in the annual staff survey about what it's like to work here – one often being positive and one less so. There are two key messages which we need to consider further as we develop our implementation plans for our strategy (a) effective local leadership and line management is key and we need to consider what support we put in place for local managers who are key in shaping staff experience and (b) autonomy and freedom to act is a key theme - we need to find the right balance between this and expectations of control if we are to truly foster innovation.

3. My twice-monthly Meet Joe sessions continue to provide a valuable opportunity to hear directly from colleagues and in the past month I appreciated being able to hear directly from colleagues at Brixham Hospital. I also joined, participated in and/or hosted our corporate induction and Trust Talk in the past two months.

4. Since my November report I have spent time with our learning disability service at Hollacombe Resource Centre and our allied health professional leads as well as joining events celebrating 25 years of our MAAT service and celebrating our latest our people awards winners at our breakfast event. I was privileged to join intensive care colleagues and families they have supported at our annual intensive care remembrance event and to give a reading at our Torbay Hospital Carol Service.

5. It has been a particular pleasure to meet with each of our new staff network chairs over the past two months. As a Board I know how committed we are to ensuring our organisation is an inclusive place to work where all our colleagues can thrive regardless of their background or characteristics. This can only truly be achieved if we have a forum and process to listen to those with lived experiences and act on the messages we hear. Each of the staff networks has an Executive Director sponsor and I am immensely grateful to the network chairs for coming forward to guide us in this very important area. They will have our absolute commitment as we look to improve our understanding and support.

6. My routine meetings with the Integrated Care Board, NHS England, the Peninsula Acute Provider Collaborative, Torbay Council and our Council of Governors continue and provide valuable opportunities for discussion and to listen to diverse voices.

7. I continue to meet regularly with our local MPs, Steve Darling, Caroline Voaden and Martin Wrigley.

Leadership update

8. Last month we announced that Martin Beaman will be appointed as our new Chair from May 2026, following the completion of Professor Chris Balch's term. Martin will continue as Vice Chair until April 2026, working closely with Professor Balch to ensure a smooth continuity of leadership.

9. Martin's clinical expertise, commitment to quality, and collaborative approach will be invaluable as we continue to develop our services and deliver for our patients and communities.

10. I would also like to thank Professor Chris Balch for his outstanding leadership and support. Chris has made a significant contribution to both our organisation and the NHS in Devon and I am grateful for the guidance he has provided to me and to colleagues.

11. I'm also pleased to confirm the appointment of James Corrigan as our substantive Chief Finance Officer, bringing continuity and leadership to this critical role.

Recovery Support Programme (RSP) exit process

12. Our self-assessment against our agreed exit criteria is attached as Appendix one to this report.

13. We have received confirmation that the NHS England national meeting to sign off RSP exits (EPQDG) will take place on 24 February 2026.

14. The next step will be for the region to arrange a check-and-challenge assurance meeting against our self-assessment against the RSP exit criteria.

15. The key areas of risk and non-compliance include our performance against the four-hour standard (impacted by high demand), recurring financial delivery and workforce reduction.

Business Planning 2025/26

16. The month of December was very challenging for us operationally because of continuing high demand for urgent and emergency care services and seasonal influenza. Alongside this we have also had another period of resident doctor Industrial Action from 07:00 on Wednesday 17 December 2025 to 07:00 on Monday 22 December 2025.I would like to place on record my sincere thank you to all our teams who have worked immensely hard throughout this month to keep our services running safely.

17. There are financial and operational considerations as industrial action will have impacted elective recovery, income and staff wellbeing.

18. The demand on our services during December also resulted in significant extra bedded capacity being open for a large part of the month which will have an impact on our December financial results. We will report on the financial implications at the February Board.

19. As at month 8 we continue to forecast delivery of our financial plan for 2025/26 but as widely reported this will be achieved with significant one-off actions which will mean our recurring deficit (our underlying financial position after removing one off actions) will be close to an estimated £100m as we enter 2026/27.

Planning for 2026/27

20. The scale of the financial challenge we face across both our own organisation and the wider Devon system is very significant and we are working with our regulators and the wider Devon system to agree a plan for the new financial year.

21. A first submission of our plan for 2026/27 was made in December 2025 and despite the inclusion of an assumed cost improvement target of circa £40m we have submitted a deficit plan of £49.4m. A deficit of this level is clearly unlikely to be accepted by our regulators but has arisen largely due to the reduction in one off income received in 2025/26.

22. The next plan submission date is February 2026 and we will need to work hard over the coming weeks to firm up savings plans and improve our bottom-line position.

Our future – our strategy

23. During the last month we have been working to finalise our renewed organisation strategy and our plan is to bring this to the Board in February 2026 for final approval.

24. Alongside this we have been working on specific implementation actions for our signature moves and strategy enablers.

25. As we launch our strategy, we plan to be clear about the implementation actions that we will commit to.

Successes – our people and teams

Maternity services rated highly in national survey

26. Families who used our maternity services earlier this year reported positive experiences in the 2025 National Maternity Survey run by the Care Quality Commission (CQC). The survey covered people who received care in January and February 2025.

27. Out of 269 people invited, 122 responded — a 46% response rate, above the national average. The average rating was 86.2%, up 4.2 percentage points on last year. Local services were in the top 20% nationally for 48 of the 63 questions and not in the bottom 20% for any. Five questions improved by at least 10% year-on-year, and none worsened by 10% or more.

28. During the coming weeks, maternity leaders will review the detailed findings with staff and service users, agree priority actions, and share progress regularly. This work will focus on building on what families value most while addressing areas where experiences can be better.

29. You can read the survey results at: CQC maternity survey.

Torbay Adult Social Care Services rated as good by the Care Quality Commission

30. The Care Quality Commission (CQC) has rated Torbay's Adult Social Care services as 'Good' following an inspection in September 2025, reflecting strong performance in co-production, integration, and person-centred care.

31. We have provided adult social care services in Torbay on behalf of Torbay Council for the past 10 years, as part of a unique partnership between the NHS and local authority.

32. The CQC inspection uses a four-point rating system: outstanding, good, requires improvement and inadequate. The inspection covered working with people, providing support, ensuring safety and leadership and workforce and Torbay was rated as good across all areas.

33. Key findings from the inspection included:
    - people and unpaid carers universally reporting positive experiences, with carers expressing very high satisfaction
    - a deep integration with health services under a Section 75 agreement since 2005 which enabled joined-up care and shared resources
    - strong partnerships with the Voluntary, Community and Social Enterprise (VCSE) sector
    - person-centred assessments which focused on independence and long-term goals
    - effective arrangements to prevent, delay, or reduce care needs, including community-based support and welfare advice
    - strong focus on hospital discharge and recovery at home, supported by a new reablement facility.

34. I am proud of our people who work tirelessly to ensure people in Torbay who receive adult social care swiftly and with compassion. Our people are committed to doing all they can to ensure people receive the care they need, in their home and in their community, supported by technology. I am also pleased that our work to reduce avoidable hospital admissions and to get people discharged and back home quickly was described as excellent.

35. This report is testament to the hard work and commitment of our colleagues and demonstrates what can be achieved through integrated working. I would like to thank my colleagues for all their hard work.

Scheme to train more nurses locally with prestigious prize

36. Our unique partnership with The Open University to give people the opportunity to study for a nursing degree while training on the job has scooped a top national award.

37. We joined forces in July 2024 to give local people who had always wanted to be a nurse the chance to become a nurse without moving away to study.

38. Since the project launched, 18 people have begun their studies while completing their clinical placements at our acute and community hospitals across Torbay and South Devon, with another 16 people waiting to begin their course in February 2026.

39. The partnership is the first of its type in the country and was named as the Nursing Times' Workplace at a national prize-giving ceremony in London last month for its innovative approach to create opportunities to address the NHS' nursing workforce challenges. More than 700 leaders from nursing and midwifery attended the event, which recognised the people, teams and organisations driving improvements in staff recruitment, retention, wellbeing and inclusion across the health and social care sector.

40. Presenting the award, Nursing Times Editor Steve Ford said the judges felt the partnership was a "genuinely inspiring and unique recruitment model that demonstrates thinking outside the box, with endless possibilities for supporting social mobility and local aspirations… it's an innovative approach to creating nursing pathways for individuals from deprived areas and those with caring responsibilities or limited prior opportunities."

41. Applications are now open to join the next cohort of students who will begin their studies next year, and in a first people can choose to specialise either as a children's or an adult's nurse.

42. You can find out more about the course, entry requirements, funding arrangements and any other questions by talking to our clinical education team at open days:
    - 09 January, 6pm to 8pm, Horizon Centre, Torbay Hospital
    - 10 January, 10am to midday, Horizon Centre, Torbay Hospital
    - 27 January, 6pm to 8pm, online via MS Teams

43. Applications close 10 February. Please email tsdft.pre-registrationnursing@nhs.net, call 01803 656677 or visit our website for more information.

Priority areas

Cardiology

44. On 03 December 2025, NHS Devon published an open letter regarding cardiology services: An open letter to the people of Devon - One Devon

45. A demonstration organised by the Heart Campaign and involving around 150 people took place on Saturday 06 December on the boundary around Torbay Hospital and received media coverage from ITV West Country and Greatest Hits Radio.

46. We are awaiting receipt of the final case for change and confirmation of the date of publication from NHS Devon. They have advised this will be published in the New Year, with public engagement scheduled for January to March 2026. We will actively support this process to ensure staff, governors and local communities have their voices heard.

47. We have been invited to attend a Torquay Chamber of Commerce Public meeting on Thursday 08 January at The Imperial at 5pm, where members of the public will have the opportunity to hear directly from local leaders about the current

Case for Change proposals and issues relating to adult social care. Our organisation will be represented by myself as Chief Executive, our Chair and our Chief Medical Officer.

Future of Adult Social Care in Torbay

48. The Board will be aware of the significant public interest in the future arrangements for the management of adult social care following an announcement by the Leader of Torbay Council that we are giving serious consideration to ending the Section 75 Partnership Agreement with Torbay Council for the delivery of Adult Social Care in Torbay.

49. Torbay and South Devon NHS Foundation Trust has a long and proud history of working in partnership with Torbay Council and Devon County Council to deliver joined-up health and social care. In Torbay, adult social care services have been delivered by the Trust under a Section 75 Agreement since 2005. Under this arrangement, Torbay Council provides the funding and retains statutory responsibilities, while the Trust delivers services on its behalf. These include commissioning care packages and managing placements in residential and nursing homes.

50. In South Devon, a different model applies, consistent with most of England, where Devon County Council remains directly responsible for adult social care. Current discussions relate only to Torbay.

51. Our integrated approach has delivered significant benefits for local residents over many years, helping reduce avoidable hospital admissions and supporting people to live well at home. We remain fully committed to providing safe, high-quality adult social care for people in Torbay and to protecting the benefits of integration wherever possible.

52. When the Torbay arrangements were first established, there was a three-way risk-sharing agreement between ourselves (TSD), the local NHS commissioner (now the Integrated Care Board) and Torbay Council. This meant growth in adult social care costs was jointly funded. Over time, that arrangement has ended, leaving us (TSD) carrying the full financial risk of rising demand.

53. As a result, the cost of delivering adult social care now exceeds the funding we receive by more than £30 million, with demand continuing to grow. This sits alongside increasing pressures on healthcare services and contributes to our overall financial deficit. Like all NHS providers, we are required to move towards a break-even position while maintaining safe, high-quality care, making it essential that we find a more sustainable solution.

54. We have explored reinstating risk-sharing, but neither Torbay Council nor Devon Integrated Care Board has been able to commit to additional funding. These discussions are ongoing and complex, and no decisions have been made.

55. Our priority is clear: to maintain safe, person-centred care and ensure sustainability for the future.

56. We understand the importance of transparency and will continue to engage with partners and stakeholders as discussions progress. Should any changes be proposed, we will follow all legal requirements for engagement and consultation,

publish assessments in public Board papers, and complete equality impact assessments. For clarity, any decision to give notice on the Section 75 Agreement would relate only to the adult social care contract – not to reducing or withdrawing NHS services.

57. Torbay Hospital will continue to provide high-quality acute care. Alongside this, we aim to expand neighbourhood-based services so more care can be delivered closer to home, including diagnostics, urgent care, outpatient clinics and rehabilitation. This approach improves access, supports prevention and reduces the need for emergency treatment. It is about enhancing choice and accessibility for local people, not taking services away. This commitment aligns with the national 10-year health plan and our emerging organisational strategy.

58. We are working closely with Torbay Council, NHS Devon, and regional and national NHS colleagues to identify solutions that safeguard services for our communities. These conversations are about sustainability, not about reducing quality or access to care. Our integrated model has brought real benefits for local people, and we want to preserve those wherever possible.

New community frailty service delivers positive impact in first month

59. Our new community frailty service, The Harbour, opened at Newton Abbot Community Hospital in November.

60. The Harbour brings together clinicians under one roof to provide specialist frailty care, holistic assessments, urgent care and diagnostics. People will also be supported by our frailty virtual ward to provide care closer to home and as a safe and effective alternative to hospital admission.

61. During its first four weeks, more than 124 older people who are living with frailty have been supported by or received care at The Harbour and we are already seeing the positive impact it is having in our communities.

62. The team has so far received 138 calls from care homes, the ambulance service and colleagues working in our acute and community hospitals to see if any of the people they are supporting are suitable to receive their care at The Harbour instead of at Torbay Hospital.

63. After assessing the individual needs, 52 people received care from another service, including our frailty virtual ward, five people were admitted to a community hospital bed, 11 people received advice and guidance so they could stay at home and 61 people were supported by the most appropriate service for their care.

64. The initial feedback from patients, their families and colleagues has been overwhelmingly positive, with one relative saying they were grateful their loved one was able to receive end of life care at home through the service.

65. The service will continue to develop in the new year, including introducing a new same day emergency care space at Newton Abbot Hospital for people living with frailty who need urgent diagnostic, assessment and hospital interventions as an alternative to coming to Torbay Hospital.

First phase of £14.2m Emergency Department upgrade opens

66. We opened the first phased of Torbay Hospital's £14.2m Emergency Department redevelopment last month – a major step towards further improving patient experience and reducing waiting times.

67. The new spaces include a brighter, more welcoming reception and waiting area, extra triage rooms and modern offices and training facilities for colleagues.

68. Early feedback from patients and families has been overwhelmingly positive, with many saying the new waiting area feels more comfortable and supportive. Colleagues have also praised the improvements, which will help them deliver care more efficiently and safely.

69. Phase two of the project will bring even more enhancements, including extra space to improve patient flow, a dedicated mental health triage area for people in crisis and upgrades to the minors' area. The full redevelopment is scheduled for completion in spring 2026.

National, regional and local issues and topics of interest

Torbay Council partners with travel and personal safety app to help keep community safe

70. Torbay Council has partnered with imabi to launch the Torbay area on Travel Guardian, a free personal safety app which gives people an easier way to report anti-social behaviour concerns, access support and stay safe when they're out and about.

71. People can access Torbay-specific information including the locations of the nearest taxi ranks, bus stops, safe spaces and medical equipment, ideal for people on a night out or travelling after dark.
72. The app offers clear reporting routes for users to report safety concerns or anti-social behaviour anonymously and real-time alerts, links to local and national support organisations and geo-location tools that allow users to share their journey with trusted contacts.

Roll out of school dental care across Devon

73. NHS Devon is funding vital oral health lessons for children in primary schools for the next three years to support them in learning good habits and to help protect their teeth for the future.

74. Open Wide and Step Inside is an oral health programmed delivered by the Dental Outreach at the Peninsula Dental Social Enterprise. These sessions are funded for all year two children (6 to 7 years old) in primary schools which sign up to the programme and the lesson includes a 15-minute animated film, a two-minute brushing song and a quiz for the children.

75. Each child receives a home pack containing a toothbrush, toothpaste, two-minute timer and information about oral health messages.

Record numbers using NHS App to manage health

76. Record numbers of people are using the NHS App to manage their health, according to the latest statistics.

77. The NHS has released a Spotify Wrapped-style end-of-year update which shows the NHS App now has more than 39 million registered users.

78. A total of 67.8 million repeat prescriptions were also ordered through the app in the past 12 months (01 December 2024 to 30 November 2025).

79. The latest usage figures show 62.3 million logins for the NHS App during November alone – a 43% increase on the monthly average over the past 12 months. There were also 20.8 million views of GP health records, 6.6 million appointments managed for hospital and other secondary care services, and 6.3 million repeat prescriptions ordered during November.

80. New analysis from NHS England has also found that more than 313,000 people used the app on Christmas Day last year, with over 200 logins every 60 seconds on average.

81. New features that have been added to the app this year include an Amazon-style prescription tracker – available at nearly 2,000 pharmacies – that lets patients see when their medication is ready to be collected and a new family feature that makes it easier for parents and carers to manage their loved ones' health.

82. The NHS App will also be a key part of the new NHS Online service which is due to launch in 2027 and will allow patients to book directly through the app to see specialists from around the country online, without leaving their home or having to wait longer for a face-to-face appointment.

Local media update

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

Key media releases and responses

Torbay and South Devon NHS Charity Christmas Appeal 2025: bringing comfort and joy to people in hospital

Fulfil your dream of becoming a nurse with our award-winning partnership with The Open University

Appointment of new Chair - Torbay and South Devon NHS Foundation Trust

Maternity experience rated highly in national survey

Scheme to train more nurses wins prestigious prize

Torbay Adult Social Care Services rated as 'Good' by Care Quality Commission

Our statement on the Section 75 Partnership Agreement

Torbay Hospital opens first phase of £14.2m Emergency Department upgrade

Coverage

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

Appendix One – Progress against RSP Exit Criteria

Self-Assessment Against Exit Criteria

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	68.01%	68.3%				
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	33mins 15secs	28 mins 34 secs				
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	8%	7.8%				
4	Elective - Virtual Elimination of 65ww in line with trajectory	IPQR report to FPC and to Board mapping performance against MTFP trajectories	99	84				
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	647	607				
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	2.1%	1.9%				
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	31480	31750				
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	72.4%	71.8%				

Point 1 – Off trajectory however December performance forecasted to be ~5% improved on December 24. National ranking has improve d by 2 places in comparison to November 24.

Point 2 – November is best performance in financial year and second-best month since pre covid. Ambulance demand was highest num bers of ambulances conveyed on record.

Point 3 – Ten consecutive months of meeting this standard. Currently ranked 40 th in the country, improved for 88 th at same point last year.

Point 4 – 65% improvement from November 24. Trajectory of 40 would have been met without impact of unforeseen issues such as los s of orthopaedic theatre, consultant absence and industrial action. Still forecasting clearance within 25/26.

Point 5 and Point 6 – Remains within 0.3% of original trajectory for proportion of waiting list. Currently ranked 55 th nationally compared to 117 at same time last year.

Point 7 - ~1000 patient improvement on same point last year. Currently ranked 15 th nationally for RTT performance and in top 10 nationally most improved.

Point 8 – Have met this standard in every reporting month this financial year.

For internal noting and discussion – performance on all metrics is ahead of RDUH and UHP position at their point of NOF 4 exit.

Self-Assessment Against Exit Criteria

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

	Exit Criteria Measures	Suggested Evidence	Evidence Position RAG					
			Oct	Nov	Dec	Jan	Feb	Mar
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 Will also request RSP audit achievement of this standard.						
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 Will also request RSP audit achievement of this standard.						
Point 9 – Strategy production progressing in line with agreed timescales and is on track to be presented to the February Board. Point 10 – Well led review and action plan presented to Public Board on 26/11/2025. Point 11 - Well Led actions built into the 'Our Plan for Better Care' Integrated improvement Plan. Monthly programme reports to B oard. Point 12- CQC action plans and MSSP improvement plans in place and are being actively progressed and monitored.								
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 out-turn 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						
Point 13 – On target to deliver 2526 plan net of Deficit Support Funding Point 14 – First MTFP submission completed in December 25. Point 15 – To be assessed in Q4 post M9 financial position completed. Point 16 – CIP FOT on plan to deliver. There is a WTE review underway in month 9 being to reconcile WTE figures to costs and ensure consistency. Situation report to Board in Q4								

Torbay and South Devon NHS Foundation Trust

Trust Board

Board Assurance Framework

Date of meeting	Date report produced
8 January 2026	2 January 2026

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	**Name and title:**	Sarah Fox Corporate Governance Manager
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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 December 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, but is responsible for one supporting objective, namely:

> Full definition and resource of Our Plan for Better Care is in place, alongside the phases of delivery contained therein.

In accordance with the Trust's Risk Management Policy and Strategy, the Board are also presented:

- the Organisational Risk Map (ORM) (providing oversight of the overarching risk position of the Trust, adjusted for inherent and residual risk); and

- a summary of the Datix Risk Register (Datix being the Trust's operational risk management system)

This facilitates the Board to review the Trust's overarching risk portfolio, and all risks scored high and very high each month. Six monthly the Board also receives the full Datix data set to ensure granular analysis of risk is undertaken by the Board.

The ORM and Datix Risk Register are presented alongside the BAF as assurance that the Trust's risk management system and the risk registers adequately underpin the BAF, providing linkage between operational and strategic risks. Together these tools evidence, to the Board, that the internal controls of the organisation are being maintained as well as reporting against strategic delivery.

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

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
BAF Highlight Report	Satisfactory	n/a
Organisational Risk Map	Satisfactory	No change
Datix Summary Report	Satisfactory	No change

Appendices

Board Assurance Highlight Report
Board Assurance Framework
Organisational Risk Map
Datix Summary Report

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

Executive Committee

Key recommendations and actions requested

To receive and note the Board Assurance Framework, Organisational Risk Map and Datix Summary Report and AGREE the recommended assurance recommendations.

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

The report supports the Board in identifying those risks that could affect the Trust's aim of supporting the people of Torbay and South Devon to live well, and to take account to ensure those risks are mitigated against and managed.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	Yes
Quality of services provided	Yes
Sustainable and efficient use of resources	Yes

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality, Safety and Patient Experience	Yes
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	

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

External Standards affected by this report and associated risks
Care Quality Commission NHS England licence and regulations National policy, guidance

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

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

BOARD ASSURANCE FRAMEWORK: HIGHLIGHT REPORT

Ref		Objective	Executive Lead	Overseeing Committee	Assurance rating*
Quality, Safety and Patient Experience					
1.		**Corporate Objective:** To deliver safe, effective, compassionate and affordable care that meets regulatory standards and provides high quality outcomes and experiences for people and their families.	CEO	Board	
	1.1	**Supporting Objective:** By Q4 2025/26, demonstrate a 10% reduction in avoidable harm incidents (falls, pressure ulcers, medication errors) through improved use of safety huddles, early warning systems, and learning from incidents and mortality reviews across all clinical areas.	CNO	QPC	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	QPC	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	QPC	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	QPC	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	QPC	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	QPC	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	QPC	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	QPC	Limited
	2.2	**Supporting Objective:** Develop a strong executive team with clear accountabilities and objectives- aligned with IIP delivery milestones.	CEO	Nomination & Renumeration	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	QPC	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	F&OC	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	F&OC	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	F&OC	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	F&OC	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	F&OC	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	F&OC	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	QPC	Limited
	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	QPC	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	QPC	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	QPC	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	Board	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	QPC	Satisfactory
	5.3	**Supporting Objective:** Strategic alignment for medium-to-long-term transformation designed, with the10 year plan principles being used as the basis for the strategy.	CSPO	F&OC	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	QPC	Satisfactory

	5.4	**Supporting Objective:** To support initiatives and work collaboratively with stakeholders and our NHS provider colleagues to deliver services that meet the needs of those living in the Peninsula now and in the future; for example: the OneDevon initiatives and PASP workstreams	CSPO	QPC	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	F&OC	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	F&OC	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	QPC	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	F&OC	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	F&OC	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	F&OC	Limited

*** Assurance rating from Board papers to be used**

Organisational Risk Map (ORM or Risk Map) – January 2026

	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 4137,416716 81,4255 ,3502, 4312, 4237, 4299, 4228	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 15 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,	**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 4 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, , 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,	**10**	Moderate	6	Up to 12	Digital and Cyber Resilience	The median risk score for all risks held on Datix against this risk type is 10 however the median of risks scored above 13 is 15, with 10 risks scoring above 13 currently recorded. The median scores are **within** the Trust's agreed risk tolerance score. The factors increasing and decreasing risk are: •EPR implementation progress •iOS mobile device hardware replacement. •Addressing collapsed fibre ducts between the two main datacentres (procuring to relocate to hosted datacentres), this project is proceeding as expected. Programme governance is set up and exec escalation in place. •Upgrade of 2008 & 2012 server platforms. •Windows 11 upgrade project. •PC/Laptop hardware replacement to meet Epic warranted environment specifications. *Imprivata single sign-on (SSO). •Horizon virtual desktop infrastructure (VDI) platform deployment. •Replacement of hardware running unsupported operating systems. •Implementation of multi-factor authentication (MFA) as per in-year NHS England Policy change. •SharePoint environment scheduled patching. •Integration of Cynerio with Aruba Clear Pass Policy Manager to improve micro segmentation of network	**High** Which is **above** the Trust's agreed risk appetite This has been adjusted upwards to reflect the significant strategic priorities in this area.
Service/ Business Interruption Risk:	1083: Inability to maintain/operate the estate in accordance with customer needs, NHS HTMs & Stat/Mand reqts within allotted funding	3684, , 3621, 3804, 2542, 3519, ,2307, 1069, 3485, , 2429, 3521, 2718, , 3823, , , , , 4201,4200, 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 18 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).	, 1697,, 3362, 2928, , , 3789, 3456, 2037, 4077, 3956, 4163 4136 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 12 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			**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)			**0**	Moderate	6	Up to 12	Strategy & Transformation	The median risk score for all risks held on Datix against this risk type is 0 however the median of risks scored above 13 is also 0, 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	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 10 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	**12**	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 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 Jan 26

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 22th Dec 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	116
Risk(s) increased to 15 and above for review	2
Reduced, closed or suspended risk(s) rated at 15 and above to note	11
Risks requiring validation	38

Risk Heat Map

Likelihood/ Probability of Risk Occurring	1 Minimal	2 Minor	3 Moderate	4 Major	5 Catastrophic	**Total**
5 Almost Certain	4	4	30	14	2	**47**
4 Likely	2	8	86	46	8	**98**
3 Possible	4	21	97	96	16	**234**
2 Unlikely	1	12	36	36	13	**150**
1 Rare	3	2	15	17	10	**54**
Total	**14**	**47**	**264**	**209**	**49**	**583**

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

Current Risk Score	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec- 25
Very High (15-25)	30	29	33	31	32	32	34	32	29	23	26	24
High (13-19)	91	95	88	82	84	88	94	93	96	87	90	92
Moderate (6-12)	603	586	578	581	580	583	576	582	592	405	404	401
Low (1-5)	78	83	92	94	94	97	98	99	104	72	64	65
Total number of risks	794	793	791	788	790	799	802	804	821	587	584	583

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

Escalation of Very High & High level risks (updated 22nd Dec 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	
4001	Pharmacy Aseptic Services - Risk to Provision of Systemic Anti-Cancer Treatments	20	⟺	09/01/2026	Clinical Safety Risk	
1083	Inability to maintain/operate the estate in accordance with customer needs, NHS HTMs &	25	⟺	30/01/2026	Financial Risk	[18/12/2025] Risk over three years old - full review last undertaken at EFM Risk Group Nov 2025. Risk to be retained.

	Stat/Mand reqts within allotted funding					
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	⟺	31/01/2026	Clinical Safety Risk	[26/11/2025] Theatres have a planned consultation starting in Jan 2026 which will potentially change the team to be able to facilitate a second team.
2801	Excessive Storage of Flammable Items in Corridors for Prolonged Periods	20	⇧	27/02/2026	Health and Safety Risk	[18/12/2025] Risk over three years old - full review last undertaken at EFM Risk Group Nov 2025. Risk to be retained. [26/11/2025] Corridor clutter cannot be tolerated and continues to be part of Tower group discussion. Feasibility of extra storage to be examined. Despite additional controls, likelihood has been increased from Possible to Likely, increasing score from 15 to 20.
3867	Clinical Coding Retention and Recruitment	20	⟺	01/12/2025	Financial Risk	
1697	Insufficient Permanent Workforce Capacity to Meet Patient Need (Overarching Risk).	20	⟺	27/01/2026	Workforce Risk	
1815	Non-Compliance With the National Cancer Waiting Time Targets.	20	⟺	28/02/2026	Performance Risk	[19/12/2025] Currently achieving 28-d FDS, however have missed the previous 3 months (mainly due Skin capacity). 31-day performance being impacted by radiotherapy physics and radiographer capacity. Good progress being made in reducing the 62-d PTL, down to 5.1%, although leave over the festive period (in clinical services) presents a risk into the New Year.
3249	Automated Dispensing System (Pharmacy)	16	⟺	28/01/2026	Performance Risk	

2957	Radiation Safety (Staff/Public) : Inadequate Management Controls (Regulatory Compliance)	16		27/12/2025	Health and Safety Risk	
4254	Torbay localities CES and TEC supply and support.	16		30/01/2026	Clinical Safety Risk	[27/11/2025] Risk reviewed controls and gaps updated. Risk score reduced to 16.
1947	Principal Overarching Risk (Medical Device Rolling Replacement Programme) (MDRRP)	16		23/01/2026	Clinical Safety Risk	[10/12/2025] New linked risk added 4020 SCBU Transport Trolley (MDRRP) (Capital) (16)
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		23/02/2026	Clinical Safety Risk	[12/12/2025] action plans for Wrong Blood in Tube incidents, have been updated and received for all care groups. Can be found with Hospital Blood Transfusion Committee meeting minutes for November 2025. MHRA Inspection undertaken and completed in December 2025, action plan following visit lead Tony Lowe
4136	Shortage of Therapeutic Radiographer and Support Workforce (Radiotherapy)	16		31/03/2026	Workforce Risk	[02/12/2025] On going agency reliance - 4 in usage. Exploring external funding of R&R to stop agency reliance. Bus. case in progress relating to 'growing our own' in relation to 3 x substantive apprentice rads and 1 x B7 Practice Educator / Education lead to assist with training undergraduates, careers focus locally and retention of current staff. Due to workforce controls re-advertisement of vacant posts are taking longer impacting overreliance on agency. 4 x agency have allowed some improvement in CWTs. Patient clinical prioritisation in place.

2948	Delay in MH Patients Being Transferred to Appropriate Placement/Assessment Environment	16	⟺	30/01/2026	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	
3664	Lack of Security Cover at Community Sites	16	⟺	31/03/2026	Health and Safety Risk	[12/11/2025] there have been multiple conversations with staff regarding layout of clinic rooms to maximise safety - maintain unobstructed path to exit room and reduce patient positioning between staff member and door waiting security walk around to discuss options reviewed at risk group today
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	
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	⟺	31/03/2026	Health and Safety Risk	[26/11/2025] New hostile vehicle measures installed to protect Newton Abbot Hospital main entrance following RTC in November 2025.
3839	BAU Support of Systems NOT Replaced By Epic	15	⟺	03/03/2026	Information and Technology Risk	[07/12/2025] Still significant amount of BAU resource aligned to Epic. Epic go live scheduled for 03rd April 2026. No clear idea of what local BAU resource for Epic looks like.

3460	Compromise or Failure of Cloud Hosted IT Services or Systems	15	⟺	02/03/2026	Information and Technology Risk	[07/12/2025] Reviewed and updated Action regarding DC migration.
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	
3823	Patient safety capacity/ PSIRF - compliance	15	⟺	28/11/2025	Service/Business Interruption Risk	
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	⟺	28/02/2026	Clinical Safety Risk	[10/12/2025] Reduction in ZUNK results due to changes within the system, weekly report being sent out to Team Leaders to chase outstanding ZUNK results.
4178	Sustainability of Dawlish MIU	15	⟺	31/03/2026	Communication and Reputational Risk	[12/11/2025] ongoing recruitment challenges noted [04/11/2025] as of 3rd November Dawlish MIU temporarily closed for review March 2026 recruitment ongoing
2920	Activity Dataset Non-Compliance for Community Setting	15	⟺	31/12/2025	Information and Technology Risk	
3774	Services that are "fragile" or have gone beyond fragility into "crisis" (Overarching Strategic Risk)	15	⟺	30/01/2026	Strategy and Transformation Risk	[11/12/2025] Risk to close- out of date
4036	Adoptive Records on IHCS	10	⇩	29/03/2026	Information Governance Risk	[12/11/2025] Score lowered - agreed by DPO at Risk Management Group

3684	Tower Block External Structural Condition (CD No 2)	5	↓	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.
3869	The Oncology Information System (OIS) - Mosaic end of life Support	4	↓	14/01/2026	Information and Technology Risk	

Torbay and South Devon NHS Foundation Trust

Board of Directors
Our Plan for Better Care

Date of meeting	Date report produced
8th January 2026	23rd December 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 December 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 is 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 Trust strategy?

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.

Torbay and South Devon NHS Foundation Trust – Our Plan for Better Care

1. Introduction and 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 December 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 Due to the need for an Extraordinary Board meeting, the OPFBC Oversight Group meeting scheduled for Performance in December was stood down. Nevertheless, the workstream highlight reports have been reviewed by the Senior Responsible Officer (SRO) to ensure continued oversight.

2.3 In response to a previous request from OPFBC Oversight Group, the performance workstream leads have reviewed and updated their deliverables to ensure

alignment with key strategic transformation priorities. The revised plans have undergone a 'check and challenge' process with the SRO and subsequent review by the Executive Committee on 18th December. The refreshed plans received broad support from the Executive Committee with an invitation for further streamlining as we move into 2026/27. As well as confirming strategic alignment this recognises the strengthening of governance during the delivery period to enable 'business as usual' performance reporting to be managed separately.

2.4 An Executive Assurance rating is applied per workstream aligned to the Board Assurance RAGs. Table 1 summarises the status position for the last quarter.

Table 1:

Programme / Workstream	Oct 25	Nov 25	Dec 25
Leadership Programme			
1.1 Governance & Assurance			
1.2 Well-Led	Complete	Complete	Complete
1.3 Board & Executive Development			
Strategy Programme			
2.1 3-5 Year Strategy			
2.2 EPIC			
2.3 Peninsula Acute Sustainability Programme			On Hold
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	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	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			

2.5 The assurance rating for both the Governance & Assurance workstream and 3-5 year strategy, has improved in month, due to strong progress in delivering key milestones and advancing planned outputs. The overarching Trust strategy, scheduled for completion in January 2026, is advancing through iterative engagement with the Executive Team. This approach ensures strategic alignment and positions the organisation to deliver a clear, cohesive direction. Collectively,

these developments provide confidence in delivery and reinforce organisational readiness for future transformation.

2.6 The PASP workstream, as originally defined within the improvement plan, has been placed on hold pending the outcome of Executive discussions with system partners. Positive progress has been made in re-engaging these partners, with recent Executive and strategic lead meetings refining a portfolio of collaborative programmes, which will be costed and prioritised in the coming weeks. In the interim, the Dermatology programme has emerged as a leading example of system-wide collaboration. It brings together clinical teams from three Devon trusts in partnership with the cancer network to drive pathway transformation. Key elements include shifting services from acute to community settings to better manage demand and introducing AI-assisted triage to optimise clinical resources and streamline patient flow.

2.7 Work is ongoing to refine the One Devon Shared Services Procurement workstream plan, ensuring that proposed deliverables align with the required level of ambition. The revised plan will set clearer expectations and strengthen accountability across all stakeholders.

2.8 The Oversight Group expressed significant concern regarding the increase in overall headcount despite the implementation of the vacancy control framework. In response, an executive-level review of vacancy management and control processes has been mandated. To inform this review, Oversight has requested a comprehensive analysis of the factors driving workforce growth and the causes of underperformance against the workforce plan.

2.9 The programme's overall assurance rating remains 'Limited', primarily due to deliverable progress. Of the 123 open deliverables in the plan, 22.8% are currently off track, with some exceeding the November 2025 target completion date and others escalating as anticipated risks. Of the 104 deliverables scheduled for completion by the end of November 2025, 69.2% have been completed. While this is below plan, it reflects an improvement from last month's 61.3% completion rate for October targets.

2.10 Risk also remains a significant driver of the overall assurance rating. During the reporting period, 108 risks were recorded on the IIP risk register and shared with the Oversight Group. Four of these risks are currently scoring 20 or above and are listed 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–M8) delivery stands at £18.4m, with full year delivery of £26.1m and a forecast outturn of

£32.1m. There remain additional CIP schemes, outside of the IIP remit, with a forecast outturn of £9.4m, bringing the total forecast outturn position to £41.5m.

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.

Table 2:

Our Plan for Better Care Workstream Dashboard								
Workstream	**Original Plan**	**Transacted YTD (M1-M8)**	**Transacted Full Year Delivery**	**Forecast Outturn (Transacted & Forecast)**	**Forecast Outturn High Delivery Risk**	**Forecast Outturn Medium Delivery Risk**	**Forecast Outturn Low Delivery Risk**	**Variance Between Original & Forecast Outturn**
2.4a Adult Social Care/Continuing Health Care	£ 8,082,000	£ 4,661,658	£ 7,321,461	£ 7,895,704	£ -	£ 574,243	£ 7,321,461	-£ 186,296
2.4b Continuing Health Care	£ 2,127,000	£ 1,779,199	£ 3,018,916	£ 3,018,916	£ -	£ -	£ 3,018,916	£ 891,916
3.1a Planned Care – Elective Care	£ 2,000,000	£ 900,000	£ 1,500,000	£ 1,506,000	£ -	£ -	£ 1,506,000	-£ 494,000
3.1b Planned Care – Diagnostics DM01	£ 580,000	£ 336,000	£ 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	£ -	£ 1,252,416	£ 1,266,165	£ -	£ 13,749	£ 1,252,416	-£ 355,835
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ 1,037,806	£ -	£ -	£ -	£ -	£ -	-£ 1,500,000
4.4a One Devon Shared Services Finance	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
4.4b One Devon Shared Services Procurement	£ 338,000	£ 45,874	£ 87,348	£ 574,120	£ -	£ 486,772	£ 87,348	£ 236,120
5.1 Workforce Plan & Transformation**	£ 19,387,192	£ 9,635,749	£ 12,418,810	£ 17,304,679	£ 100,000	£ 1,684,000	£ 15,520,679	-£ 2,082,513
Total	**£ 36,886,192**	**£ 18,396,286**	**£ 26,102,951**	**£ 32,069,584**	**£ 100,000**	**£ 2,758,764**	**£ 29,210,820**	**-£ 4,816,608**

*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.

6. Assurance

6.1 Noting the above, 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

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

Our Plan for Better Care

Torbay and South Devon NHS Foundation Trust

December 2025

Our Estate
Our People
Our Digital

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** (Significant Assurance): On track, with assurance rating improved as many deliverables are now progressing as planned. The risk management framework is under review, and the Executive team has requested further clarity to support a deep dive on deliverables and consultant input. Quality Improvement (QI) deliverables have been transitioned to the Culture, Organisational Development & Learning workstream (5.3).
- **Executive & Board Development** (Satisfactory Assurance): Progress remains satisfactory, with notable achievements in recruitment and development milestones. Key risks are actively managed. The Leadership Behavioural Framework has advanced, as referenced in the Board Paper (26.11.2025) under Leadership Competencies; however, the deliverable is behind schedule and remains off-track due to earlier delays in Board scheduling. Recovery planning and integration into the development programme are now a priority.

Strategy Programme

- **3-5 Year Strategy** (Significant Assurance): On track for January board sign-off. Language has been simplified for a wider audience, with an emphasis on 'signature moves' and key enablers for the year ahead. Work is underway to integrate this with next year's transformation plan. The Executive team will prioritise transformation resource allocation before year-end.
- **EPIC** (Satisfactory Assurance): Downgraded to 'watch', though progress is improving. Benefits realisation has shifted from green to amber due to uncertainty around system-level benefits and the cash-out process. Estates risks have been resolved, and the medical device escalation has been mitigated. Oncology build is progressing, and a cutover plan for prescribing will be developed; consultant training (approximately 2.5 days per consultant) requires urgent planning. OPFBC highlighted the risk of inequity in overtime payments compared to other trusts, which needs further exploration with CMO support and oversight. Additionally, clarity is required on the process for ensuring overtime costs are correctly recharged to the EPR budget and will be actioned.
- **PASP** (On Hold): The programme remains largely on hold; however, the Dermatology workstream stands out as a positive example of effective collaboration, strong clinical engagement, and strategic workforce planning across the system as originally intended.
- **Adult Social Care** (Limited Assurance): Progressing, though delivery is slowed by resource constraints. Project management capacity remains limited following the end of Channel 3 support; recruitment has been slow, but job evaluation at the Council is now underway. The CPSO is urgently exploring options to secure additional resource. The Liquid Logic replacement remains off track due to SBS data migration delays and complex system interdependencies.
- **Continuing Health Care** (Limited Assurance): Urgent meeting with the ICB is required to gain a detailed understanding of income and expenditure, as well as the specifics of the risk-share arrangement. Recent analysis has identified a significant shortfall in the income required to sustain the CHC service. The CFO is actively supporting these discussions. Recruitment progress: three full-time nurses have been successfully appointed to support targeted review activity and pre-employment checks are underway. IT system challenges: integration of multiple systems remains the ultimate goal; however, this continues to pose a risk, particularly regarding access to legacy data. This is being investigated by key stakeholders.
- **Children & Family Health Devon** (Limited Assurance): Programme manager appointed. Staff consultation is on track to launch, with a 70-day consultation period agreed to accommodate the Christmas period. Temporary placement has been confirmed with DPT, and drop-in sessions are scheduled to support engagement. Financial negotiations regarding overheads and estates recharge remain in progress and IT specification misalignment for laptops continues. All under discussion between CFOs and will be resolved prior to transfer completion.

High-Level Programme Summary (2)

Performance Programme

In response to a request from the OPFBC Oversight Group, the performance workstream leads have reviewed and updated their deliverables to ensure alignment with key strategic transformation priorities. The revised plans have undergone a 'check and challenge' process with the SRO and subsequent review by the Executive Committee on 18th December. The refreshed plans received broad support from the Executive Committee with an invitation for further streamlining as we move into 2026/27. As well as confirming strategic alignment this recognises the strengthening of governance during the delivery period to enable 'business as usual' performance reporting to be managed separately.

Finance Programme

- **Sustainable Financial Improvement Programme Process** (Satisfactory Assurance): Progress on Service Line Reporting (SLR) and productivity has been slower than anticipated, resulting in limited Q2 data availability. Accuracy remains a priority, and the finance team is actively addressing this. To accelerate progress and ensure alignment, it is recommended that a cross-cutting productivity group be established, incorporating clinical and operational input.
- **Sustainable Financial Improvement Programme Delivery** (Limited Assurance): A total of 39 CIP schemes opportunities remain outstanding. OPFBC emphasised the urgent need to prioritise completion and formal sign-off of all associated documentation to ensure delivery and progression in year (some are original, some are additional added). Capacity is reported as challenging across care groups to formulate. CEO is to formally write to Care Groups to obtain more clarification and set direction. Delivered to date: £41.3m across green and amber-rated schemes. Outstanding high-risk schemes: £0.27m. The continued reliance on non-recurrent savings presents a significant risk to future financial sustainability and requires focused mitigation within forward planning. A robust approach addressing non-recurrent savings to safeguard long-term financial resilience is being aligned to planning for next year.
- **Finance Capability & Capacity** (Limited Assurance): Recruitment and structural changes are progressing slowly due to job-matching and consultation delays. The competency assessment has been delayed; while not a blocker, it remains a required step to be undertaken. The development programme continues despite ongoing resource constraints.
- **Managed Services & Subsidiary Company Arrangements:** On hold pending national direction; likely deferred to 2026–27.
- **One Devon Shared Services Finance** (Satisfactory Assurance): One Devon shared finance services is progressing however, live risk recently identified in week around SBS system readiness for April 2026 go-live for provider environment which is being driven by system SRO. Further information will be obtained by the CFO in the next coming month and exploration of mitigation.
- **One Devon Shared Services Procurement** (Limited Assurance): The OPFBC noted that the new workstream deliverables lacked clarity and included extended timelines (up to 2027), which were challenged. The workstream must also incorporate logistics, a robust savings plan for 2026–27, and a stronger contract management approach. Additional work will be undertaken during the month aligning to year 2 of the programme and investigation for why some schemes haven't been transacted as yet via SRO oversight.

High-Level Programme Summary (3)

People Programme

- **Workforce Plan & Transformation** (Limited Assurance): Despite plans for headcount reduction, workforce numbers have increased. Delivery against the revised reduction target remains significantly behind plan, with only 73 posts transacted recurrently against a target of 259. Escalation capacity and reliance on agency/bank staff continue to rise, highlighting that the current vacancy control framework is ineffective and requires urgent review. This review will be SRO-led, include reconciliation of actual numbers vs plan, and identify corrective actions. An executive-level assessment of workforce controls is recommended, including consideration of a vacancy freeze and a comprehensive deep dive to inform and support difficult decisions.
- **People & Education Capability & Capacity** (Limited Assurance): Additional capacity within the team is positively driving reductions in ER cases, with closure times improving significantly from 203 to 121 days. The refreshed Directorate Work Plan is in draft form, informed by recent strategy workshops; the skills survey has closed with 89 responses and analysis is underway; and ten policies are scheduled for ratification, increasing compliance from 33% to 45%. Customer service satisfaction has been benchmarked at 3.74 out of 5, while long-term sickness cases have reduced from 339 to 300, reflecting early impact of targeted interventions.
- **Culture, OD & Learning** (Limited Assurance): Significant achievements include the launch of a cross-trust leadership webinar series, strengthened engagement with staff networks, and advancement of wellbeing and occupational health plans. Deliverables on cultural indicators and gap assessments have been completed, while implementation of the restorative culture approach and organisational design review remain on track. Staff survey engagement and KPI development are underway, with early improvements noted in pulse survey response rates. Key risks relate to aligning policies and processes with cultural ambitions, mitigated through structured implementation plans and collaboration with partner organisations. The next period will focus on embedding evaluation mechanisms, finalising wellbeing proposals, and progressing mediation and occupational health reviews to support staff experience and organisational resilience.

Workstream Progress Summary December

Programme / Workstream	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
Leadership Programme					
1.1 Governance & Assurance					
1.2 Well-Led			Complete	Complete	Complete
1.3 Board & Executive Development					
Strategy Programme					
2.1 3-5 Year Strategy					
2.2 EPIC					
2.3 Peninsula Acute Sustainability Programme					On Hold
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	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	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:

- PASP workstream, as originally scoped, has been placed on hold, pending the outcome of inter-Trust Executive discussions.
- Work continues to develop the One Devon Shared Services-Procurement workstream plan to ensure the deliverables reflect the required level of ambition
- Managing Our Estates remains under review, pending the outcome of the Executive review of the EFM' Director's assessment report.
- Managed Services & Subsidiary company arrangements remains on hold pending national direction.

The Improvement Programmes Impact to CIP (M8)

Torbay and South Devon NHS Foundation Trust

Our Plan for Better Care Programme Dashboard

Programme	Original Plan	Transacted YTD (M1-M8)	Transacted Full Year Delivery	Forecast Outturn (Transacted & Forecast)	Forecast Outturn High Delivery Risk	Forecast Outturn Medium Delivery Risk	Forecast Outturn Low Delivery Risk	Variance Between Original & Forecast Outturn
Strategy	£ 10,209,000	£ 6,440,857	£ 10,340,377	£ 10,914,620	£ -	£ 574,243	£ 10,340,377	£ 705,620
Performance	£ 5,452,000	£ 1,236,000	£ 3,256,416	£ 3,276,165	£ -	£ 13,749	£ 3,262,416	-£ 2,175,835
Finance	£ 1,838,000	£ 1,083,680	£ 87,348	£ 574,120	£ -	£ 486,772	£ 87,348	-£ 1,263,880
People	£ 19,387,192	£ 9,635,749	£ 12,418,810	£ 17,304,679	£ 100,000	£ 1,684,000	£ 15,520,679	-£ 2,082,513
Total	**£ 36,886,192**	**£ 18,396,286**	**£ 26,102,951**	**£ 32,069,584**	**£ 100,000**	**£ 2,758,764**	**£ 29,210,820**	**-£ 4,816,608**

Our Plan for Better Care Workstream Dashboard

Workstream	Original Plan	Transacted YTD (M1-M8)	Transacted Full Year Delivery	Forecast Outturn (Transacted & Forecast)	Forecast Outturn High Delivery Risk	Forecast Outturn Medium Delivery Risk	Forecast Outturn Low Delivery Risk	Variance Between Original & Forecast Outturn
2.4a Adult Social Care/Continuing Health Care	£ 8,082,000	£ 4,661,658	£ 7,321,461	£ 7,895,704	£ -	£ 574,243	£ 7,321,461	-£ 186,296
2.4b Continuing Health Care	£ 2,127,000	£ 1,779,199	£ 3,018,916	£ 3,018,916	£ -	£ -	£ 3,018,916	£ 891,916
3.1a Planned Care – Elective Care	£ 2,000,000	£ 900,000	£ 1,500,000	£ 1,506,000	£ -	£ -	£ 1,506,000	-£ 494,000
3.1b Planned Care – Diagnostics DM01	£ 580,000	£ 336,000	£ 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	£ -	£ 1,252,416	£ 1,266,165	£ -	£ 13,749	£ 1,252,416	-£ 355,835
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ 1,037,806	£ -	£ -	£ -	£ -	£ -	-£ 1,500,000
4.4a One Devon Shared Services Finance	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
4.4b One Devon Shared Services Procurement	£ 338,000	£ 45,874	£ 87,348	£ 574,120	£ -	£ 486,772	£ 87,348	£ 236,120
5.1 Workforce Plan & Transformation**	£ 19,387,192	£ 9,635,749	£ 12,418,810	£ 17,304,679	£ 100,000	£ 1,684,000	£ 15,520,679	-£ 2,082,513
Total	**£ 36,886,192**	**£ 18,396,286**	**£ 26,102,951**	**£ 32,069,584**	**£ 100,000**	**£ 2,758,764**	**£ 29,210,820**	**-£ 4,816,608**

*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–M8) delivery stands at **£18.4m,** with full year delivery of **£26.1m** and a forecast outturn of **£32.1m.** Highlighting a variance of **£4.8m**.

The dashboard opposite summarises the CIP position by programme and further by workstream.

There remain additional CIP schemes, outside of the IIP remit, with a forecast outturn of **£9.4m**, bringing the total forecast outturn position to **£41.5m**

Reliance on non-recurrent CIP schemes particularly for workforce reductions remains a challenge. Urgent action continues to be taken to identify and develop mitigating plans and to convert non-recurrent schemes to recurrent. This is being monitored through the revised Executive Operational Group meeting with the Care Groups.

Highest Risks to Delivery (1)

Definitions

Movement in month – Key:

★	New Risk	⬇	A decrease in risk score
⬌	The score remains the same	⬆	A rise in risk score

Torbay and South Devon NHS Foundation Trust

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	⬌
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	⬌

Highest Risks to Delivery (2)

Definitions

Movement in month – Key:

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

Torbay and South Devon NHS Foundation Trust

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 1and 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. 11) The Consultation Paper was presented at the Partnership Forum meeting as planned on 20th Nov. This went through without difficulty. The Paper was formally presented on the same day to the staff as the next phase of the process. Whilst the Consultation period is ongoing, it has been agreed to trial a different way of rostering, to reduce staff burnout, from 8th Dec. Risk score to be reviewed by senior clinical team w/c 8th Dec	20	↔

- During this reporting period 108 risks were recorded on the IIP risk register & shared with OPFBC.
- **4 of these risks are currently scoring 20 or above.**
- **5 new risks are presented for approval:** (1x CFHD, 1x ASC, 2x One Devon Shared Services- Finance & 1x Elective Centre of Excellence). These new risks will be formalised for January reporting.
- **4 risks have reduced residual scores in month**; *Board & Exec Development - Recruitment to substantive executive positions (1.3-03), Board & Exec Development - RSP resource and support is withdrawn (1.3-06), Child Family Health Devon - Change and uncertainty result in staff turnover and reduced capacity to deliver services effectively (2.5-03) and Continuing Health Care - Resource available to reduce backlog and sustain the position (2.4b-05).*
- **3 risks have increased in month**; *Board & Executive Development - Tension between organisational focus and system priorities (1.3-04), Board & Executive Development - Conflict and division between board members (1.3-07), Maternity - Capacity to deliver MNIP requirements and other maternity national priorities (3.4-02).*
- **1 risk presented for closure**; *Adult Social Care - ContrOCC data migration issue remains unresolved (2.4-10).*
- **2 risks presented for merging**; *Community Frailty - Inability to resource new service adequately on go live (3.3a-04) and uptake of bank shifts and the onboarding/local induction of these staff to the service for the 17th November (3.3a-10) with closure of risk 3.3a-10.*
- **Please see Appendix B for the full detailed IIP Risk Register.**

BUILDING A Brighter Future

NHS
Torbay and South Devon
NHS Foundation Trust

Appendices

Torbay and South Devon NHS Foundation Trust

Leadership Programme

Senior Responsible Owner – Joe Teape, CEO

Stable and successful Board with continuous effective leadership development. Robust governance framework at all levels to ensure statutory duties and regulatory compliance is adhered to and the Board are sighted on risk, data and robust plans to make informed decisions.

Governance & Assurance

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Delivery of the governance improvement workstream remains on track, with significant progress achieved during November. Six deliverables moved from Off Track to On Track or Complete, and the workstream continues to advance socialisation and alignment activities.
- ✓ The refreshed governance model was approved by the Executive Committee in November and subsequently progressed to the Board, supported by updated Terms of Reference, documentation, and communications shared with key stakeholders. This provides strong assurance regarding the design and agreement of the future governance structure, although consistent implementation will be essential to maintain assurance as the workstream progresses.
- ✓ Performance oversight improvements have also advanced. A refreshed report was submitted to November committees, and data automation is improving. However, completion and sustainability remain dependent on confirmed metric ownership, clear definitions, and appropriate resourcing.
- ✓ Risk management enhancements are developing well, with diagnostic work completed and revised scoring approaches in progress. Next steps are being overseen by the Audit Committee, Head of Internal Audit, and Executive Committee. Implementation, training, and system changes are planned for future phases in line with the current schedule.
- ✓ Governance and assurance plans were scoped and agreed at the Executive Committee on 12 November 2025. Board members have been actively engaged, and the Well Led action plan was presented in the Board Pack on 26 November 2025, marking this deliverable as complete.

Next Steps

- ➢ The updated Balanced Scorecard dashboard is scheduled to go live for December Care Group meetings. Further development of the Integrated Quality and Performance Report (IQPR) continues, incorporating feedback from November submissions; this remains an iterative process and is not yet final.
- ➢ The Board approved the refreshed Terms of Reference at its meeting on 26 November, with roll-out planned during December. Organisation-wide communications will follow Board approval.
- ➢ Executive Committee to approve the onward delegation framework, and the Audit Committee tor eviewed the revised scoring matrix.

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, 29/10, 26/11)	↑
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, 29/10,) (ExCo 12&20/11)	↑
% Risk Management Training undertaken	0	>90% Q3 26/27	Training data not available yet. Not due for delivery yet	↔
Refreshed IPQR, aligned to best practice with robust governance applied	Existing	Refreshed version ratified	On track	↑

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
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Significant

Board & Executive Development

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The workstream has progressed well, with the planned deliverable to initiate and embed a regular programme of communication activity now underway. This includes key messages from executives, feedback loops, quick wins, organisational direction, and success stories.
- ✓ Recruitment activity for the CFO, CPO, and CSPO roles remains on track. The CSPO is now substantively in post, while recruitment proposals and approvals for the CFO and CPO positions were completed earlier in the year. Both processes were approved by the NED Nomination and Remuneration Committee on 17 November and are now progressing. Interim appointments remain in place until March 2026, with substantive campaigns scheduled as planned. Overall, progress continues in line with agreed timelines and governance expectations.
- ✓ Development of the Leadership Behavioural Framework and associated compact has advanced, as noted in the Board Development section of the Well Led Board Paper (26 November). Finalisation and socialisation of the compact, communication to senior leaders, and integration into Board and Executive development sessions were planned. However, subsequent milestones, including identifying behavioural gaps and embedding the framework within 360 feedback and appraisal processes, have moved off track due to dependency on initial compact approval. This work will be rescheduled and incorporated into the development programme when prioritised.
- ✓ Progress on communication activity for key Executive messages has also commenced. Aims and objectives have been confirmed, stakeholder analysis and audience segmentation completed, and a review of communication channels finalised. Insights from the summer 2025/26 internal communications survey are informing ongoing improvements. Work to identify new communication requirements has been integrated into Executive visibility plans, while key messages aligned to the strategic narrative and measures of outputs and outcomes have been drafted and shared with the CEO, with discussions scheduled in forthcoming meetings.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Substantive executive leadership posts filled by 30th March 2025	75%	100% of posts substantively filled	75%	↑
Delivery of Executive development sessions as scheduled	4	100%	All scheduled with 25% completed	↔
Delivery of board development sessions as scheduled	12	100%	All scheduled 2025 with a plan for 2026 due to be approved (26/11)	↑
Board engagement & participation (12-month rolling)	89% - March 2025	>85% attendance at Board	>90%	↑
Agreed QI methodology in place and with evidence of embedding across the organisation	Deliverable closed in the IIP 1.3 and transferred to IIP Domain 5 - People			
Board & leadership effectiveness rating (survey & 360° feedback)	N/A	85%+ positive feedback	Work yet to commence	
Exec portfolios defined and shared widely	75%	Complete	Complete	★
Objective setting and appraisal completion for all board members by 24/06/2025	47%	100%	100%	↔

Next Steps

- ➢ Leadership Behavioural Framework – review of planning schedule for development programme and development of compact
- ➢ Regular programme of communications from Executives - Identify new communication requirements, agree key messages aligned to strategic narrative, agree measures of outputs and outcomes

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
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

Torbay and South Devon NHS Foundation Trust

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 continues to progress well, with all planned deliverables on schedule. Preparatory activity is advancing to support timely completion in line with agreed milestones.
- ✓ Development of the new overarching Trust strategy, scheduled for completion in January 2026, is progressing through informal sharing of draft elements during this reporting period. The Executive Team is actively reviewing key components to ensure alignment ahead of finalisation.
- ✓ Current efforts are focused on achieving alignment between care group operational plans and the corporate strategy. Once signature moves, enabling actions, and accountable Executive Leads are confirmed, implementation activity will commence as planned.

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

Next Steps

- Key Executive leads and accountability to be identified
- Begin alignment of Care group strategies will be aligned with the Trust strategy throughout the course of strategy completion and 2026/27 business plan development

Risk	Mitigation
Delay in strategy development and adoption 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	Significant

EPIC

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The Epic Programme has been downgraded to a "Watch" status with a score of 7/10, compared to an average of 6.8/10 across other Epic implementations. This reflects emerging risks requiring Executive oversight, alongside continued progress in key areas.
- ✓ Issues requiring OPFBC Oversight included Estates work at TSD which was previously at risk due to electrical capacity and fire safety requirements, and an incomplete critical path plan. External consultants have since confirmed that electrical supply and Tower Block issues are resolved. Contractors' programme for non-Tower Block works is accepted, with completion expected by early March. Recent escalations regarding medical devices have also been addressed.
- ✓ Integration of Haemonetics (Blood Transfusion LIMS) with Epic remains at risk due to resource constraints in the TSD lab. Validation scripts have not been produced owing to staff availability, and this requires close monitoring.
- ✓ Overall configuration, data migration, and training remain on track. As of 12 November, 833 super users were identified, with 75% registered for training commencing 8 December. The FLD Stage 4 Readiness Assessment took place in mid-November, with positive verbal feedback received.
- ✓ The programme remains in a strong position for configuration and readiness, with targeted actions underway to address residual risks. No material change to overall timelines is anticipated at this stage.

Next Steps

- ➢ The 'User and System Readiness' phase continues up to Jan 23rd, 2026. In the next month EPIC priorities will include the completion of activity planning for Go-Live continues at pace, with registration for Super User training completed and progress against End-User training on track. Preparations are underway for the 120-Day Go-Live Readiness Assessment scheduled for 9 December, alongside attendance at the Royal National Orthopaedic Hospital Go-Live review on 2 December to capture lessons learned. The assessment of fire safety risks and the High-Rise Buildings approach has been completed, and round two of full-scale data validation is progressing as planned.

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 Watch	↓
Benefits realisation – aligned to FBC submission and workgroup change plans	As per FBC	Current from FBC £164M – 10 years	Work on developing Benefits profiles continues, along with identification of emergent benefits. 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 27th 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	

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

Peninsula Acute Sustainability Programme

Torbay and South Devon NHS Foundation Trust

Summary Position

- ✓ This workstream requires input from Trust Chair, CEO, CMO and CSO in order to review and agree specific deliverables with system partners. Key stakeholders understand that a meeting is required to progress this (agreed at Oversight meeting). Until this work is finalised, the deliverables of this workstream are on hold.
- ✓ The PAPC meeting will reset the Trust view of the priorities for the work and how TSD will contribute to leading PASP.
- ✓ Oversight noted recent progress in re-engaging system partners, with two productive meetings held involving the CMO, CFO, COO, and strategy leads. These sessions focused on refining a list of collaborative programmes, which will be costed and prioritised over the coming weeks.
- ✓ Dermatology was highlighted as a strong example of effective system working, demonstrating collaboration across the three Devon provider teams and the cancer network. The programme combines continuous improvement with targeted transformational change, delivering immediate operational benefits while supporting longer-term service development.
- ✓ Specifically, the Dermatology programme demonstrates strong system-wide collaboration, engaging four clinical teams across three Devon trusts in partnership with the cancer network. It is driving pathway transformation by shifting services from acute to community settings to better manage demand, while introducing AI-assisted triage systems to optimise clinical resources and streamline patient flow. The approach blends strategic, top-down direction with collaborative, bottom-up design to deliver impactful change. Workforce planning is supported through partnership with Health Education England, including two workshops scheduled this winter. A robust framework for shared learning and relationship-building has been established, positioning this initiative as a model for future projects.

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).			

Next Steps

- ➢ Escalation meeting to agree our expectations of PASP and key deliverables/KPIs needs to be scheduled.
- ➢ PAPC meeting date confirmed and agenda item to reset the Trust view of the priorities for the work and how TSD will contribute to leading PASP.

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
No CIP aligned to workstream					

Assurance	Rating
Executive Sponsor Rating	No

Adult Social Care

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Delivery across the three programme areas continues to progress, with positive momentum in several workstreams and overall risk position improving following the closure of one risk. However, assurance levels vary, and a coordinated approach across deliverables to training was recommended to avoid siloed development.
- ✓ Case Management System (CMS): Data migration for LAS and ContrOCC is progressing well, enabling full end-to-end testing for UAT in January. Key approvals are in place, but challenges with NHS email/System C Jira and the SBS baseline plan & testing plan pose risks to timelines but assurance was given at Oversight that SBS will go live on 1 April 2026. This workstream remains off-track and escalated.
- ✓ Operating Model: Structural analysis and benchmarking are complete, and engagement with carers has begun. Progress slowed following the departure of the project manager, limiting assurance. This workstream is off-track but recoverable.
- ✓ Service Line Reporting (SLR): Strong engagement and findings shared with finance provide high assurance. Minor delay in final reporting due to finance pressures is recoverable in December.
- ✓ Practice Model: Embedding of the 3 Conversations model is progressing well, with workshops completed and preparations underway for partnership board presentation. Some delays in quality standards and training development remain, but overall progress is on track.
- ✓ Timely Interventions: The improvement plan has been partially developed, focusing on reducing overdue reviews and improving timeliness of assessments through a strengths-based approach.
- ✓ Direct Payments: Improvement plans are advancing, though benefits realisation for Direct Payments is slower than planned due to workforce capacity. Confidence and consistency continue to grow.
- ✓ Front Door & Home First: Transformation activity is delivering positive operational impact, with referrals reducing for eight consecutive months. Further alignment with Ward Improvement plans is required for Home First.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Direct Payments: Proportion of adults receiving long-term community support who receive a Direct Payment (%)	19.3%	25%	18.2%	↓
Practice Model: Practitioners trained (%). Share of staff in scope who have completed the practice model training.	0	100%	15%	↑
SLR: Share of total spend with agreed apportionment and mapping. (%)	0	100%	80%	
Review Performance (proportion of people who have had a review)	66.4%	>59%	64.6%	↓
Operating Model: Proportion of roadmap milestones delivered to agreed dates (%)	0%	100%	15%	↑
Front Door: Contacts resolved at first point without onward referral (%)	Output from planned milestone Jan 2026			
Home First: Permanent admissions to residential/nursing care homes per 100,000 of population	Initial work on KPI's will be completed on 28.11.2025, noting that improvement activity itself starts on 20.01.2026			
Average Growth In People Supported (Q2 from Q1)	9.75	<6	5.6	↑
Number of OP People in Residential Care	866	600	737.6	↓

Next Steps

➢ Key actions include resolving NHS email/System C Jira issues, aligning ContrOCC CMS testing with SBS plans, completing LAS data migration for UAT, and progressing workforce redesign, SLR reporting, and practice quality standards. Additional priorities cover Direct Payments improvements, ASC Front Door transformation, Home First planning, ICO cost model analysis, and timely intervention workflow reviews.

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
Two schemes	£7,981	£7,221	£7,796	(£186)	

Assurance	Rating
Executive Sponsor Rating	Limited

Continuing Health Care

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Recruitment of three full-time nurses to support review activity has progressed to pre-employment checks, with one expected to start within two weeks and the remaining two within eight weeks.
- ✓ NHSE KPIs for 28-day performance (84.8%) and long waits over 12 weeks (0) continue to be met, with TSDFT consistently achieving mandated standards. Client numbers remain aligned with regional conversion rates.
- ✓ Work is ongoing to resolve IT issues linked to ICB and LA system changes. Meetings have been held with ICB and Trust IT teams, and costs to support transition arrangements have been submitted.
- ✓ The ICB governance model confirms CHC will remain within TSD. A comprehensive CHC self-assessment has been completed and work now focuses on reviewing governance structures and reporting arrangements to ensure full compliance with statutory and regulatory requirements, providing assurance to Executives and the Board.
- ✓ Business planning for 2026/27 is progressing, including demand and capacity modelling and workforce review to address growth trends and integration with Torbay ASC for case management and assessment functions.
- ✓ SLR analysis identified a significant income shortfall for CHC. Contractual negotiations and discussions on income and expenditure are ongoing between TSDFT CFO and the ICB to develop risk-share arrangements.
- ✓ Strategic and commissioning discussions remain on track, supported by engagement with ICB and local partners. Forward planning depends on completion of the CHC self-assessment (now complete), ICB process review, and outstanding deliverables.
- ✓ Oversight noted IT escalation, and the COO and CPSO will establish governance to manage interdependencies between EPR, Liquid Logic, and ICB systems. The CPSO will formally request urgent clarification from the ICB on the future of CHC teams, contracts, and supporting systems.

Key Performance Indicators	Baseline	Target	Current Position	Trend
To manage year on year cost growth to be > or equal to 3%	1.4%	3%	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	223	↓
CIP target reached 25/26	0	£2.2m	£3.2m	↑
CHC Forecast (performance against expenditure budget) **Expenditure Type** CHC Total FNC Interim Funding Adult IIP IPC Pilot	£56,085 (Original baseline)	£56,085 (Full Year Budget - After transacted CIP)	£56,025 Full Year Spend from (Month 8 Financials)	↑

Next Steps

- ➢ Focus on self-assessment with ICB to produce work plan
- ➢ Strengthen of governance and reporting structure across TSD ICB around model CHC
- ➢ Completion of IT project forms related to the project risk around multiple IT systems

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
Continuing Healthcare Reviews	£2,127	£3,019	£3,135	£1,008	

Assurance	Rating
Executive Sponsor Rating	Limited

Child & Family Health Devon

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The Options Appraisal, including the ICB-requested Due Diligence review, was approved by the ICB Procurement Committee on 26 November 2025.
- ✓ The review of financial implications and the provision of an assurance report to the Finance Performance Committee is currently off track. Negotiations have commenced between Trust CFOs to resolve outstanding issues.
- ✓ The fortnightly collaborative Single Provider Planning Group continues to operate effectively, supported by a dedicated action plan which remains on track.
- ✓ The consultation plan was approved by the TSDFT Partnership Board on 20 November 2025. The 70-day consultation process launched on 8 December 2025, and further Q&A sessions will continue following the launch event. Staff-side representatives remain actively engaged in the programme of work with CFHD, ensuring ongoing involvement and input.
- ✓ The IM&T transfer was successfully completed on 31 October 2025. However, financial decisions regarding IT recharges between TSD and DPT remain outstanding and require resolution.
- ✓ Additional resource has been secured through the HR Business Partner, and HR support has been confirmed within TSDFT to ensure workforce requirements are met.
- ✓ The CFO assurance statement remains in progress. Oversight has received, discussed, and approved a new risk relating to the outstanding financial decision. This risk will be formally included in the next reporting cycle.

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	Approval of options appraisal and ICB requested Due Diligence Options Appraisal	30 September 2025	Approved on 29th October 2025	★
Identify financial risks	Baseline will be confirmed following decision about single service provider.	September 25	Delayed negotiations in progress.	⇔
Reduce / remove interoperability challenges within CFHD	Baseline will be confirmed following decision about single service provider.	3 months post-transfer completion	Commence at go-live	⇔
Agree TUPE transfer of staff to new provider	Tupe 340 staff on 1 April 2026	31 March 26	Launch of staff consultation from 8 December 2025	↑

Next Steps

- Consultation letter and additional paperwork to sent to all TSDFT staff to inform about launch of consultation on 08/12/25
- 3 launch meeting arranged for 8, 9 and 17 December 2025
- Complete and understand financial risk implications
- Continue staff engagement during Consultation Process
- TSDFT Programme meetings to continue fortnightly to identity, map and resolve transfer issues.

Risk	Mitigation
Outstanding conclusion of financial decisions in respect of transfer from TSDFT to DPT	Escalated risk to Oversight Board. Staff consultation and transfer work continues despite lack of clarity about the financial issue. Requires a discussion between CFOs

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	Limited

Torbay and South Devon NHS Foundation Trust

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

- ✓ Overall delivery is steady, with key governance structures embedded and several core deliverables completed. Most completed items are operating as BAU with clear oversight. Variances relate mainly to resource and IT constraints, which continue to impact timelines for a small number of workstreams.
- ✓ Deliverables that are on track / completed include: Elective Delivery Board fully implemented; PTL review completed and operational; winter planning actions progressing through winter governance; demand and capacity work advancing with updated modelling and a refreshed business case.
- ✓ Deliverables that are experiencing delays / variances: NetCall rollout remains delayed due to IT server issues requiring close monitoring through Elective delivery group; recruitment gaps continue to affect the TIF recovery plan, requiring the consideration of alternative recruitmentoptions; theatres refurbishment has slipped but remains recoverable; location for glaucoma/medical retina diagnostic lanes is not yet agreed as subject to weighted criteria review.

Next Steps

- ➢ Develop detailed milestones, dependencies, and decision points for each deliverable of refreshed POP
- ➢ Service Improvements: Finalize MSK physiotherapy relocation business case; recruit peri-operative coordinators to enhance preassessment and reduce cancellations.
- ➢ Operational Efficiency: Fix texting service for alternative provider offers (Hip & Knee) and develop business case to close theatre gaps and reduce fallow time.

Key Performance Indicators	Baseline	Target	Current Position	Trend
RTT 18 week wait by March 2026	58.56	66.6%	67.7%	★
RTT 52 week wait by March 2026	3.74%	<1% of waiting list	1.9%	↑
Theatre utilisation rates	80%	85%	81.92%	↑
Theatre fallow sessions	81%	85%	84.1%	↑
Reduce all long waiters over 78 week and 65 weeks	9	0	18	↔
Wait to 1st activity by March 2026	63%	70.3%	71.8%	★
Validation in the last 12 weeks	38%	90%	86.2%	↓
Achieve activity volumes as per Targeted Investment Fund (TIF) business case	18 / 40	25 / 60	These metrics are already routinely reported through EOG, with progress also monitored through the Elective Delivery Group.	
Achieve Activity vs 24/25 ytd Elective Ordinar	1,640 (last year ytd)	1,907 (plan ytd)		
Achieve Activity vs 24/25 ytd - Elective Day Case	15,760	15,838		
Achieve Activity vs 24/25 ytd Outpatient New	44,490	45,381		
Achieve Activity vs Plan Outpatient Follow Up	121,087	127,929		
Reduce LCAD in Ophthalmology for Medical Retina and Glaucoma	18%	>5%		
Activity against plan 19/20 baseline	Activity v 19/20 levels by POD Planned Care	114% of 19/20 baseline		

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
Additional income from activity schedule to achieve 114%	£2m	£1.2m	£1.2m	(£0.8m)	

Assurance	Rating
Executive Sponsor Rating	Limited

Diagnostics DM01

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Overall progress across the recovery and diagnostics workstreams is strong, with the majority of deliverables completed or progressing to plan. Key risks relate to external provider delays, contractual dependencies, and slow recruitment in specific services. Most benefits are on track to be realised, with continued governance oversight in place to manage remaining off-track items.
- ✓ Completed deliverables: Weekly monitoring of tactical recovery actions now embedded in BAU, with established escalation routes via Deputy COO. Longer-term recovery plans and trajectories completed and approved at the Elective Recovery Board. Demand and capacity modelling completed and signed off. Referral threshold and CDC complexity review complete, with widened MRI criteria improving utilisation and easing acute pressures.
- ✓ Deliverables that are on track: Internal workforce issues in NOUS progressing under senior HR oversight with delivery on track for December. Endoscopy capacity plan advancing, with recruitment still required but overall trajectory maintained. Financial benefits expected to fall into next year's CIP.
- ✓ Deliverables that are experiencing delays: CDC contract reprofiling remains delayed due to finalising contractual documentation - legal support now delivered, with expected completion in December. Imaging reporting outsourcing review is off track, with ultrasound backlog pressures escalated to commissioners following withdrawal of ICB-funded service. MRI business case remains deliverable but requires scope refinement - options now aligned with CDC and Neighbourhood Fund opportunities.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Achieve <5% for 6 weeks diagnostics	35%	5%	28.8% (Dec 2025)	↑
CT Urgent 2ww - Reporting turnaround time - in days	15	3	7 (Nov 2025)	↑
CT Urgent - Reporting turnaround time - in days	19	5	12 (Nov 2025)	↑
CT Routine - Reporting turnaround time - in days	21	10	15 (Nov 2025)	↑
MRI Urgent 2ww - Reporting turnaround time - in days	8	3	6 (Nov 2025)	↑
MRI Urgent - Reporting turnaround time - in days	19	5	13 (Nov 2025)	↑
MRI Routine - Reporting turnaround time - in days	20	10	20 (Nov 2025)	↓
X-ray Urgent 2ww - Reporting turnaround time - in days	1	3	0 (Nov 2025)	★
X-ray Urgent - Reporting turnaround time - in days	1	5	1 (Nov 2025)	★
X-ray Routine - Reporting turnaround time - in days	2	10	2 (Nov 2025)	★

Next Steps

- ➢ Develop detailed milestones, dependencies, and decision points for each deliverable of refreshed POP

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
Endoscopy Workforce Transformation	£80k				Financial Benefit 2026/27
Mobile Scanning Unit	£500k	£504k	£504k	£4k	

Assurance	Rating
Executive Sponsor Rating	Limited

Outpatients Transformation

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Outpatient Transformation Steering Group has been established, with the first meeting scheduled for 05/12/2025. A mandate for the centralisation of outpatient services was presented to EXCO on 10/11/2025.
- ✓ The 3.1c Planned Care Outpatient Transformation Workstream has been refreshed to sharpen delivery focus and align with the NHS England Outpatient Transformation Programme. Key priorities include reducing DNAs, expanding PIFU pathways, increasing utilisation of Advice & Guidance, standardising outpatient pathways, developing digital approaches to redesign outpatient delivery, reducing follow-up appointments in line with NHSE's future model, and optimising outpatient estate and capacity.
- ✓ The BookWise system is in the Build phase, with configuration underway for deployment across Level 2 Outpatients, Crowthorne, Level 8 Hutchings, H&L, Ophthalmology, and Newton Abbot. A total of 125 licences have been allocated, with remaining licences to be issued to community sites. An additional 250 licences will be required to cover all acute and community sites. Go-live has been rescheduled to March 2026 from February 2026 due to configuration issues.
- ✓ The 6:4:2 room booking process has been implemented across the trust. However, a limited audit of Level 2 and Crowthorne indicates it is not being used. Specialties that are not releasing clinical rooms for others are being challenged and educated further. Current utilisation shows significant opportunity for improvement.
- ✓ Business planning remains on schedule with strong Care Group engagement.

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%	5.0 (Nov 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.		1:2.6 (Nov 25)	
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		35%	
First Follow Up			This metric is already routinely reported through the EOG	

Next Steps

- ➢ Develop detailed milestones, dependencies, and decision points for each deliverable of refreshed POP
- ➢ Mapping of space utilisation for the trust starting in L2, Crowthorn.
- ➢ Monitor 6:4:2 booking process and challenge booked but not used clinic rooms.
- ➢ Set up a visit to Southampton Outpatient department
- ➢ Create and circulate an outpatient feedback survey to clinicians, nursing, operational and admin colleagues to get improvement feedback.
- ➢ Set up workshop with senior nursing, clinical and operational teams to develop new ways of working.

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
Outpatient transformation	£500k	£0	£0	£-500k	Closed not progressing

Assurance	Rating
Executive Sponsor Rating	Limited

Cancer Services

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ In dermatology, the outline business case is completed in draft (for Autonomous AI). It is now with the Clinical and Operational leads for finalisation of operational and financial. Led by PASP, a Devon-wide strategic workforce meeting is planned for 4th December 2025.
- ✓ The third round of planning workshops are underway, planning to be completed by 10th December 2025. Progress remains on track with the delivery timetable. Cancer Services is fully engaged with the Care Group and is participating in all scheduled workshops.
- ✓ Radiotherapy remains a significant performance risk. Staff shortages remain high and the department is unable to recruit to substantive posts. Have extended use of agency until end of December, awaiting director approval to extend this until end of Q4. Performance recovery is not expected in 2025/26, for radiotherapy waiting times.
- ✓ The Medium-Term Planning Framework set the requirements for the Cancer Waiting Times standard over the next 3 years. The Trust is currently finalising their trajectories for next year. The principle is that the Cancer standards will be met – any activity and performance impacts from the EPR (or otherwise) will be mitigated in routine/urgent RTT activity, protecting cancer delivery.
- ✓ In regard to cancer performance, the 28-day FDS was achieved in both October and November, which brings the Trust back inline with forecast trajectories. A reduction in the Cancer PTL backlog continues to be evident, with the PTL now at 4.8%, which coincides with improvements to both FDS and 62-day waiting time standards.

Key Performance Indicators	Baseline (June 2025 – submitted figures)	Target	Current Position (November 2025)	Trend
28-day Cancer standard	80.64%	80% (by March 2026)	76.3%	↑
62-day Cancer standard	75.38%	75% (by March 2026)	73.5%	↑
31-day Treatment standard	93.6%	96%	93.1%	↑
62-day backlog	8.9%	< 6%	4.8%	↑

Next Steps

- ➢ Develop detailed milestones, dependencies, and decision points for each deliverable of refreshed POP

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
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Limited

UEC Flow

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Timely Handover Protocol - Despite growing demand for ED and new peaks of attendance, November has been the busiest month this year (2604) and handover performance has been the best month (28 minutes 34 secs). There has been improvement on 45-minute handover per ambulance which is down to 414 which will be the lowest the Trust has seen.
- ✓ Flow and Ward - Go See / Ward visits have been initiated, with some delay due to capacity of stakeholders due to the industrial action. Collection of the baseline data has been extended to 21 November 2025. This data will be collated and thematic review developed which will discussed and decisions made at meeting scheduled for 9 December 2025.
- ✓ Demand Management - This programme, which is proposed to be a deliverable in refreshed UEC Flow Plan on Page (POP) consists of 7 areas of activity. The operational lead and management responsibilities have been confirmed for AMU Pathway. Head Injury pathway SOP draft finalised and circulated to ED/AMU/Frailty Leads for review and comment.
- ✓ Internal professional standards (IPS) – Work has been progressing to develop a draft UEC IPS with input from specialties. Workshops to agree and finalise the Draft UEC IPS are booked for AHPs 3rd Dec, Operational teams 4th Dec and Clinical teams 11th Dec.
- ✓ Frailty Phase One launched 25 November 2025.The number of patients calls were 67 which converted into 59% referrals declined, 28% referrals accepted and 13% referrals only receiving advice. A total of 41% of referrals avoided ED/AMU attendance due to The Harbour. Evaluation of outcomes is ongoing.

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

Key Performance Indicators	Baseline	Target	Current Position	Trend
4 hour performance	70.09	78%	68.31%	↑
Average Ambulance handover time	47 mins	45 mins	29 mins	↑
45 min Max handover per ambulance	659	0	414	↑
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%	84.5% (Nov)	↑
Max 12 hrs in the ED	8.71% ED	10%	7.8%	↑
No criteria to reside	6.7%	5%	8.2%	↑
Average pre noon discharges	21.8%	33%	19.5%	↓
Non elective length of stay = No update yet for November		Target TBC – Requested support from Planning & Performance Team.	5.0 days (Nov)	↑
Community Hospital length of stay No update yet for November	13.9 days		13.9 days (Oct)	
ED Conversion rate – Baseline should be 31% for last 6 month	31%		32%	↑
Discharges–Formal reports available next month (Jan) Baseline average for 12 months Nov 24 to Oct25) P0: P1 - P3:	 1398 428		 1548 416	↑ ↓

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
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Limited

Community Services Redesign (Frailty)

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Service went live on 25th November 2025, with IVR option switch-over delays resolved ahead of go-live.
- ✓ Staff consultation was completed on 16th November, and outcomes will be shared with staff. Relocation of the team to Newton Abbot Hospital was completed on 21st November. Recruitment for substantive clinical and non-clinical posts is at shortlisting stage, with interviews scheduled for November and December; a Band 7 OT appointment has been made.
- ✓ A patient tracker has been developed and is in use to record activity linked to Infoflex and Cp2, enabling daily evaluation of activity and out-of-hours call volumes for potential longer-term service direction. A frailty dashboard is under development to demonstrate service utilisation, outcomes, and demand.
- ✓ All go-live SOPs were completed ahead of service opening, with outstanding SOPs and new ways of working being developed iteratively to support new starters and service evolution.
- ✓ Stakeholder engagement events have been completed, and posters and communications have been disseminated internally and externally.
- ✓ Infrastructure was moved on 21st November ahead of go-live, and ring-fenced bed utilisation is effective.

Next Steps

- ➢ Phase 1 Daily learning log being used to resolve operational issues and improve week on week service deliver eg: IVR amendments, call routing and changes to answerphone message
- ➢ Phase 1 Develop BI dashboard for reporting daily activity eg: weekly status report demonstrates impact in and out of hospital
- ➢ Phase 2 Logistics planning under way focussing on longest lead in times for workforce, equipment, estates and EPIC transition ahead of go FSDEC go live eg: highlighting delays with full review of milestones planned for 11 December 2025

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
Current workforce does not fully meet the operational service provision times to be effectively redirecting patients later in the day	Temporary staffing and SPA swap from within existing team. Developing call handling

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

Elective Centre of Excellence

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Progress across the programme remains broadly on track, with key preparatory work underway for accreditation, capital schemes, and future service expansion. Most workstreams are progressing as planned, though strategic decisions and external funding dependencies are creating delays in a small number of areas. No new cost pressures are reported, and risks remain focused on strategic direction, funding confirmation, and potential impacts on waiting lists during theatre downtime.

- ✓ Deliverables that are on track: GIRFT theatre accreditation progressing well, with NED (Non-Executive Director) engagement secured and documentation in preparation. Theatre refurbishment programme advancing - mitigation plans for downtime to be finalised mid-December. Business case for increased activity in the current theatres is progressing through EOG this month. OMFS (Oral and maxillofacial surgery) expansion proposal submitted nationally - awaiting decision before implementation planning can begin. Ophthalmology linear lane pathways moving forward, pending confirmation of location and funding. Robotic surgery evaluation ongoing, with further work required before progressing to business case stage. Day case centre strategy being explored with workforce with discussions ongoing through Planned Care Group. Demand and capacity modelling incorporated into business planning to support investment decisions.

- ✓ Strategic review of theatre replacement and NEL (Non-elective) capacity remains delayed pending executive discussion and agreement on future direction (elective vs emergency expansion).

Key Performance Indicators	Baseline	Target	Current Position (November)	Trend (month-month)
The Ophthalmology proposals would result in the following additional appointments (per yr) • Glaucoma • MR • Cornea	N/A	5,760 4,800 960	No current position. Baseline and current data monitoring scheme to be developed with BI team.	
The OMFS proposals would result in the following additional appointments (per yr) • OP appointments • Procedure appointments	N/A	10,290 7,392		

Next Steps

- ➢ Develop detailed milestones, dependencies, and decision points for each deliverable of refreshed POP
- ➢ Strategic meeting around SRU expansion vs. Elective expansion with Care Group and Executives.
- ➢ Submit information for accreditation process.
- ➢ Submit increasing utilisation in theatres to Elective Operations Group. Funding source ERF.

Risk	Mitigation
Funding for further elective theatre capacity expansion	Facilitate strategic discussions to define the organisation's long-term approach, ensuring alignment with overall objectives. The Care Group should evaluate options and provide a clear recommendation for the preferred course of action

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

Maternity and Neonatal Safety Improvement Programme

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The second Perinatal Improvement Board (PIB) meeting was held successfully, with agreement to revert to monthly meetings to meet oversight requirements. Workstream updates provided via highlight reports and discussion during meeting.
- ✓ Plan in place to develop PIB so that it will adopt an assurance focus, in addition to its delivery focus, following recent significant events and the increased level of oversight that is required.
- ✓ Overarching workstream goals and golden threads updated, following feedback from MNVP, and formally agreed by PIB members
- ✓ A new Clinical Lead is now in post and has assumed responsibility for the Clinical Lead role within the maternity programme, as well as for the Clinical Pathways and Infrastructure workstream
- ✓ The Perinatal Compliance Lead position has been filled through an internal appointment. Discussions are underway to agree an appropriate transition period before the individual moves fully into post, ensuring they can support the ongoing development of the programme
- ✓ A Maternity Safety Support Programme (MSSP) 'Renew and Reset' meeting is scheduled for 8 January 2026, at which the future level of support for the programme will be confirmed. It is anticipated that the programme will receive targeted support for a period of six months
- ✓ Some slippage has occurred due to limited leadership capacity, including delays in KPI development, project scope alignment, and meeting planner finalisation. Mitigation actions are in progress to address these areas.

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	10/10	↑
Birthrate Plus (BR+) Establishment review	100% compliant for most recent report published April 2021	100% compliant by December 2025	See comment below	↔
Maternity Safety Support Programme Exit Criteria	<20% complete	60% complete by March 2026	25% complete	↑
A medical workforce to meet service acuity and activity requirements	Demand and capacity planning shows that Gynae services has sufficient capacity to meet current demand. This planning did not include Obstetrics, and gaps remain around renumeration and protected time to complete obstetric leadership roles. Women's Health will not be seeking funding for additional workforce within the remainder of 25/26 financial year. Review longer- term workforce needs to ensure resilience and succession planning over the next 2-5 years as part of 26/27 business planning. fully established by end of 25/26			↔
Improved triage model	60% compliant with national standards	100% compliance with national standards by Q3 25/26	60% compliant	↔

Next Steps

- ➢ Define and Plan: Develop KPIs for each workstream, create a meeting planner for oversight, and ensure Workstream Leads engage with Project Leads to agree scope and expectations. Project Leads to produce detailed plans with aims, KPIs, and deliverables.
- ➢ Prepare and Support: Finalize presentation materials for the MSSP 'Renew and Reset' meeting on 8 January 2026 and provide support for the new Perinatal Compliance Lead to begin key tasks

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
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Limited

Managing Our Estate

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The review of Capital Development and EFM interconnectivity and governance has been completed with consolidating outputs of KLOE. The Workplace Director and David Jones assessments report are both subject to review and consideration by executive team. Recommendations have been enacted for joint Workplace and Capital Development meetings, and both the function of Capital Development Team and EFM/ Workplace Team to be reported through to same Board level Director of DCEO/COO.
- ✓ The EFM Director has submitted the assessment report incorporating critical areas of focus to Executive leads on 5 November 2025 which is now subject to review and consideration.
- ✓ Work to introduce CAFM is progressing slowly due to limited leadership resources in estates. Interim Estates Lead is being requested, and this post holder would drive development and delivery of digital estates plan including CAFM.
- ✓ The work to develop the 6-facet survey started on 1 October 2025. Meeting scheduled week commencing 1 December 2025 to confirm progress and is subject to a slight delay with completion aimed for January 2026.
- ✓ Mobilisation plan for development of Dawlish H&WB Hub completed (Linked to estate rationalisation) and subject to strategic decision-making regarding development of neighbourhood health and wellbeing hubs. This is now being led by Care Group Director for Families and Communities.
- ✓ Sustainability and Wellbeing Group will not be established as there is no portfolio holder in place currently. Progress of this deliverable is subject to outcome of review of the EFM assessment report submitted by Workplace Director.

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

- ➢ EFM Director's assessment report is with Executive Team for review and consideration.
- ➢ Development of business plans for 2026.27 that support both improvements in Estates & Facilities and overall TSD financial improvement.
- ➢ Secure interim resources to enable progress of deliverables in critical areas.

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		
16 Workplace CIP Schemes	£1,462	£1,392	£1,467	£5	14	1	1

Assurance	Rating
Executive Sponsor Rating	Limited

Torbay and South Devon NHS Foundation Trust

Finance Programme

Senior Responsible Owner – James Corrigan, 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

- ✓ Introduction of SLR continues to be in hand by the costing team within Finance. However, limited capacity has slowed the pace, primarily due to time spent addressing queries from the previous dataset. While this has caused delays, the work will significantly improve the accuracy of Q2 data once produced.
- ✓ Work on productivity has made limited progress. This requires a renewed focus going forward as part of the development of the 26/27 operating plan and as part of the reshaped Our Plan for Better Care in year 2. It is proposed to establish a productivity workstream to gain better grip and control on productivity improvement.
- ✓ Oversight heard that SLR programme prioritises 6 key clinical service reviews within the transformation programme for 2026/27, with the current workstream focused on ensuring data quality and provision. The group also heard that within 2026/27 there is a proposal to reshape the approach by establishing a cross-cutting productivity programme supported by a dedicated group with operational and clinical input. This will align productivity and SLR outputs to drive decisions on service sustainability, cost versus income analysis, and workforce implications. Accurate and timely data will underpin transformation and recovery, with clear accountability and senior leadership to ensure delivery. This work is central to achieving financial stability and reducing recurring deficits.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Introduction of SLR	Reporting unavailable	Reporting available & embedded	In hand by the costing team within Finance, but capacity is limiting pace. Delayed due to the impact of addressing queries from the previous dataset; this will drive improvement to the accuracy of the Q2 data which it is produced. Completion date to be confirm.	⇔

Next Steps

- ➢ Completion of introduction of SLR and productivity reporting, analysis and support

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
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

Sustainable Financial Improvement Programme Delivery

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Delivery for Month 8 is £2.92m against a plan of £4.21m, representing a variance of £1.29m under plan. Year-to-date delivery stands at £21.74m compared to a planned £21.86m, a variance of £0.12m under plan.
- ✓ The forecast outturn (delivered and forecast) remains at £41.54m, aligned to the original plan of £41.54m. It is noted that this includes a reliance on non-recurrent delivery, which will have ongoing implications for future years and therefore remains a key area of focus within the full financial review meetings.
- ✓ There is evidence of increasing maturity across several workstreams, with schemes progressing from Red to Amber and Amber to Green. However, £0.27m of the forecast outturn remains Red RAG-rated and will continue to be monitored through PMO and Care Group governance to ensure appropriate mitigation.
- ✓ Currently, there are 39 outstanding CIP schemes, of which 8 are unapproved but worked up, and 31 potential opportunities have been added to Trust-wide schemes. These opportunities are being scoped with finance and operational colleagues to develop project outline documents for progression through the CIP governance process.
- ✓ Oversight has raised concern regarding the number of outstanding CIP schemes and requested urgent communication with scheme leads to expedite completion of paperwork and the approval process. Concern also remains regarding the reliance on non-recurrent savings and the associated impact into the next financial year.
- ✓ Planning process for 2026/27 will now be examining the ongoing financial pressures in the context of developing ULP and MTFP. Recurrent impact of CIP delivery, identifying new CIP schemes, use of SLR and productivity data all featuring in the planning process now.

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

Key Performance Indicators	Baseline	Target	Current Position (Month 8)	Trend
Total CIP target (£) vs. delivered (£)	£41.5 m	£41.5 m	£30,460,628 transacted full year	↑
% of recurrent vs. non-recurrent savings	79% of plan recurrent	79% delivered recurrent	59%	↓
Efficiency and productivity improvements demonstrated in NHSE monitoring, NCC data	As per NHSE planning guidance targets 2025/26	As per operating plan submission 2025/26	TBC	
Total CIP target (£) vs. forecast (£)	N/A	£41.5m	£41.5m	↓

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
See KPI's for composite CIP Scheme values.					

Assurance	Rating
Executive Sponsor Rating	Limited

Financial Capability & Capacity

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Finance is awaiting Workforce to provide the agreed criteria for assessing finance team competencies. This matter has been discussed between the Chief People Officer (CPO) and Chief Finance Officer (CFO) and escalated to the Oversight Board. Oversight noted that the planned competency assessment, intended to align with the operational management review, has been delayed. However, this delay does not impact the continuation of the overall process. Oversight also confirmed that the finance development programme remains in train.
- ✓ The development of the financial briefing pack for all staff has not commenced due to limited finance team capacity. Progress has been further delayed by vacancies and consultation dependencies referenced within other areas of the workstream's deliverables.
- ✓ Roles within the new finance structure have all been AFC matched. Vacant Band 8c roles have been added to Trac, and the HR lead made contact on 28 November 2025. The process is now awaiting confirmation from staff-side regarding the consultation start date.
- ✓ The achievement of Level 1 Finance Accreditation has been delayed due to limited capacity within the current team and the need to recruit senior finance staff (as referenced in Deliverable 1). However, an initial meeting to restart progress took place on 27 November 2025, and actions have been allocated to complete the outstanding criteria required for accreditation.
- ✓ The Budget Holder Training offer has been drafted and is currently under review by the Senior Leadership Team.

Key Performance Indicators	Baseline	Target	Current Position	Trend
% of finance staff with completed PDRs	41% (April 25)	100%	58.6%	↑
% 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 recruit to empty 8c roles.
- ➢ Review and trial budget holder training pack
- ➢ Finalise ULP for planning return
- ➢ Submit first planning return for 2627 and beyond
- ➢ Progress Level 1 accreditation evidence gathering

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
No CIP associated with scheme					

Assurance	Rating
Executive Sponsor Rating	Limited

One Devon Shared Services (Finance)

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ All Chief Finance Officers (CFOs) across Devon met on 7 November to agree the Future Target Operating Model (FTOM). At this stage, agreement on the FTOM was not reached, and further discussions are planned. HR, Finance, and Staff-side meetings are actively reviewing steps for staff who may be impacted by TUPE transfers. T&SD staff members identified as likely to be directly affected have been notified, with HR support available as required. Further discussions are expected in the coming weeks as the process becomes more formalised.
- ✓ Chart of Accounts meetings are ongoing with all Trusts and Shared Business Services (SBS). Cost centre codes specific to T&SD have now been allocated, and T&SD finance teams have reviewed and updated these. More tailored subgroup meetings are taking place to ensure staff understand the structure and format of the new cost centres.
- ✓ The first System Demonstration Model is now live on the intranet, providing an introduction to functionality and an overview of how the new system will operate in relation to staff roles. This resource is available to all finance staff, with additional demonstrations scheduled for upload in the coming weeks. Data collection and cleansing activities are underway for Supplier, Customer, and User data. This process ensures duplication and inaccuracies are resolved prior to system migration.
- ✓ Financial and Management Accounts working groups continue to meet regularly, with representation from SBS and all Trusts. These sessions focus on reporting requirements and address emerging issues. Regular leadership engagement sessions are being held for TSD finance staff. These informal sessions with SBS client-side teams provide opportunities for queries and concerns to be addressed, alongside updates on progress and upcoming tasks.
- ✓ Oversight noted a potential risk that the SBS system, intended for shared services, may not be ready for provider environments by the planned go-live date of 1 April. A remediation and implementation plan has been requested, and mitigations are being considered should the system implementation be delayed.

Next Steps

- ➢ Finalisation of the Finance Target Operating Model
- ➢ Progression with staffing re-organisation
- ➢ Recommendations regarding Charitable funds finance processes will be reviewed

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
Although most of the workstream is on track there is an emerging risk regarding the Board not approving the Finance Target Operating Model ("FTOM") and One Devon Collaborative Corporate Services (("CCS") which could impact the timing of the new systems being implemented, the One Devon finance moves and the TUPE transfers to SBS.	Review of the FTOM and CCS by the Board to confirm agreement and allow progression of the system implementations
5 x members of the Treasury team have been notified that it is likely that their roles will become redundant after 1st April 2026. There is a high likelihood that some or all of this group will look for a new role, which will impact the Treasury team's ability to process invoices and pay suppliers. Two of the team have already either secured a new role or are at interview stage.	A request was sent to workforce approval for 3 x B2 Accounts payable assistants to cover the gap by staff leaving. This has been approved with effect from 8th Dec 2025 to 31st March 2026. We are in the process of reviewing applications for these roles.

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

One Devon Shared Services (Procurement)

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Following OPFBC Oversight Group concerns regarding savings delivery and ambition within the plan, a meeting was held on 13 November 2025 between Shared Service Devon, Finance, and PMO. The Workstream Lead has reviewed and refined the Plan on a Page to clearly define objectives and deliverables. The revised plan has been signed off by the Chief Procurement Officer and will continue to be refined as the Shared Procurement Service progresses.
- ✓ Leadership for the workstream has transitioned to Chief Procurement Officer for Shared Procurement Service. The new procurement structure went live on 1 December 2025, and a development day for all staff was held on 2 December 2025. At Oversight's request, work is ongoing to review risk (4.4b-01) on resource sufficiency to deliver planned objectives due to significant staffing gaps within the Procurement Department, the consequences and mitigations.
- ✓ Oversight discussed the revised plan and agreed that clearer expectations, defined savings plans for 2026/27, and stronger accountability are required. This includes implementing a more robust contract management approach.
- ✓ Capita has delivered eight schemes year-to-date for TSDFT; however, two cannot be transacted as CIP savings due to insufficient budget, and one (£150k End User Devices) is a capital saving. While additional schemes are in the pipeline, none are expected to meet the £338k target or offset Capita's contract charges. A separate Shared Procurement Service scheme delivered £48k savings under the Peninsula Procurement Savings Alliance. Oversight requested a review of the two untransactable schemes to confirm budget availability and ensure overspends do not prevent CIP transactions.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Devon PS live with agreed governance and TOM in place	TBC as work progresses with development of POP	Policies sign off by Trust committee		
Accelerated savings programme in place savings delivery	Nil	£338k	YTD Transacted £87.3k revenue CIP savings at Month 8.. *(Peninsula Procurement Savings Alliance (PPSA) contract saving unrelated to Capita delivered for £48k.)*	⇔
Go live of Procurement Shared Service	1/12/25	Service operational	Go-Live achieved on 01/12/25	↑
Successful go live of SBS Fusion Phase 1 for Procurement	TBC as work progresses with development of POP	System operational		
Baseline procurement maturity re-assessed	TBC as work progresses with development of POP	Improvement in assessment level achieved		
Successful go live of SBS Fusion Phase 2 for Procurement	TBC as work progresses with development of POP	Service operational		

Next Steps

- ➢ Stand up formal risk register
- ➢ Review of risk 4.4b-01 – Resource sufficiency

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
Capita	£338.0	£87.3	£0	(£250.7)	
Workplace - Laundry	£48.2	£0.0	£48.2	£0.0	

Assurance	Rating
Executive Sponsor Rating	No

Torbay and South Devon NHS Foundation Trust

People Programme

Senior Responsible Owner – Jess Piper

Delivery of a Workforce Plan to ensures the right size workforce is in place to support improved patient outcomes. Delivering a People programme that fosters a positive, inclusive culture with high levels of staff engagement. Developing a people strategy aligned to the Trust's long-term vision, priorities and values.

Workforce Plan & Transformation

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ A key development has been the approval of a revised workforce controls process by the Executive team. This new approach strengthens oversight and ensures decision-making remains executive-led in line with NHSE and ICB requirements. It is designed to help the organisation reduce workforce costs and achieve planned reductions set out in the 2025/26 operational plan, while still enabling recruitment to critical clinical and client care posts to maintain safety and performance standards.
- ✓ Progress has also been made on e-rostering initiatives. For Agenda for Change staff, the Data Protection Impact Assessment has been approved, and arrangements are underway to grant Viridian access to HealthRoster, with the initial build expected to take one to two weeks. For medical staff, procurement has identified an alternative framework that could allow a direct award to Rotamap, the system currently used by anaesthetics. A paper will be presented to ExCo to confirm the preferred direction and timelines, taking into account the potential impact of EPIC if that option is pursued.
- ✓ The second round of the Mutually Agreed Resignation Scheme (MARS) has been approved, although the timeline has been adjusted so that completion will fall into the next financial year. In addition, a new monthly workforce report has been developed to improve accuracy and efficiency in reporting workforce data. The final version is being refined and will be launched for month eight reporting.
- ✓ Significant progress has also been made on the People Digital programme. Wave 2, which focuses on contract and system consolidation for One Devon LMS, will be deployed in stages. The Azure database, designed to host data from ESR, EVA, and other platforms to support integration and reduce manual data entry, will go live on 9 February. Complex offboarding workflows, robotic process automation, and the Manager Portal will follow on 23 March, with the Learning Management System and complex onboarding workflows scheduled for 18 May. Work continues with PMO support to develop a local implementation plan for these stages, and a waterfall diagram illustrating the component parts required to deliver headcount and pay reductions will be presented next month.
- ✓ Despite these advances, the Oversight Group has raised significant concerns that overall headcount continues to rise despite the implementation of a vacancy control framework. This has prompted a requirement for an executive-level review of vacancy management and control processes across the Trust. To support this review, Oversight has requested a detailed analysis of the drivers behind workforce growth and the reasons for under-delivery against the workforce plan. In addition, a targeted risk reassessment is required.

Next Steps

- ➢ Develop a local implementation plan to support wave 2 of People Digital
- ➢ Launch new Workforce Report
- ➢ Review first draft of E-Rostering Dashboard
- ➢ Develop a waterfall diagram to represent the component parts to deliver the headcount and pay reductions.
- ➢ Progress with the relevant milestones following decision from ExCo on direction of travel for Medical E-Rostering

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)	M8 Target: 6439 **M8 Actual: 6715**	↓
Total Recurrent Workforce CIP reduction (WTE)	6812.08	Planned target: -329 Revised target: -136 (removal of 205 CR plus break glass vacancies)	M8 -73wte recurrently removed from baseline establishment	↔
Pay Cost Reduction	£365.9m	£20.4m (reduction) £15.88m (rebase removal of CR)	M8 Forecast: 15.2m **Delivered: 12.9m**	↑
MARS Scheme (50WTE reduction)	0	50 WTE	26.04	↓
Reduction in Agency spend by 30%	£10.1m	£7.1m total spend (reduction £3m)	M8 Forecast: £6.2m **YTD: £4.4m**	↔
Reduction in Bank spend by 10%	£21.1m	£19m total spend (reduction £2m)	M8 Forecast: £19.1m **YTD: £13.6m**	↓

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
All CIP schemes which include pay elements	£20.4m	£12.9m	£17.8m	(£2.6m)	

Assurance	Rating
Executive Sponsor Rating	Limited

People & Education Capability & Capacity

Delivered

- ✓ Progress has been made across key deliverables within the P&E Directorate. Work has commenced on the refreshed workstreams, with a draft directorate work plan now in development. This plan is informed by analysis of the recent insights survey and outputs from workshops, providing a clear direction of travel. There is a noted interdependency with ongoing work on KPIs, which will be incorporated as the plan evolves. In parallel, the directorate-wide development plan is advancing following the closure of the survey on 1 December, which received 89 responses. Analysis of these responses is underway to shape a revised development plan. Similarly, survey data is being used to inform the renewed talent, career, and succession pathway framework, ensuring alignment with workforce priorities.
- ✓ The critical path for completing these deliverables is dependent on outputs from the Trust People Strategy design workshops held in December 2025. These outputs will define future focus areas and key people priorities, which will be integrated into the draft directorate plans. These drafts are scheduled for discussion at workshops planned for 26 January, ensuring stakeholder engagement and alignment.
- ✓ Further progress has been achieved in strengthening leadership, governance, and reporting structures. The newly established Risk Review Group met in December and began baselining open risks for tracking and reporting through PEGG and the 5.2 workstream. Additionally, refinement work on KPIs has been completed, enabling preliminary discussions on the design of the workforce performance dashboard to commence.
- ✓ Policy improvement remains a key area of focus and presents some risk. A comprehensive review of all policies is underway, with the aim of ensuring all policies are up to date by the end of the financial year. To mitigate capacity challenges, additional ER support has been secured through extra staff days and a bank request for administrative assistance funded via RSP. Twelve policies are scheduled for ratification at the extraordinary Partnership Forum on 12 December, which will increase the proportion of in-date policies from 33% to 45%, marking a significant improvement.
- ✓ Overall, the directorate is on track with its deliverables, supported by clear governance structures and additional capacity where required. Dependencies on People Strategy outputs are being actively managed, and risks associated with policy updates are mitigated through targeted resourcing and accelerated

Next Steps

- ➢ Skills survey analysis and directorate development plan drafted.
- ➢ Refreshed directorate work plan drafted with strategy workshop outputs integrated.
- ➢ KPIs signed off and stakeholder meeting to be organised to consult on dashboard design.
- ➢ Work on directorate restructure plans continuing, ready for sharing in the new year.
- ➢ Plans for 10 policies to be ratified at extraordinary 12 December Partnership Forum, bringing total in date policies to 45% (increase of 12%).

Key Performance Indicators	Baseline	Target	Current Position	Trend
% of People and Education policies reviewed within review period.	44%	100% by 31/03/2026	45%	↑
Number of high-risk vacancies impacting delivery of workforce improvement plan.	10	0	0	↑
% progress of skills and capabilities based on People and Education gap analysis	Awaiting confirmation post survey analysis.	100%	Analysis to be completed by end 12/2025.	**N/A**
Number of risks reported and % mitigated through effective governance	Dec: 12 open, 4 due to close at PEGG	TBC	First risk review group meeting 04/12/2025 to establish baseline.	N/A
Number of open formal ER cases per 1000 organisation headcount	7.5 (May 2025)	7.5	10.6	↓
Reduction in the number of open long term sickness absence cases	266 (May 2025 – previously reported as 189)	245 cases	300	↑
Governance structure in place	50%	100%	100%	↔
Stakeholder satisfaction with directorate governance framework using monthly Likert scale survey	First survey results to provide benchmark.	> 3.5/5.0	Survey out. Deadline for completion Friday 05/12/2025.	**N/A**
Customer services satisfaction rating	3.74 (Dec – 21 responses)	> 3.5/5	First survey completed Dec 2025 to establish baseline.	N/A

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
No CIP associated with Scheme					

Assurance	Rating
Executive Sponsor Rating	Limited

Culture, Organisational Development & Learning

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Progress continues across multiple cultural and workforce initiatives, with strong engagement and governance in place. All staff network chairs have been engaged to develop an organisation-wide engagement and promotion plan, supported by Communications. Executive sponsors have been introduced and are now scheduling bi-monthly meetings, ensuring sustained leadership visibility and support.
- ✓ The Cultural Insights Review Group met on 21 November and agreed alignment with PSIRF and JLC processes, embedding enhanced care for staff within these frameworks. Work on reasonable adjustments is progressing, with a survey issued to all managers to capture insights; this will inform policy review once closed. Engagement with ER has commenced to ensure robust implementation.
- ✓ Leadership development is being strengthened through the launch of a new cross-trust webinar series in collaboration with RDUH. This initiative represents a first-of-its-kind joint approach and will act as a test of change to inform future leadership development strategies. Occupational Health arrangements have been reviewed, with a one-year extension negotiated on the current contract. Further engagement with Optima and stakeholders is scheduled to explore future provision options.
- ✓ Health and Wellbeing proposals are advancing, with Phase 1 due for presentation to the Executive Committee in December following stakeholder feedback. In addition, work with Clinical Psychology and Chaplaincy teams is underway to formalise data capture for staff attending debriefing sessions, including the development of registration and survey tools.
- ✓ The Restorative and Just Learning Culture programme has progressed to a new draft implementation plan aligned with the 5.3 workplan. This reflects a structured rollout approach, with some elements already in delivery and full implementation planned over a longer timeframe to ensure effectiveness. External engagement with Mersey Care NHS Foundation Trust is scheduled to support training and rollout of the internal offer.
- ✓ A new deliverable has been introduced, focusing on evaluation and embedding the 5.3 culture, OD, and learning approach. Additionally, work has commenced to define new KPIs for CPD, student experience, clinical supervision, and NETs, with meetings scheduled to scope metrics that better capture outcomes.
- ✓ Overall, assurance can be provided that key initiatives are progressing to plan, with strong governance, stakeholder engagement, and risk mitigation measures in place to support delivery.

Next Steps

- ➢ OD and ER team to agree on mediation service and offers.
- ➢ Work towards collating data and insights from NETs, student experience, CPD and clinical supervision.
- ➢ Meet with Finance to review budget for Occ Health provision.
- ➢ Just and restorative learning culture project implementation plan and timelines

Key Performance Indicators	Baseline	Target	Current Position	Trend
Staff Feedback: National Staff Survey	39%	45%	39%	⇔
Staff Feedback: Pulse Survey Response Rate	1.96% (Q1)	45%	5.54% (Q2)	⇔
Recommend as a Place to Work Staff Survey People Pulse	 62% 34% (Q1)	 66% 66%	 62% 45% (Q2)	⇔
Compliments Received	332 (2024/25) 76 (Q4 2024/25)	20% increase	81 Compliments (Q2 2025/26)	⇔
Datix closure from last annual period	801 (2024/25)	20% decrease	342 incidents still open from 2024/25	⇔
Workforce and Retention data Workforce and Stability data	88.90% 79.41%	90% 81%	88.87% 80.45%	⇑

Risk	Mitigation
Risk: Ability to support the organisation transform its learning culture. **Cause:** Current policies and process are not aligned to the organisational ambitions of a just and restorative learning culture. **Consequence:** Increased dissatisfaction from staff contributing to a negative blame culture. People feeling unsafe to speak up and/or feeling a sense of it is not meaningful to do so. And an organisation which does not learn from previous incidents leading to repetition and risk of moral, psychological and physical injury.	a) Workstream is currently identifying areas at most risk and review actions aligned. b) Exploring if any mutual-aid could be available from neighbouring organisations/ future system working. c) Potential to adopt national policy. d) Commencing project to progress 'just and learning' approach. PMO being aligned through RSP support.\Much of this work relies on outcomes from 5.2 to drive change

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

Torbay and South Devon NHS Foundation Trust

Board of Directors

Committee Chairs' Report

Date of meeting	Date report produced
8 January 2026	30 December 2025

Author(s)		Report approved by	
Name and title:	Sophie Byrne PA to Chairman	**Name and title:**	Sarah Fox Corporate Governance Manager
Phone:		**Date:**	31 December 2025
Email:	s.byrne10@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 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 – 11 December 2025
Charity 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: • Fundraising Report – Satisfactory Assurance – note • Finance Report – Satisfactory Assurance – note • Charitable Funds Standing Financial Instructions – Satisfactory Assurance – note • Charity Investment Policy – Satisfactory Assurance – note • Investment Manager Report – Satisfactory Assurance – note • Committee Effectiveness Review – Satisfactory Assurance – note **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 SATISFACTORY ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	Following the Investment Manager report, the committee has asked the Charity Finance Manager to appraise the option of transferring the Charity's cash holdings to a Liquidity Fund (currently yielding 4%) to maximise short term returns. Following review of the Charitable Funds Standing Financial Instructions the committee has asked that a co-ordinated piece of work commences to align all governing documents for the Charity (including the Charity's original governing documents, terms of reference for the Committee and the Fundraising Operational Group, and financial instructions and policies).
ADVISE:	There has been a lack of progress on the charitable funds restructure plan due to capacity constraints in the Finance Department. This is expected to change once the Director of Operational Finance commences in post in December releasing the Charity Finance Manager.

ASSURE:	The committee was assured that: • The investment portfolio is performing well against the ARC Steady Growth benchmark • Fundraising continues to over perform on previous years
RISK:	
CELEBRATE OUTSTANDING:	• The charity has supported the refurbishment of the maternity bereavement room following feedback from families. The refurbishment has transformed the room into a more peaceful environment in which families can receive and process difficult news. Up to 20 families a month are supported in the maternity bereavement room. • The staff lottery is now able to offer a £1000 cash prize which is attracting more attention and generating much needed funds for the general pot. • Successful development session held at Ashburton Health and Wellbeing Centre with the League of Friends from Torquay, Newton Abbot, Paignton and Totnes. Better understanding of challenges facing each charity and opportunities to support each other. Commitment to annual shared development session.

Committee Chairs' Report – 15th December 2025

People 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: • 5.1 Delivering the Workforce Plan Report – Limited Assurance • 5.2 – People and Education Capability and Capacity Work Stream: Progress Report – Satisfactory Assurance • 5.3 – Culture Plan, Development and Learning- Update – Limited Assurance • Employee Relations Update – Limited Assurance • GMC National Training Survey Report – Satisfactory • People Digital – Limited Assurance • People Performance Report – Limited Assurance • Workforce Controls Review & Recommendation paper – Limited Assurance • Workforce Strategy and Operational Plan (Draft) – 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 ratings above and TAKE ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	The workforce plan for 25/26 will not be delivered. Various internal factors are compounding non-delivery including non-recurrent CIP delivery, bank usage increasing due to Timely Handover Protocol (THP), underlying growth in workforce. Workforce controls do not appear to be having the desired effect. Break glass panel has approved 525 of the 586 reviewed roles. The underlying growth in the workforce is not understood and a lack of consensus between the People and Finance functions on the methodology to count and report WTE, reductions in WTE and pay costs. Committee was appraised of a review that has been requested by the CEO.

	Committee requested that: • the methodology for counting WTE for the 26/27 plan (and MTFP) is written down and approved through the appropriate governance • safety vs quality is an intentional focus of any workforce reduction/control decisions • the CMO and CNO take an active role in work to understand and agree the required shape of the future workforce so that any workforce reduction plans have medical and clinical ownership and support.
ADVISE:	Delivery of Wave 2 of the People Digital Programme (Feb-May 2026) will run concurrent to EPIC implementation. Successful delivery of Wave 2 will depend on local change and programme management which is yet to be identified and mobilised.
ASSURE:	Demonstrable progress has been made with the establishment of staff networks and a good account of next steps. Establishment of the Cultural Insights Review Group, its 'enhanced care for staff' subgroup, and alignment with PSIRF and Restorative Just and Learning culture, provides a focused approach for systematically reviewing cultural indicators across the Trust, addressing issues and embedding learning. A good example of bringing People and Quality indicators together, and a wider professional cohort for a more holistic cultural view. An overall positive GMC National Training Survey Report where Torbay and South Devon NHS Foundation Trust performed well against the regional peninsula benchmark group. Committee noted the following as indicators to watch alongside existing culture work: • Obs. & Gynae results remain challenging with little year on year progress • Over a quarter of respondents to questions about discriminatory behaviour report experiencing micro-aggressions and hearing discriminatory language based on protected characteristics

	• Female trainees (particularly in surgery, emergency medicine, medicine and anaesthetics) reporting experiences of sexual harassment **Post committee: Chair has asked for an update on actions taken based on these specific indicators.*
RISK:	The BAF was reviewed with clear updates for supporting objectives. A review of 'very high' and 'high' risks will be completed in the new year and brought back to People and Quality Committee for scrutiny. Achievement of 10% bank usage reduction (and associated cost savings) was highlighted to the committee as at risk. The Timely Handover Protocol within ED is driving increased use of bank nursing.
CELEBRATE OUTSTANDING:	Staff story from Michael Burnett-Hall highlighted the positive impact that our partnership with the Open University is having by offering more accessible opportunities to study and train to be a Registered Nurse. Those within our local community that need a local training offer can study remotely and have guaranteed placements locally at Torbay and South Devon NHS Trust. A great example of our anchor institution role in action and an innovative partnership that is bringing diversity to our workforce.

Torbay and South Devon NHS Foundation Trust

Board of Directors

Torbay and South Devon NHS Charity Impact Report 2024/25

Date of meeting	Date report produced
08.01.2026	22.12.2025

Author(s)		Report approved by	
Name and title:	Jane Harris, Associate Director of Communications and Partnerships	**Name and title:**	Joe Teape, Chief Executive and Liz Edwards-Smith, Chair of Charity Committee
		Date:	23.12.2025

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

Executive summary

The Torbay and South Devon NHS Charity Impact Report for 2024/25 is being presented following approval by the Charity Committee.

The Charity's annual report and accounts for 2024/25 will be submitted to the Charity Commission this month and the impact report is a companion item.

Board is asked to RECEIVE the report and NOTE the progress made.

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	Satisfactory	N/A
2	Satisfactory	N/A

Appendices

Torbay and South Devon NHS Charity impact report 2024/25

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

The Charity impact report 2024/25 was presented to and approved by the Charity Committee on 10 September 2025.

Key recommendations and actions requested

The Board is asked to AGREE the recommendation assurance rating and take SATISFACTORY ASSURANCE as to those matters discussed.

The Board is asked to RECEIVE the Torbay and South Devon NHS Charity Impact Report 2024/25.

How does this report further our Trust strategy?

This report furthers the approved Fundraising Strategy for Torbay and South Devon NHS Charity.

By supporting our Charity, people are helping to make things better for people in Torbay and South Devon. Our fundraising mission is to work with Torbay and South Devon NHS Foundation Trust to make a positive impact on the health and wellbeing of people who use our services and our dedicated, talented and amazing people. By investing in innovative healthcare initiatives and promoting the wellbeing of our people, we strive to create an inclusive culture that benefits all those who come into contact with our Charity. Our intent is to ensure equity of opportunity for all our health and social care services to benefit from our Charity

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Prioritising pillars of work that enable our charity to grow and become more sustainable supports the health and wellbeing of our local communities and build an abundance model
Quality of services provided	Prioritising work to grow our charity income enables us to improve the quality of services we provide
Sustainable and efficient use of resources	Prioritising work to improve the governance and infrastructure of the charity enables the best use of resources

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality, Safety and Patient Experience	Increasing charitable income to improve patient experience and outcomes
Leadership and Governance	Putting our charity on a more sustainable footing with improved governance
Performance	Working with Fundraising Operational Group to identify opportunities through charitable funding to decrease waiting times and meet key targets
People and Culture	Enabling income stream for staff wellbeing support and activities and improving equity of access to charitable funds
Strategy and Business Intelligence	Building an abundance model, bringing new monies into our footprint
Finance	Putting our charity on a more sustainable footing with improved governance

Risk

Our Torbay and South Devon NHS Charity has a comprehensive risk register which is reviewed at Fundraising Operational Group. Any matters of escalation are reviewed by Charity Committee on a quarterly basis.

The core risk that the production of the impact report mitigates against are maintenance of donor confidence, visibility and sustainability of the charity and regulatory and administrative compliance.

Risks lodged on Datix:

All the Charities risks are logged on Datix.

External Standards affected by this report and associated risks

Charity Commission

Torbay and South Devon NHS Charity Impact Report 2024/25

1. Introduction and background

Our Torbay and South Devon NHS Charity plays a vital role in supporting the health and wellbeing of people across our communities, funding projects and initiatives that go beyond what core NHS funding can provide.

In 2024/25, the Charity raised over £383,000, enabling us to deliver a wide range of improvements for patients, families, and staff.

This report highlights the impact of these projects and the generosity of our supporters, volunteers, and partners, whose commitment has helped us make a tangible difference across hospital, community, and adult social care services.

2. Purpose of report

This report is presented to provide the Board with an overview of the Charity's activities, achievements, and financial performance during 2024/25.

It demonstrates how charitable funds have been used to enhance patient care, reduce health inequalities, support staff wellbeing, and strengthen partnerships with local organisations.

The report also outlines our future priorities and strategic direction, ensuring continued alignment with our organisational vision for better health and care for all

3. Impact highlights

During 2024/25, the Charity funded a diverse range of projects, including the transformation of Louisa Cary Ward into a vibrant, child-friendly environment, the purchase of dual scalp coolers for chemotherapy patients, and the creation of a restorative garden for coronary care.

We supported young adult carers, delivered art and yoga therapy for cancer patients, and provided new equipment and experiences for people with profound disabilities.

These initiatives have improved patient experience, promoted inclusion, and addressed health inequalities across Torbay and South Devon.

4. Financial summary

The Charity received over £383,000 in donations, legacies, and grants during the year.

Funds were allocated to capital equipment, patient care projects, staff training and development and staff welfare.

Our approach ensures that every pound is used wisely and transparently, with robust governance and a focus on maximising impact for local people and NHS staff.

It is noteworthy that fundraising for 2024/25 (year one of our five-year fundraising strategy) exceeded the target set. Achieving this in the current financial climate is a

significant accomplishment. This provides a solid foundation for year two of our fundraising strategy and demonstrates the potential for continued growth in support of our objectives.

5. Looking ahead

Building on this year's achievements, the Charity moves into the second year of its ambitious five-year fundraising strategy, with priorities including staff wellbeing, reducing health inequalities and supporting innovation in care.

We will continue to develop partnerships, grow unrestricted funds, and deliver on our new initiatives, for example the staff lottery and microgrants scheme which have launched this year (2025/26), ensuring we remain responsive to the needs of our communities and aligned with Torbay and South Devon NHS Foundation Trust's strategic vision.

6. Assurance recommendations and summary

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

The Board is asked to RECEIVE the Torbay and South Devon NHS Charity Impact Report 2024/25 and NOTE the progress made.

This report includes the following assurance recommendations:

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

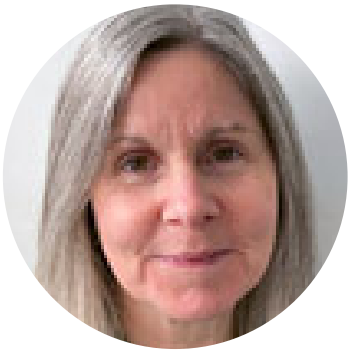
Torbay+ South Devon NHS Charity

Annual report 2024-25

Helping to make things better


Torbay
South Devon
NHS charity
NASHVILLE

Welcome



I am delighted to welcome you to our Torbay and South Devon NHS Charity Annual Report for 2024/25.

A year in which the power of community, compassion and innovation has truly shone through.

Thanks to the generosity of our supporters, we raised over £383,000, enabling us to deliver projects that have had a tangible and lasting impact on the lives of patients, families and staff across Torbay and South Devon.

From the transformation of the Louisa Cary ward into a vibrant seaside-themed space for children, to the purchase of dual scalp coolers that ease the burden of chemotherapy and the creation of a restorative garden for coronary care patients, every initiative has been rooted in care, dignity, and hope.

Beyond our hospital walls, our charity has supported yoga and art therapy for cancer patients, community wellbeing initiatives and staff development programmes—all designed to enhance health and happiness across Torbay and South Devon.

Thank you for helping us make things better.

These achievements are only possible because of the incredible people who walk alongside us: our fundraisers, donors, volunteers, many local businesses and those who leave us a gift in their Wills.

We recognise the trust that people put in us to use the money they give us wisely, making things better for local people and NHS staff.

Our Torbay and South Devon NHS Charity aims to support the full range of services offered by Torbay and South Devon NHS Foundation Trust – adult social care, community services and hospital-based services while working closely with other charities who also support health and wellbeing locally. We are proud to work in collaboration with charities such as Rowcroft Hospice, Devon Air Ambulance, and our eight dedicated Leagues of Friends, whose shared commitment to wellbeing strengthens our people and communities every day.

As we look ahead, we remain focused on delivering projects that make a real difference—projects that go beyond what the NHS alone can provide, and that reflect the values of kindness, inclusion, and innovation at the heart of our charity.

Liz Edwards-Smith, Chair of Charity Committee


INFLATABLE 5K
Torbay
South Devon
NHS Charity
INFLATABLE 5K
06147
5K

Thank you

At Torbay and South Devon NHS Foundation Trust we're proud to be part of a community that consistently steps up to support one another. Our NHS Charity is a vital part of that community – helping us go further, reach wider and do more for the people we serve.

This year, our NHS Charity has enabled us to deliver projects that simply wouldn't be possible through core NHS funding alone, making a huge difference to the care and treatment our services can offer to our people and communities.

We've always believed that care should be shaped around what matters most to people. That's why we were the first trust in England to integrate hospital, community and social care. And it's why we continue to innovate—whether that's through nationally recognised clinical services or through the work of our NHS Charity, which brings added value to everything we do.

The pandemic reminded us just how much the NHS means to people. It also highlighted the inequalities and pressures that still exist.

My reflections on the recent publication of the 10-year health plan for England is that we are well placed to lead the way on many areas here at Torbay and South Devon – we always have integrated and established neighbourhood teams (with more to do), have a digital lab that is leading the way in developing new technology and an integrated approach to prevention that we need to truly build on given the inequalities within our population and the high levels of need in rural and coastal communities.

We need to also build further here on the amazing voluntary sector we work with.

Thanks to the generosity of our supporters—and the momentum we've built through partnerships like NHS Charities Together—we're now in a stronger position to respond to our challenges with compassion, creativity and purpose.

To everyone who has donated, fundraised, volunteered or shared our story: thank you. Your support is helping us make things better, every day, for everyone in Torbay and South Devon.

Joe Teape, Chief Executive, Torbay and South Devon NHS Foundation Trust

Torbay+ South Devon NHS Charity

Our annual report

Our Torbay and South Devon NHS Charity is here to provide better care for people in Torbay and South Devon from birth to the end of life and everything in between.

Thanks to supporters like you, we gave over £398,000 in 2024/25 to improve the health and happiness of people who use our services, providing specialist equipment, improving the physical environment, supporting the wellbeing of all and reducing health inequalities.

We are delighted to be able to share with you some of the projects and improvements your donations and support have helped us to fund during the year and share the positive impact they have made.

Our vision

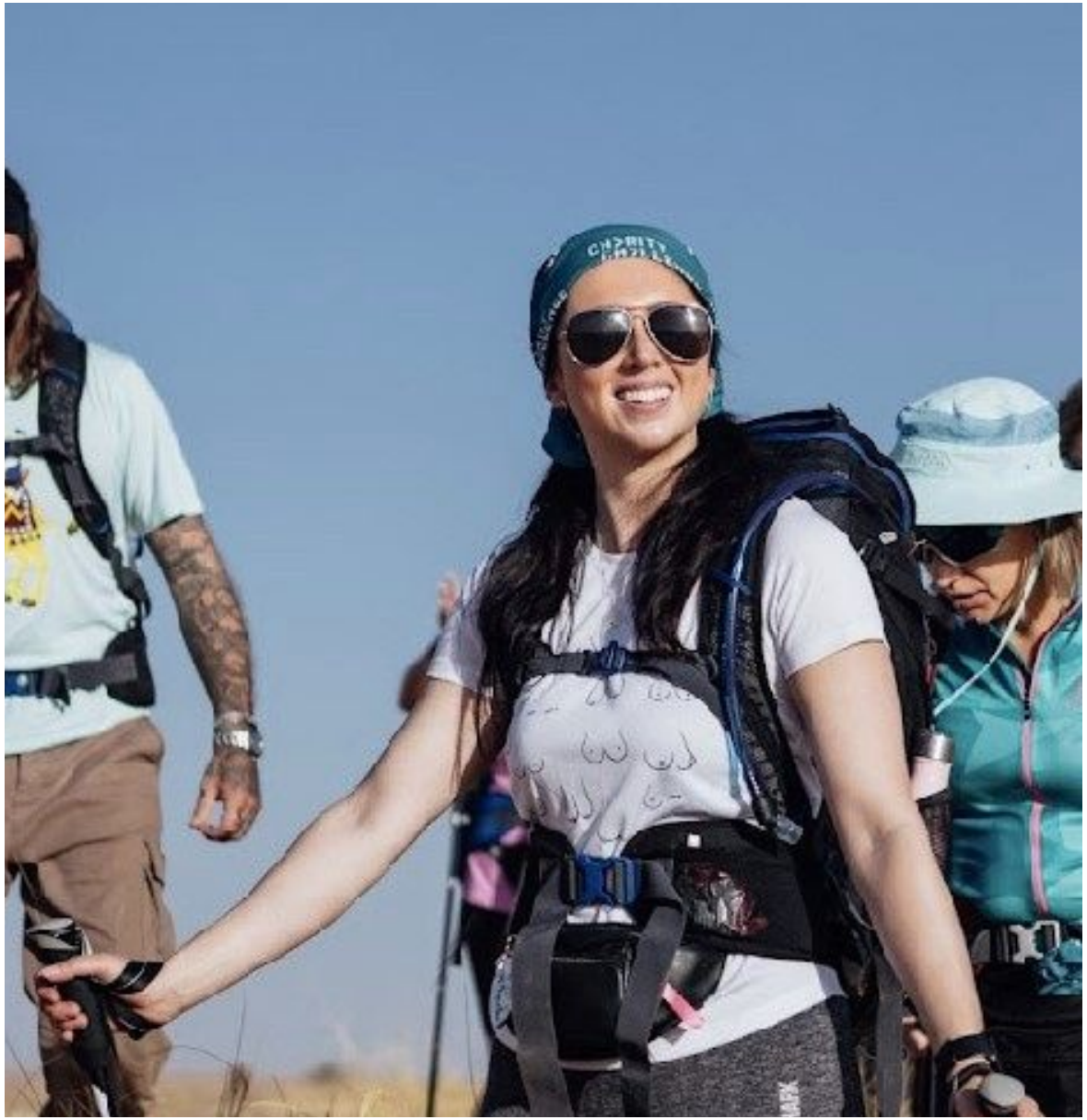
Our vision is to provide better care for you, your family and neighbours, from birth to the end of life and everything in between. By supporting us, you are helping to make things better for people in Torbay and South Devon.

Our fundraising mission is to work with Torbay and South Devon NHS Foundation Trust to make a positive impact on the health and wellbeing of people who use our services and our dedicated, talented and amazing people. By investing in innovative healthcare initiatives and promoting the wellbeing of all, we strive to create an inclusive culture that benefits all those who come into contact with our charity. Our intent is to ensure equity of opportunity for all our health and social care services to benefit from our charity.

Our NHS values drive us to support excellent care every day, ensuring that the needs of our people and our communities are cared for both now and in the future.

How you can get involved

- Fundraise for us
- Regular or one-off donation (online)
- Offline donation
- Remembering a loved one
- Leaving a gift in your will
- Donate while you shop via www.easyfundraising.org.uk
- Follow us on social media and share our story
- Email: tsdft.charity@nhs.net
- Website: https://charity.torbayandsouthdevon.nhs.uk/



How you helped

Thank you are just two small words that often don't seem enough to recognise the time, energy, kindness, commitment and care that you show our charity.

Without you, we simply couldn't do what we do. Any success we have is due to your support and we couldn't be more grateful.

Here are a few examples of the lengths you went to this year to fundraise for us.

> *I've chosen to support the Unit because everyday I meet the most incredible people and I really see the difference that we can make to the patients that we see. Our aim is to accurately diagnose and treat breast cancer, achieving the best outcome possible for our patients. But, if we can also make their journey that little bit more comfortable along the way, we are really doing our job well*
>
> Phoebe Sage, Radiographer, Breast Care Unit

Our year in numbers

74

kilometers cycled over beaches, gravel and backroads by Chris Balch and his sons Sam and Roger

50

different wards, services and areas supported

£12,840

our largest single donation (excluding legacies)

100

miles cycled by Scott and Zoe Davies from Torbay Hospital to Bristol Childrens Hospital

22.6

miles rowed by the Blades Crew in the Great River Race

50p

our smallest single donation

Working together

None of the important and impactful projects we fund across Torbay and South Devon would be possible without the generous support of our fundraisers and donors.

We would like to take this opportunity to thank all the individuals, families, local businesses, community groups and other organisations who have supported our Torbay and South Devon NHS Charity throughout the year.

We've highlighted just a few on the following pages, but we are grateful for every single person who has supported our charity this year.

Voluntary income

£253,000

Donations

£124,000

Legacies

£6,000

Grants

Grant expenditure

£64,000

Capital equipment

£250,000

Patient care projects

£49,000

Staff training and development

£35,000

Staff welfare

Reducing health inequalities

Building confidence and resilience in our young adult carers

There are hundreds of young adult carers in Torbay and South Devon. Being a young adult carer can affect a young person's health, social life and self-confidence with many struggling to manage their education, working life and caring role, which can cause pressure and stress.

While the Torbay Young Adult Carers Service is funded by Torbay and South Devon NHS Foundation Trust to support young people aged 16 - 25 with caring responsibilities, their activities, which give young adult carers a break, time with other young carers and a chance to build vital resilience, confidence and skills, are only possible thanks to donations and funds raised.

A huge thank you to Torquay Rotary, Brixham Sorophomists and to Sports England for supporting our young adult carers in 2024/25.

Thanks to their support, local young carers aged 16-25 were able to access regular drop-in sessions, enjoy activities such as bike rides and bowling, and even challenge themselves with a once-in-a lifetime opportunity of a week's sailing adventure on board an iconic 72 ft Challenge racing yacht for a small number of carers.

Reducing health inequalities

A breath of hope . . .

Thanks to a grant from Torbay Council we were able to partner with our award-winning smokefree pregnancy team to create a film and social media campaign aimed at encouraging expectant mothers to quit smoking during pregnancy.

This initiative, will help the dedicated smokefree pregnancy team to go over and above in their support for mums to be, by addressing a gap in smoking cessation support for mothers before 15 weeks of pregnancy.

Improving experience

Healing through art

Every week, beautiful artwork is created in the Moving On art group—an initiative that offers free creative sessions to people recovering from breast cancer, for up to two years after treatment.

Thanks to the kindness and generosity of our supporters, more than 50 individuals have already taken part in the Moving On art and meditation groups, finding comfort, connection and confidence through creativity.

> *I've always liked art, when you are doing it, you don't think about anything else – it's good for your mental health. My treatment took me to some dark places and when you finish, you worry a lot and think a lot 'will it come back'? Art takes me away from everything and the group is really friendly, it's good to meet people in the same situation who properly understand what you've been through.*
>
> Steph

Improving experience and our environment

Ricky Grant Day Unit now has a dual Paxman Scalp Cooling machine—doubling capacity for this vital treatment. Scalp cooling helps reduce hair loss during chemotherapy, and thanks to this upgrade, every patient who requests it can now access it.

Seven new specialist chemotherapy armchairs have been funded by our Charity, replacing older chairs on the Ricky Grant and Turner wards.

Patients receiving treatment for up to nine hours can now do so in greater comfort.

Young patients on Louisa Cary ward explored music and digital media through a six-week creative programme and delivered by Sound Communities CIC—bringing joy and expression to hospital stays.

New vibrant wallcoverings featuring our amazing colleagues have been installed across Torbay Hospital.

Funded by NHS Charities Together, these eye-catching vinyls raise awareness and celebrate the work of our charity.

Improving experience

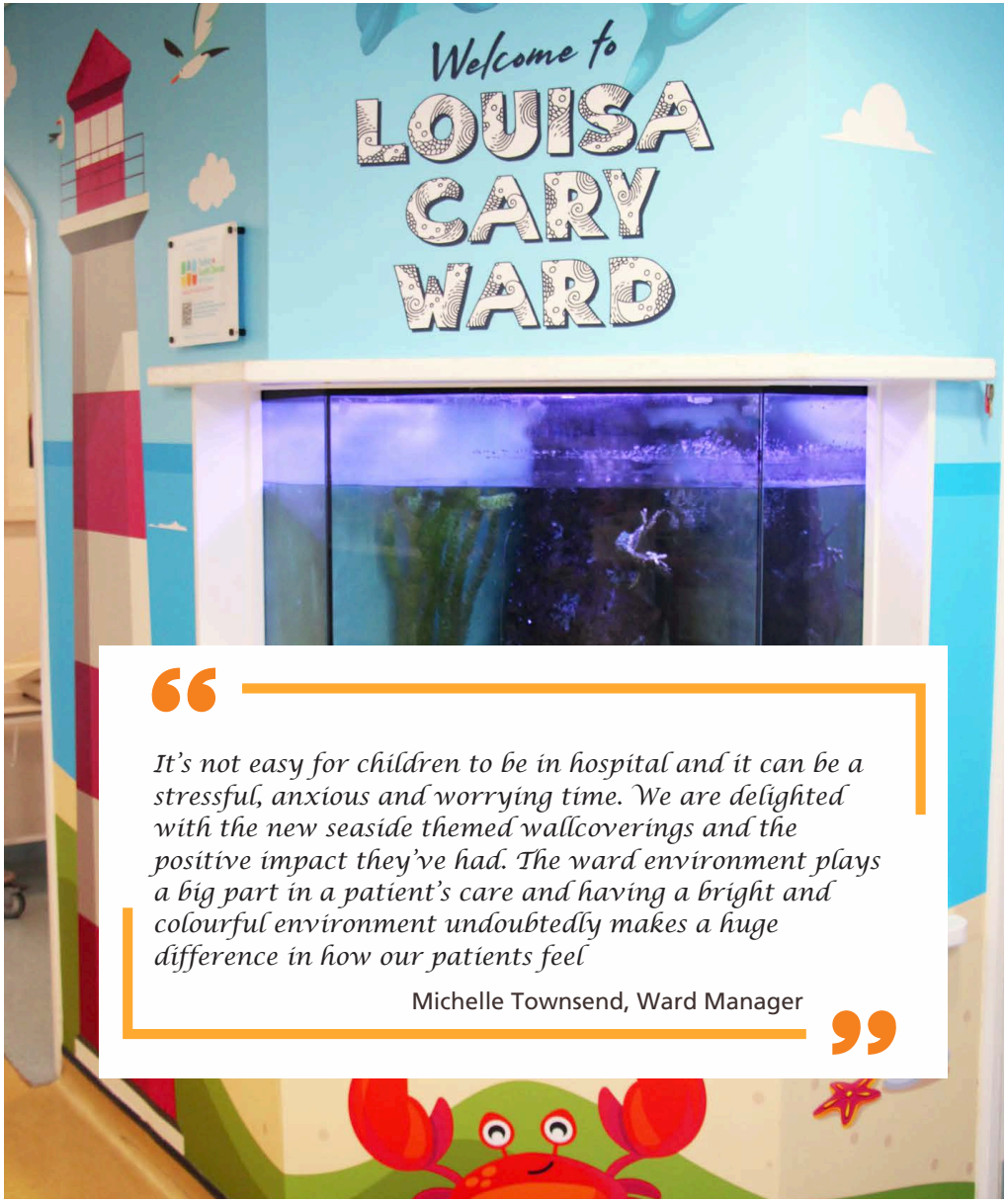
Waves of kindness

Thanks to the incredible generosity of NHS charity fundraisers, Torbay Hospital's children's ward now features vibrant seaside-themed wallcoverings that brighten the space for thousands of young patients each year.

Among the many supporters who made this possible, Scott and Zoe Davies from Torquay raised an incredible £5,000 through a fundraising challenge last July, in heartfelt thanks to the staff at Torbay Hospital and Bristol Royal Hospital for Children who saved their son Dempsey's life in 2023.

The final design was shaped by ideas from children, families and staff, ensuring the space reflects the voices of those who use it. The seaside theme continues into the older children's area, with age-appropriate images like dolphins and turtles.

With your continued support, we aim to raise further funds to transform the short stay assessment unit and paediatric emergency department—creating hospital spaces that are not only functional, but also welcoming, engaging and full of hope for children and their families.



> *It's not easy for children to be in hospital and it can be a stressful, anxious and worrying time. We are delighted with the new seaside themed wallcoverings and the positive impact they've had. The ward environment plays a big part in a patient's care and having a bright and colourful environment undoubtedly makes a huge difference in how our patients feel*
>
> Michelle Townsend, Ward Manager

Supporting our NHS people

Thanks to the generosity of our corporate sponsors, Torbay and South Devon NHS Foundation Trust were able to hold their annual our people celebration event.

More than 180 NHS award winners came together for a night to remember (and a classic disco) so that we could recognise and reward them for their dedication and commitment, care and compassion and innovation and achievements.

As part of the evening we awarded our first ever Charity Champion Award, given to a member of staff who has gone above and beyond for our charity.

We were delighted to have three winners in the 2024 Awards. Jane Read, Cheryl McKinnon and Gill Walach, recognising the hard work of three members of staff in our Special Care Baby Unit, our young adult carers service and on Templer ward.

> *It was a real pleasure to be part of such a special evening, and SDS was proud to support the event through sponsorship.*
>
> *Thank you and congratulations to everyone involved. It was inspiring to see the recognition given to so many deserving individuals.*


Our People
AT THEIR BEST
Our People
AWARDS
Congratulations
Our People's Choice Team

Supporting our people

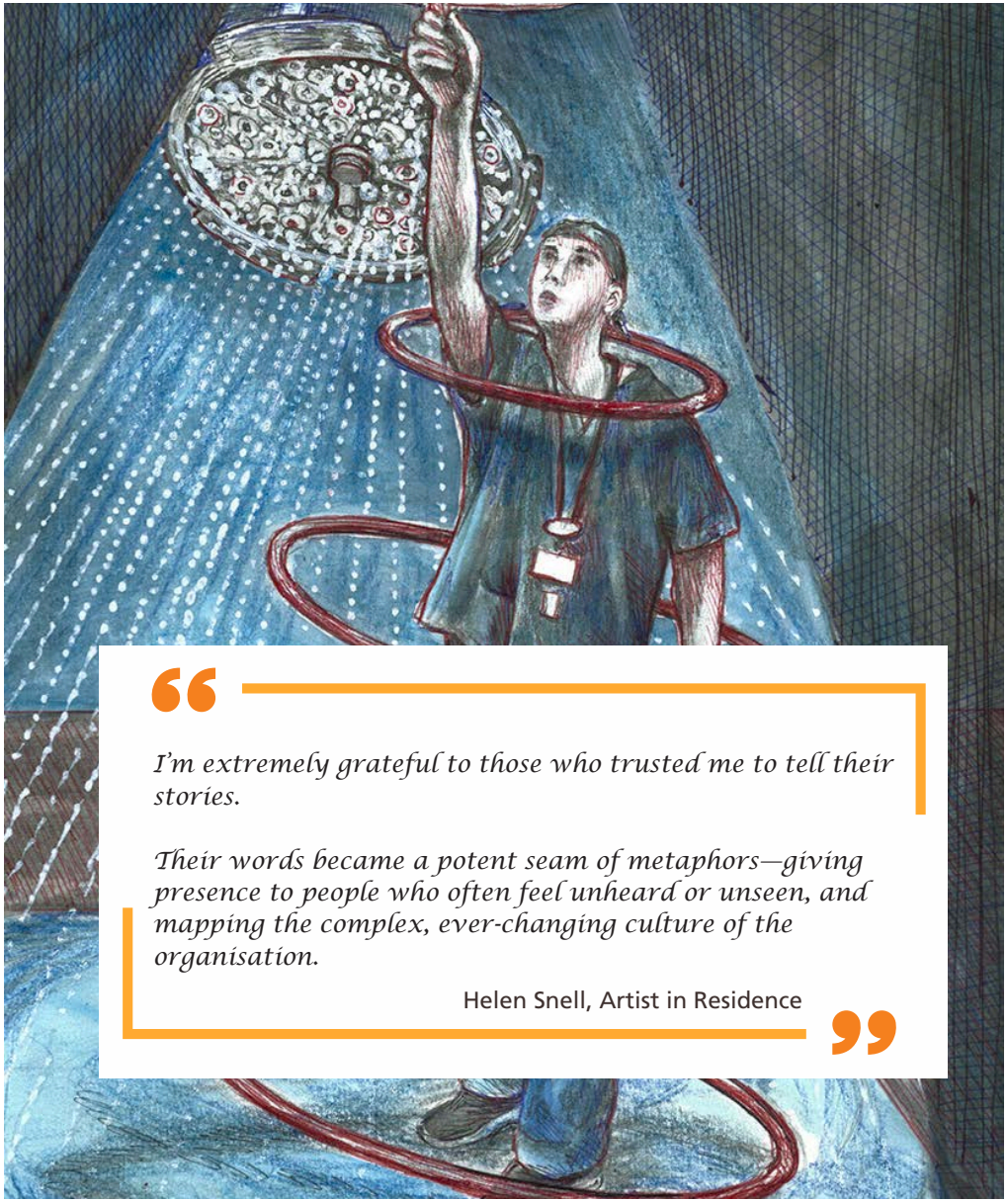
From silence to canvas

For the past three years, artist Helen Snell has worked closely with people who work for Torbay and South Devon NHS Foundation Trust to explore themes of wellbeing and burnout through art—capturing the emotional journey of those who cared for others during and after the pandemic.

From the early days of lockdown to the long road of recovery, clinical and non-clinical staff gave everything to support patients at home and in the community.

To mark the fifth anniversary of the first lockdown, our charity proudly funded a permanent exhibition in the Board Room at Torbay Hospital titled And breathe, said the machine. This powerful collection reflects the thoughts, emotions and lived experiences of NHS staff during one of the most challenging periods in healthcare history.

Appointed artist-in-residence in 2022 through funding secured from NHS Charities Together, Helen shadowed staff in a wide range of roles—from cleaners to surgeons, pharmacists to scrub nurses—inviting them to reflect on their work environments as metaphorical spaces and to share their views on wellbeing within the NHS.



> *I'm extremely grateful to those who trusted me to tell their stories.*
>
> *Their words became a potent seam of metaphors—giving presence to people who often feel unheard or unseen, and mapping the complex, ever-changing culture of the organisation.*
>
> Helen Snell, Artist in Residence

Improving experience

Big smiles, small moves

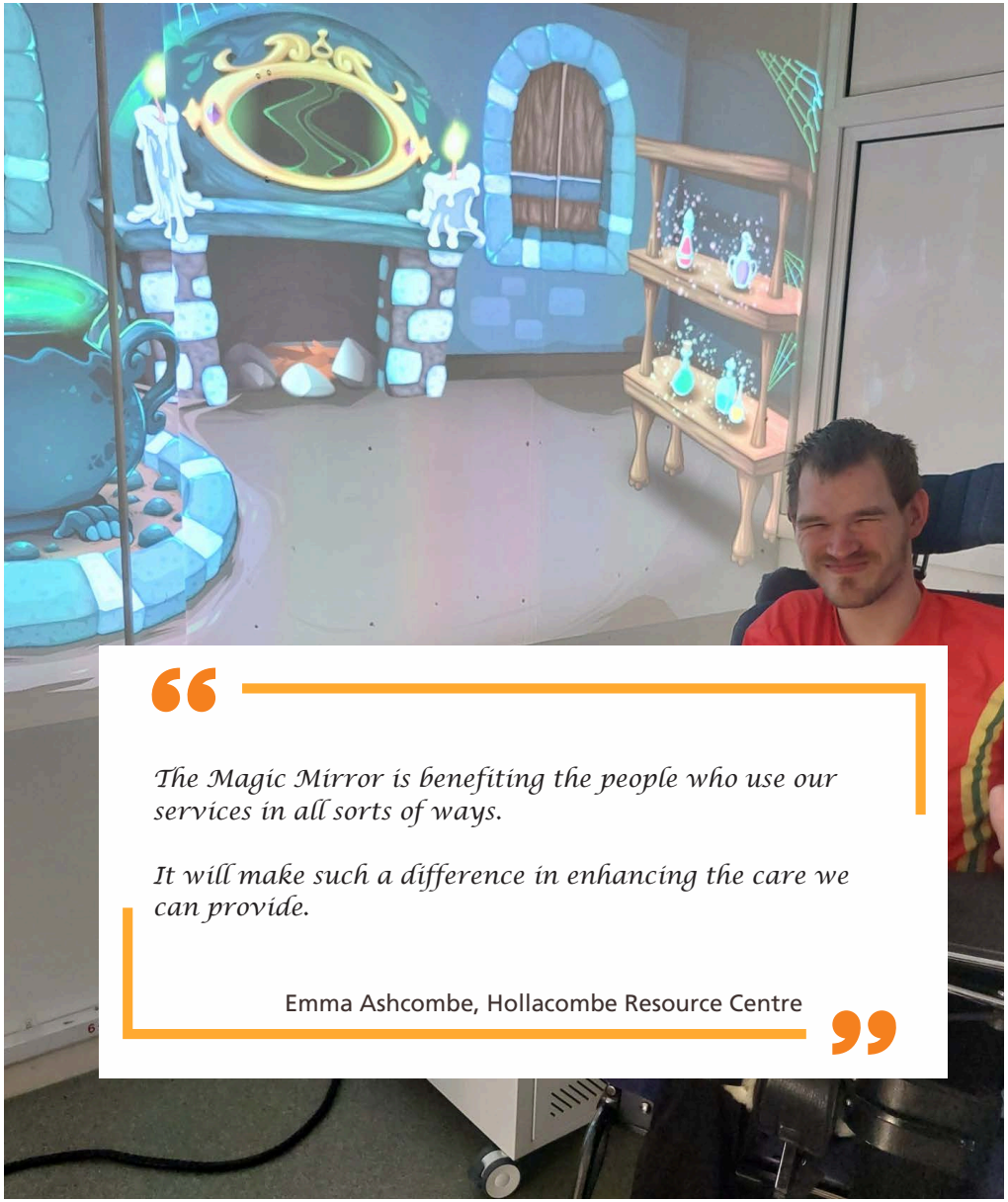
Thanks to a generous grant from the Claire Milne Charitable Trust, adults living with profound disabilities at Hollacombe Resource Centre are now enjoying the benefits of a new Magic Mirror—an interactive screen that responds to even the smallest movements.

The Magic Mirror projects images and games onto a screen, allowing users to engage in fun, sensory experiences that support physiotherapy.

Whether playing games solo or as part of a group, participants are encouraged to move, interact and enjoy.

The benefits go far beyond play.

The Magic Mirror helps improve mobility, cognitive behaviour, and memory —especially for younger adults, who now have access to familiar technology that has supported their development since school.



> *The Magic Mirror is benefiting the people who use our services in all sorts of ways.*
>
> *It will make such a difference in enhancing the care we can provide.*
>
> Emma Ashcombe, Hollacombe Resource Centre


EXHIBITION FIELDS
1901
SIMON
2079
100%
RECYCLED
RUN

Our star fundraisers

April 2024

David Jones ran the London Marathon to support our Special Care Baby Unit following the care his son Luka received.

Their work is truly commendable, and it's heartwarming to know that Luca received such dedicated care in the first weeks of his life.

May 2024

Seven people ran half marathons or 10Ks for our charity, braving hills and torrential rain in the Great West Run in Exeter.

June 2024

Young Katie Wreyford walked 28 miles in the 'Moors to Moreleigh' challenge raising funds for Louisa Cary ward at Torbay Hospital. Katie was keen to ensure the money raised helps fund craft and art kits to help support older children on the ward.

53 people ran for our charity in the Inflatable 5k event. The seven teams included staff and supporters from Templer ward, Torview midwives, Emergency Department, Radiology, Health and Social Care, Communications and Site Support Services.

Without this help, the patience, understanding and kindness of the doctors and nurses on the ward and the ongoing support I am still receiving, I wouldn't be here today

Our star fundraisers

July 2024

Zoë and Scott Davies undertook an epic 500km bike ride from Torbay Hospital to Bristol Children's Hospital raising funds to give back to the teams that supported their son Dempsey.

> *To say thank you is basically impossible. There's not a word in the dictionary that describes our feelings towards all the teams that were on shift that day, and there on after with Dempsey's incredible care, even to this day.*
>
> *If there was I would definitely be shouting it from the rooftops*

August 2024

Torquay teenager Lottie Bryon-Edmond has raised more than £15,000 for a memorial to ensure local organ donors, are not forgotten. In August, Lottie, who received a liver transplant at 5 weeks old, undertook a sailing challenge as part of her fundraising efforts. The memorial will be installed in Torbay Hospital in autumn 2025.

Our star fundraisers

September 2024

Ten brave people from Compass House Medical Centre, Brixham jumped out of a plane at 15,000 ft to support local people undergoing treatment for breast cancer.

This cause is dear to all of our hearts at Compass House, and we are very grateful for all the amazing work the Torbay Breast Care Unit have been doing over the years supporting dear colleagues, friends and family and our patients in Torbay.

This is our way of saying thank you and helping to give something back to the Unit and future patients

25 people signed up to run the Torbay half marathon our behalf, unfortunately due to weather condition, the event was cancelled. Rather than letting the charity or their sponsors down, all our runners then ran the route 'their way' ensuring that the charity still received the vital funds raised.

We cheered on the Blades Crew as they took part in the Great London River Race, rowing 21.6 miles along the River Thames and competing against 400 boats.

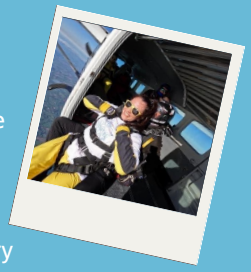
The team's raised funds for Ricky Grant Day Unit which provides chemotherapy and associated treatments, plus education and advice for those living with cancer.

Our star fundraisers

October 2024

During national Baby Loss Week, Tamsin Field jumped out of a plane at 15,000 feet in memory of baby Oscar.

Oscar was born sleeping in February 2024, and since then Tamsin tirelessly raised funds for Torbay's maternity bereavement suite and to raise awareness of baby loss.



November 2024

Elliot started his hoops challenge for part of his primary school Civic award. Setting himself a challenge of shooting 200 basketball hoops each month Elliot had a very personal reason for choosing to fundraise for the special care baby unit

December 2024

We were overwhelmed by the generosity of local businesses and the kindness of our supporters and fundraisers who all wanted to help make life a little more joyous, festive and fun for people who use our services.

I was born prematurely at 34 weeks to my mum and dad's surprise.

The team on the Unit took great care of me and reassured my mum and dad.

Whether it was donations of gifts for people in hospital or Christmas stockings for young adult carers, NHS staff taking part in our Big Christmas Cake Bake or people lighting up their houses, it felt like the whole of Torbay and South Devon came together to help make things better.

Our star fundraisers

January 2025

David from Dirtbag Waste Disposal kindly collected and recycled local people's Christmas trees while supporting our special care baby unit.

We think it's wonderful that he was able to support and care for the next generation while helping to save the planet for them.

February 2025

Duncan and his daughter Alaska ran the Exeter Half Marathon to raise funds for Ricky Grant Day Unit following the care his wife received on the Unit in 2024.

They raised a staggering £16,000!

March 2025

Radiographer Phoebe Sage, a staff member in our Breast Care Unit, took on an epic trek in Cuba to raise funds for patients supported by the Unit.

We want to give something meaningful back to the Unit and future patients.

They need to replace treatment chairs for the comfort of those receiving chemotherapy which can last for hours over many months.

Spotlight on . . .

Some of our NHS people really do give new meaning to going the extra mile when it comes to fundraising for our charity.

Consultant in Anaesthetics and Pain Medicine, Douglas Natusch ran the Torbay Half Marathon to raise funds for new virtual reality (VR) equipment, designed to help reduce pain and discomfort for people living with chronic pain.

> *VR alters the sensory input to your brain, the programming can help people relax if they are feel stressed and afraid, to learn to move again gently. People sometimes find they can do sophisticated movements, as part of activities and games in VR, that they may be too afraid to consider trying without the headset on. The ability to learn to move without fear is an important step in helping people change their relationship to pain and suffering. Having more equipment allows us to reach more people and also to allow people to practice at home.*

Leaving a legacy

This year, generous gifts left in Wills have helped us raise £124,000, supporting areas such as our coronary care unit.

By including a gift in your Will, you can help ensure your loved ones are looked after, while also making a lasting difference to future generations in Torbay and South Devon.

A gift in a Will received by the unit transformed a previously unloved outside space, adding plants, flowers and garden furniture to benefit both patients and staff. Sister Jackie had the vision and is working hard to make this space into a beautiful garden.

> *This is just the beginning; I've planted spring bulbs today and hope in the spring to paint the garden furniture and add climbing plants, trelliswork, poetry and hopefully even a water feature. I love gardening and it has been fantastic to see how this project has made such a difference to everyone*

Ward manager, Sam, is over the moon with the outcome:

> *When the plants arrived the whole ward was buzzing, now patients have a space to sit outside and you can see green plants and flowers through the windows. We'd like to say a huge thank you to the amazing person who left a gift in their Will.*

Please get in touch at tsdft.charity@nhs.net to find out more about leaving a gift in your Will, or visit: www.charity.torbayandsouthdevon.nhs.uk

Looking forward to making even more of an impact next year!

Torbay+ South Devon NHS Charity

Our future

We have set an ambitious fundraising strategy for the next five years that puts people at the heart of everything we do and is aligned to the vision of the Torbay and South Devon NHS Foundation Trust for better health and care for all.

Our vision is to provide better care for you, your family and your neighbours, from birth to the end of life and everything in between. By supporting us, you are helping to make things better for people in Torbay and South Devon.

For the next year, we have identified the following priorities for spending the monies raised through donations, legacies and grants:

- improving the health and wellbeing of our staff, in the context of ongoing operational pressures
- purchasing of medical equipment
- purchasing items to improve the experience of people who use our services and their carers
- staff training and development
- reducing health inequalities
- supporting health education.

Our fundraising mission is to work with Torbay and South Devon NHS Foundation Trust to make a positive impact on the health and wellbeing of people who use their services and the dedicated, talented and amazing people and volunteers who deliver care and services.

Over the next year, we will focus on:

- developing our trust and grants fundraising to bring new and additional monies into Torbay and South Devon through projects which are aligned to our fundraising principles
- ensuring excellent governance and ethical standards of charity practice
- launching a staff lottery to provide a dedicated income stream to support the wellbeing of our teams, enabling them to deliver better care
- as we build our unrestricted funds, delivering an effective and accessible microgrants scheme to support improvements aligned to our fundraising principles
- developing our brand to ensure that our ability to deliver impact is understood
- building and strengthening partnerships with key health, VCSE and charity organisations locally to deliver greater impact
- generating financial support for Torbay and South Devon NHS Foundation Trust's recognition and awards programme.

Torbay+ South Devon NHS Charity

Torbay and South Devon NHS Charity
Torbay and South Devon NHS Foundation Trust,
Hengrave House, Torbay Hospital, Newton Road
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Torbay and South Devon NHS Foundation Trust

Trust Board

Operational Performance Report

Date of meeting	Date report produced
8 January 2026	23rd December 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
		Date:	31st December 2025

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

Executive summary

This report provides a consolidated update on key operational performance issues and measures to provide the necessary assurance to the Trust 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. The assurance ratings in this report are based on current delivery against trajectories and the outcomes of the Executive Operations Group review meetings.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
UEC 4 Hour Performance	Limited	No Change
UEC Ambulance Handover	Satisfactory	Improved
UEC 12 Hour Performance	Satisfactory	No Change
RTT 65 week waiters	Limited	No Change
RTT 18 week, RTT 52 week total waiting list size, % first appointment within 18 weeks	Satisfactory	No Change
Cancer Performance	Satisfactory	Improved
Diagnostic Performance	Limited	No Change

Appendices

Committees that have previously discussed/agreed the report, and outcomes of that discussion
This report summarises the outputs from the Executive Operations Group, led by the Executive Directors and attended by the Care Group senior leadership, which took place on 10th December 2025. Scrutiny was undertaken on the key performance indicators in care group balanced scorecards and the reasons for any over or under performance, action plans in place and timeframes for any required recover were noted. 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.

Key recommendations and actions requested
The Board are asked to AGREE the recommended assurance ratings.

How does this report further our Trust strategy?
Ensures timely access to services that are safe and provide good patient experience.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	All impacted by detail in this report
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 associated with RSP exit due to not meeting operational performance trajectories. This is explained in alternative reports

Risks lodged on Datix:

External Standards affected by this report and associated risks

Operational Performance Report

1. Introduction and background

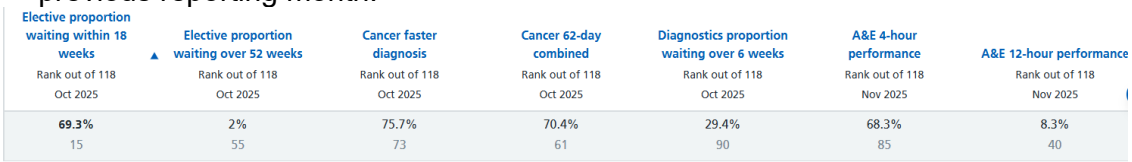
1. This report provides a consolidated update on key operational performance issues and measures to provide the necessary assurance to the Board in respect of the key performance indicators measured to enable exit from the national RSP. This report will cover performance detail on the progress on the 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. Purpose of report

2. Due to the nature of the national performance reporting schedule, this report will provide the nationally reported performance position for November 2025 in UEC, and October 2025 in all elective metrics. The paper will also include detail on the forecasted positions in each of these performance domains for November and December where available.

3. National Benchmarking

3. The table below reflects latest published data (as at 22/12/25) and demonstrates the current position in the Trust for the key performance metrics in relation to other providers across the country and a comparison in the national ranking against the previous reporting month.



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 118	Rank out of 118	Rank out of 118
Oct 2025	Oct 2025	Oct 2025	Oct 2025	Oct 2025	Nov 2025	Nov 2025
69.3%	2%	75.7%	70.4%	29.4%	68.3%	8.3%
15	55	73	61	90	85	40

Metric	Previous reported rank (out of 118)*	Latest available rank (out of 118)*	Improved/ Worsened
RTT 18-week wait	12 (Aug 2025)	15 (Oct 2025)	Worsened
RTT 52-week wait	46 (Aug 2025)	55 (Oct 2025)	Worsened
Cancer FDS	113 (Aug 2025)	73 (Oct 2025)	Improved
Cancer 62-day wait	94 (Aug 2025)	61 (Oct 2025)	Improved
Diagnostics wait over 6-weeks	102 (Aug 2025)	90 (Oct 2025)	Improved
UEC – 4-hour wait	83 (Sept 2025)	85 (Nov 2025)	Worsened
UEC 12-hour wait	59 (Sept 2025)	40 (Nov 2025)	Improved

*National published data

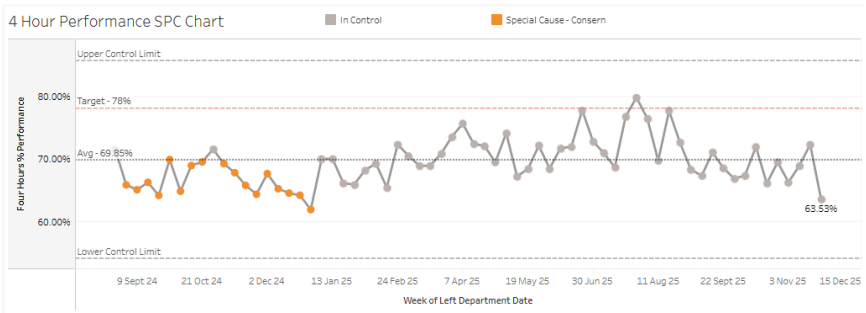
4. Urgent and Emergency Care

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Operational Plan trajectory Nov 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			3275	3108	2532	1625	1268	839	1530	1159	725	943	1823	810	624	1821
Average handover time (mins)	45 mins		109	95	84	62	47	36	52	45	32	38	60	33	29	42mins
Total average time in ED (hours/minutes)			06:18	06:17	06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		854	793	818	677	615	415	688	494	457	426	655	585	549	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		12.6%	12.8%	13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.8%	8.4%
UEC 4-hour target (RAG against local trajectory to national target)	78%		67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	72.6%
% patient discharges pre-noon	33%		22.3%	20.4%	19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		9.5%	6.6%	8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	5%

4-hour and 12-Hour Performance

4. The Trust did not achieve the revised monthly trajectory of 72.6% or national target of 78.0% for 4-hour performance in November 2025. 4-hour performance for November 2025 was 68.3%, which is 0.3% improvement from October, and 4.3% below trajectory. In the 25/26 performance and finance response submitted to the ICB in November, the Trust identified that it did not believe it would meet the 78% standard by the end of the financial year.

5. The current December forecast shows that the Trust will not return to the revised trajectory of 73.6%. The current December performance has returned to being more than 70%, however this has been aided by the performance improvements experienced during industrial action and the seasonal end of December challenge of demand and acuity is still forecast to impact performance. 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 Quarter 3.



6. In November 2025, the ICO managed 10,142 all type UEC attendances. The Emergency Department recorded 7,075 type 1 attendances which was the 7th consecutive month of more than 7000 attendances. The current all type UEC demand growth in FY25/26 is 4.36% against a planned increase of 2%, with the majority of growth being experienced in type 1 (5.48% growth).

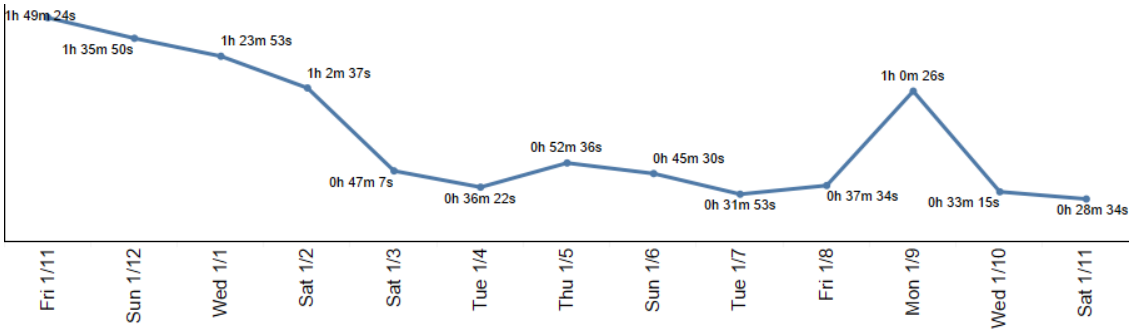
7. The number of patients waiting longer than 12 hours for admission or discharge in the emergency department reduced from 585 in October to 549 in November 2025. 297 of these were >75 yrs of age which will be a key performance and quality indicator for the delivery of the new frailty programme.

8. 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 10th consecutive month. The December forecast for this performance measure is

to improve further and to continue to meet the RSP exit criteria and the national standard.

Ambulance Handover Delays

9. The total number of ambulance conveyances to the Trust in November 2025 was 2604 which is the highest number of conveyances the Trust has managed. When compared to the numbers conveyed in November 2024, this is a 26% increase. The November handover average was the best performance in this reporting year and the second-best performance since April 2023 at 28 mins 34 secs. Ambulance handover dashboard: average handover time:



10. 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 of around 20-25% to same month last year. November 2025 conveyances were a 26% increase on November 2025 and were the highest on record. Despite the increases in demand, the additional focus on ambulance handovers has seen a significant improvement with the average ambulance handover time in November being below 30 minutes (28 mins 55 seconds).

11. It is important to note that while improvements in ambulance handover performance have been clear, there has been a associated impact in the requirement to open additional escalation spaces and the costs associated with these. Work is ongoing to quantify the numbers of patients that have been accommodated in the ED corridor, the cohort area and other escalation areas across the Trust. This detail will be shared in next months report, alongside an understanding of the financial implications.

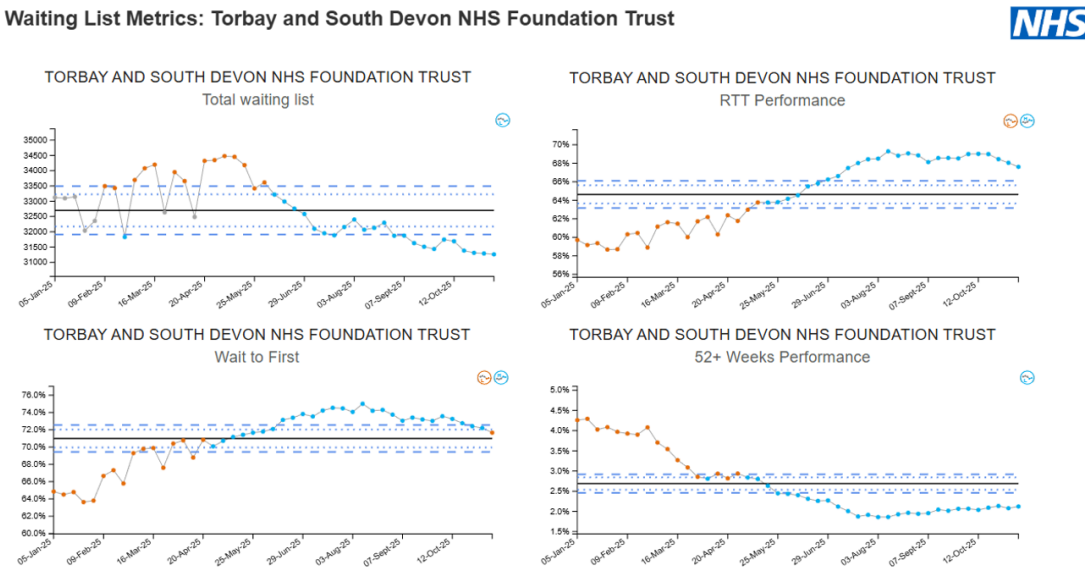
12. A national request has been received to reduce bed occupancy to 80% by Christmas Eve to support the expected surge in urgent demand after Christmas. The actual position for bed occupancy on Christmas Eve was 86.2%, primarily driven by post-industrial impacts and acuity.

13. 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.

5. Elective Care – RTT

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Operational Plan trajectory Nov 2025
Oversight Framework																
Elective recovery																
RTT 78 week wait incomplete pathway	0		6	0	12	14	7	4	8	8	9	16	13	16	9	0
RTT 65 week wait incomplete pathway	0		239	229	204	215	141	145	126	95	97	105	110	109	84	3
RTT 52 week wait incomplete pathway	268		1276	1265	1238	1209	931	914	805	740	615	618	615	647	607	505
RTT % Incomplete pathways <18 wks	66.8%		61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	65.1%
RTT Wait for first appointment <18 weeks	70.3%		65.3%	64.6%	63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	68.8%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		71.5%	82.1%	75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	75.0%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	76.7%
Cancer: No of patients waiting >62 days to start treatment	138		77	110	95	94	111	133	225	223	220	257	176	132	91	138
Cancer: % of patients > 62 days to start treatment	tbc		5.0%	7.0%	6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	tbc

14. The table above represents the most recent month's Trust level data and is not the final nationally reported position. November shows an improving position against the RSP exit criteria for 78ww, 65ww, 52ww, and wait for first outpatient appointment.



15. The charts detail the finalised October position and also the forecasted November 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.

16. Activity to the end of November and variance to plan and previous year is shown in the table below. The headlines are:
    - Non-elective and A&E attendances - seeing more patients than last year being 5% for ED and 4% for non-elective admissions;
    - Elective outpatient 1st activity, we are 1% behind last year and 5% below plan although we have reported more outpatient attendances with procedure recorded;

- Elective inpatients are showing a greater variance to plan representing 495 cases below planned levels of activity. For day cases, activity is above both plan and last year.

Activity to the end of November and variance to plan and previous year

Attendance Type	Setting	24/25	25/26 Plan	25/26	Variance against Plan	variance against last year
Spell	Day Case	27,104	27,113	27,947	3%	3%
	Elective	2,358	2,721	2,226	-18.2%	-6%
	Non-Elective	26,514	27,083	27,925	3.1%	5%
		55,976	56,917	58,098	2.1%	4%
Attendance	First	61,592	63,871	60,494	-5.3%	-2%
	Follow-up	163,631	172,733	161,153	-6.7%	-2%
Procedure	First	17,721	17,946	18,628	3.8%	5%
	Follow-up	58,233	49,551	58,301	17.7%	0%
		301,177	304,101	298,576	-1.8%	-1%
Attendance	A&E Dept Type 1	54,139	58,229	57,571	-1.1%	6%
	A&E Dept Type 3	28,937	29,899	29,890	0.0%	3%
		83,076	88,128	87,461	-0.8%	5%

17. The significant variance to plan, particularly in elective ordinary is due to the levels of backlog clearance for orthopaedics being detailed with the operational plan that has not been delivered. When activity is compared to variance to 2024/2025 the under delivery in elective ordinary has been offset by an increase in delivery of non-elective activity which is mainly due to a significant increase in orthopaedic trauma during 2025/2026.

18. It should be noted that while having not delivered the activity plan currently for 2025/2026, the Trust is on target to meet the ERF activity target of 114% actvity v levels undertaken in 2019/2020 with a current delivery of 116.1%. This has been supported through improvements in counting and coding, particularly in day case activity and outpatients activity with a procedure.

19. A national mandate of clearance of 65 week waits by 21st December 2025 is in place. The Trust had originally forecast to reduce 65 week waits to ~40 patients when original projections were made in September, however, several key issues have arisen through November and December 2025 which has impacted the ability to meet this, which includes industrial action, a malfunction in theatre C, which caused a total of 52 operating sessions for orthopaedics to be cancelled and a further period of industrial action, high demand for trauma and consultant sickness.

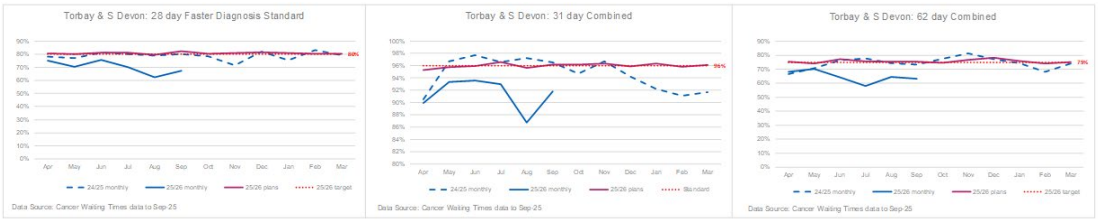
20. The current forecast for 21st December following all of the issues outlined above is ~76 patients, which has been achieved through mitigation of the impact of these issues, re-providing as much capacity as is possible and through robust oversight of the PTL. The team has shadow booked activity through to the end of January and based on this the Trust are forecasting 48 65-week waiters at the end of January. There is further opportunity to reduce this number with the additional scrutiny and actions being targeted at orthopaedic long waiters. Based on the oversight provided of these actions and the clearance run rate between November and end of January, it is recommended that the Board can take assurance that the 65 weeks wait position will be cleared at the end of March 26 and the trajectory will be met.

21. The committee is asked to note that assurance is **limited** against delivery of the 78,65, and 52 weeks wait elimination standard. **Satisfactory** assurance can be provided on all other RTT metrics within the exit criteria, noting the risks articulated.

6. Cancer and Diagnostics

22. The core 28-day faster diagnostic cancer standard was met in October at 75.7% and is forecast to reach the 75% target in November 2025. The Trusts 62-day cancer position will return to national expectations in October and is also forecast to achieve in November.

23. At the time of reporting, the early indications for December performance identify that both of the key cancer standards will continue to meet the required trajectories for the third consecutive month, therefore enabling the Trust to exit Tier 2 oversight for cancer within three months of entry into this process.



24. Diagnostic performance (DM01) has remained a challenge throughout FY25/26 with a performance in October of 29.4% and a November forecast of 28% of patients waiting over 6 weeks for their diagnostic test. Improvements have been made in several modalities however these have been offset by continued challenges in both non obstetric ultrasound and flexi cystoscopy.

25. 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.

26. The Board is asked to take **satisfactory** assurance against delivery of the 62-day and 28-day cancer performance targets. **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.

7. Assurance recommendations and summary

It is recommended that, noting the above, the Committee AGREE the overarching assurance ratings to those matters reviewed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
UEC 4 Hour Performance	Limited	No Change

UEC Ambulance Handover	Satisfactory	Improved
UEC 12 Hour Performance	Satisfactory	No Change
RTT 65 week waiters	Limited	No Change
RTT 18 week, RTT 52 week total waiting list size, % first appointment within 18 weeks	Satisfactory	No Change
Cancer Performance	Satisfactory	Improved
Diagnostic Performance	Limited	No Change

Torbay and South Devon NHS Foundation Trust

Board of Directors

Month 8 Finance Report

Date of meeting	Date report produced
8th January 2026	15th December 2025

Author(s)		Report approved by	
Name and title:	Nichola Rees Finance Partner	**Name and title:**	James Corrigan Interim CFO
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

The Trust finance report seeks to provide assurance to the Board of Directors on the financial position year to date (YTD) as at November 2025 and forecast out turn (FOT) for the year ending 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 6).

As at month 8 the Trust is reporting a net YTD deficit of **£16.2m** against a planned deficit of **£11.1m.** The **£5.1m** variance relates to phasing of the month 7 & 8 deficit report funding which is now expected to be earnt back in month 12. The net forecast deficit for the year end (based on a forecast by care group – slide 9) is as planned at **£8.0m.**

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 £18.9 at month 6 to £13.9m in month 8 due to recovery actions. The main risks relate to cost pressures and slippage in recurrent CIP schemes.

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 £11m of the further savings required of which £2.8m are high-risk actions (M7 £3.6m), leaving a gap of £1.9m. The current net risk to delivering the forecast outturn is therefore £5.6m (M7 £7.4m).

The Trust is reporting £21.7m YTD CIP achievement, £0.1m behind plan (slide 6) although recurrent delivery is lower than plan (£16.0m v £12.2m). The annual forecast is to achieve the £41.5m plan, albeit split recurring £24.4m (vs £32.8m plan) and non-recurring £17.1m (vs £8.7m plan).

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 increased from £81.8m to £99.5m in most part due to the under delivery of recurrent CIP.

Cash forecast shows risk around short-term performance due to the delayed deficit support funding (DSF). £4.5m additional Revenue PDC Cash Support has been applied for to mitigate the delay/withdrawal of DSF to Q4 (slide 15).

As at month 7, Devon ICS is reporting a year to date £32.3m deficit, £24.8m higher than plan. The forecast for the year end is to breakeven at system level. (slide 17).

The Board 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.

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

Appendix 1 – Finance Report

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

Executive Committee - Review

Key recommendations and actions requested
The Board is requested to AGREE the overall assurance level relating to the financial position of TSDFT as SATISFACTORY assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce. The Board is also asked to NOTE the following: • The Trust financial performance is off plan by £5.1m YTD due to deficit support funding (DSF). • FOT to 30th November 2025 is on plan as the Trust has been advised by the ICB to assume 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.

NHS
Torbay and South Devon
NHS Foundation Trust

Monthly Financial Performance Report

Month 8

Executive Summary

Torbay and South Devon NHS Foundation Trust

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the financial position year to date (YTD) as at November 2025 and forecast out turn (FOT) for the year ending 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 6). As at month 8 the Trust is reporting a net YTD deficit of **£16.2m** against a planned deficit of **£11.1m.** The **£5.1m** variance relates to phasing of the month 7 & 8 deficit report funding which is now expected to be earnt back in month 12. The net forecast deficit for the year end (based on a forecast by care group – slide 9) is as planned at **£8.0m.**

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 £18.9 at month 6 to £13.9m in month 8 due to recovery actions. The main risks relate to cost pressures and slippage in recurrent CIP schemes. 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 £11m of the further savings required of which £2.8m are high-risk actions (M7 £3.6m), leaving a gap of £1.9m. The current net risk to delivering the forecast outturn is therefore £5.6m (M7 £7.4m).

The Trust is reporting £21.7m YTD CIP achievement, £0.1m behind plan (slide 6) although recurrent delivery is lower than plan (£16.0m v £12.2m). The annual forecast is to achieve the £41.5m plan, albeit split recurring £24.4m (vs £32.8m plan) and non-recurring £17.1m (vs £8.7m plan).

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 increased from £81.8m to £99.5m mainly due to the under delivery of recurrent CIP.

Cash forecast shows risk around short-term performance due to the delayed deficit support funding (DSF). £4.5m additional Revenue PDC Cash Support has been applied for to mitigate the delay/withdrawal of DSF to Q4 (slide 15).

As at month 7, Devon ICS is reporting a year to date £32.3m deficit, £24.8m higher than plan. The forecast for the year end is to breakeven at system level. (slide 17).

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 8

Torbay and South Devon NHS Foundation Trust

	M8				YTD M8				Financial Year			
	PY 24/25	CY 25/26			PY 24/25	CY 25/26			PY 24/25	CY 25/26		
	Actual £m	Plan £m	Actual £m	Var +/(-) £m	Actual £m	Plan £m	Actual £m	Var +/(-) £m	Actual £m	Plan £m	Forecast Outturn £m	Var +/(-) £m
Operating Income	58.8	62.4	61.4	(1.0)	472.9	499.4	500.4	1.0	729.3	749.5	759.6	10.2
Operating Expenditure - Pay	(30.6)	(30.7)	(32.4)	(1.6)	(243.7)	(253.3)	(256.4)	(3.1)	(389.0)	(375.6)	(381.3)	(5.6)
Operating Expenditure Non-Pay and Financing Cost	(32.7)	(31.6)	(31.5)	0.1	(244.4)	(257.2)	(260.2)	(3.0)	(373.5)	(381.8)	(386.3)	(4.5)
Surplus / (Deficit) Sub Total	**(4.5)**	**0.2**	**(2.4)**	**(2.6)**	**(15.2)**	**(11.1)**	**(16.2)**	**(5.1)**	**(33.2)**	**(8.0)**	**(8.0)**	**0.0**
Excluding Non Recurrent Deficit Funding	*0.0*	*0.0*	*0.0*	0.0	*0.0*	*(20.6)*	*(15.4)*	5.1	*0.0*	*(30.8)*	*(30.8)*	0.0
Surplus / (Deficit) Total	**(4.5)**	**0.2**	**(2.4)**	**(2.6)**	**(15.2)**	**(31.7)**	**(31.6)**	**0.0**	**(33.2)**	**(38.8)**	**(38.8)**	**0.0**

The Trust's financial position at the end of November shows a year-to-date deficit of **£16.2m**, against a planned deficit of **£11.1m.** The **£5.1m** variances relates to a delay in phasing of the month 8 deficit support funding. This position excluding the deficit support funding of **£15.4m** would be a year-to-date deficit of **£31.6m**

Year to date - Income **£1m** better than plan (Pass Through Drugs & Devices £1.7m, offset lower than plan CIP delivery £0.7m). Pay costs are higher than plan **£3.1m**, Non pay costs **£3.0m** higher than plan (slide 12).

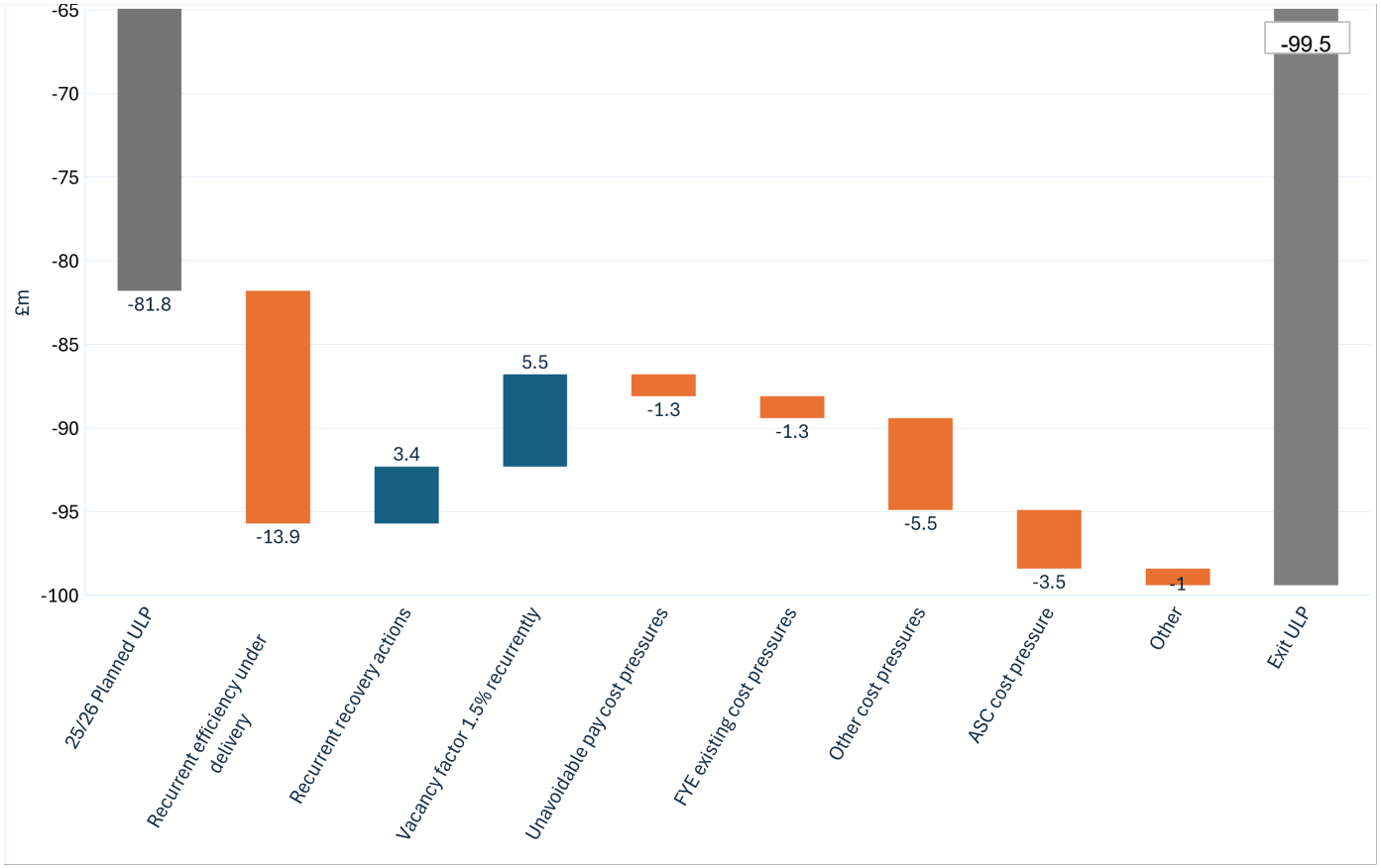
The Trust is reporting a year end forecast of an **£8.0m** deficit including support funding of **£30.8m.** Work has now been concluded on revising the forecast outturn including risks and mitigations and is set out on slide 5. The position excluding support funding is **£38.8m deficit**.

Forecast - Income **£10.2m** higher than plan - Pass Through Drugs & Devices £3.5m, Council grant £0.7m, R&D & Education £1.7m, EPR £1.9m (offset with costs), other income £4.5m, offset by lower than plan CIP delivery £2m. Pay costs higher than plan **£5.6m** mainly temporary staffing costs and industrial action, Non pay costs **£4.5m** 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
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

Torbay and South Devon NHS Foundation Trust

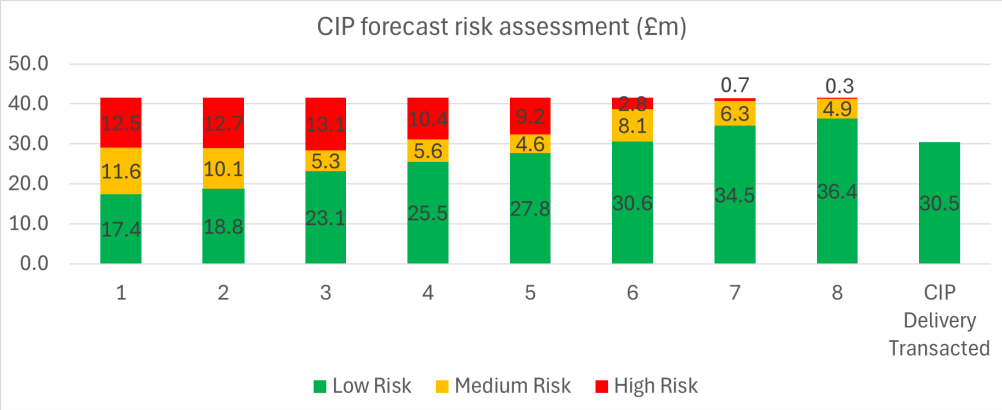
- Following a review of the month 6 forecast, the gross risk was assessed as £18.9m to delivering the £8m planned deficit. The gross risk has reduced from £18.9m at month 6 to £13.9m in month 8 due to recovery actions.
- Actions are in place to reduce run rates further and in total these actions give 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 £21.9m (M7 £25.8m), against the planned deficit of £8m; presenting a £13.9m (M7 £17.8m) deficit to plan.
- There are robust plans to deliver £11m of the further savings (of which £2.8m are high-risk actions), leaving a gap of £1.9m.

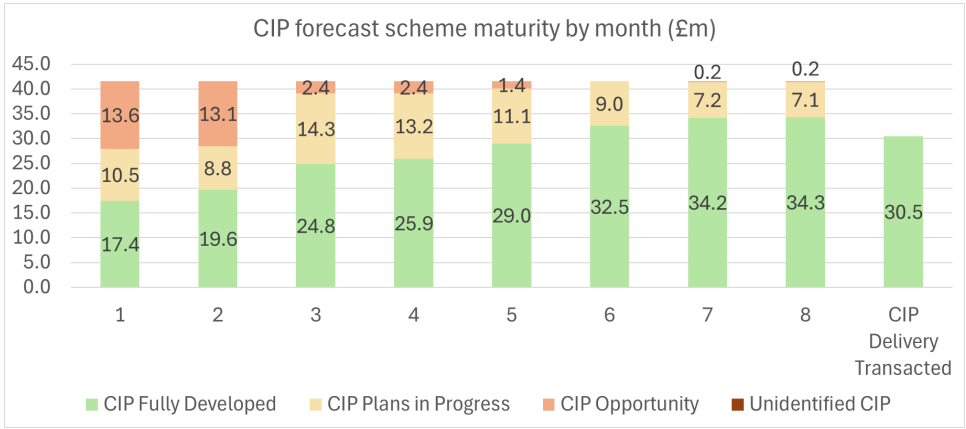
Efficiencies/CIP – maturity & risk

Torbay and South Devon NHS Foundation Trust

	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	16.0	12.2	(3.8)	32.8	24.4	(8.3)
Non-recurrent efficiencies	5.9	9.6	3.7	8.7	17.1	8.3
Total	**21.9**	**21.7**	**(0.1)**	**41.5**	**41.5**	**0.0**
Recurrent %	73%	56%		79%	59%	
Non-recurrent %	27%	44%		21%	41%	

Care Group	High Risk Forecast CIP Delivery £m
Medicine and Urgent Care	0.1
Planned Care and Surgery	0.1
Shared Corporate Services	0.1
Grand Total	**0.3**





The Trust is reporting £21.7m YTD CIP achievement, £0.1m plan. The annual forecast is to still achieve the £41.5m plan although at M8 forecast the recurring figure is £24.4m (£8.3m less than plan) and non-recurring £17.1m (£8.3m 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

Torbay and South Devon NHS Foundation Trust

Total CIP Delivery	Delivered YTD			Forecast Outturn		
Care Group	Plan £m	Delivery £m	Var +/(-)	Plan £m	Delivery £m	Var +/(-)
Families & Communities	3.7	4.4	0.7	6.4	6.9	0.5
Medicine and Urgent Care	2.7	2.8	0.1	4.6	4.6	(0.0)
Planned Care and Surgery	4.9	5.0	0.2	8.4	8.6	0.2
Shared Corporate Services	5.0	3.8	(1.2)	13.0	12.1	(0.8)
Children and Family Health Devon	0.6	0.7	0.1	0.7	1.0	0.3
Adult Social Care – Torbay	5.0	5.0	0.0	8.4	8.4	(0.1)
Total	**21.9**	**21.7**	**(0.1)**	**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	1.8	2.9	1.1	3.8	4.9	1.1
Medicine and Urgent Care	2.4	1.3	(1.0)	4.0	2.5	(1.5)
Planned Care and Surgery	3.2	2.1	(1.1)	5.6	3.9	(1.7)
Shared Corporate Services	3.8	1.2	(2.6)	11.3	5.3	(6.0)
Children and Family Health Devon	0.0	0.0	(0.0)	0.1	0.0	(0.1)
Adult Social Care – Torbay	4.8	4.7	(0.1)	8.1	7.9	(0.1)
Total	**16.0**	**12.2**	**(3.8)**	**32.8**	**24.4**	**(8.3)**
Recurrent as a % of Total	**73%**	**56%**		**79%**	**59%**	

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 £0.3m of high risk rated schemes within this as noted on slide 6.

Care Group Summary

NHS Torbay and South Devon NHS Foundation Trust

Care Groups	M8				YTD M8 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)	0.2	(0.0)	0.2	0.2	1.3	0.2	1.2	1.0	1.9	0.0	1.3	1.3
Families & Communities	(10.0)	(11.4)	(11.2)	0.2	(85.0)	(93.1)	(92.4)	0.7	(127.2)	(138.6)	(138.7)	(0.2)
Medicine and Urgent Care	(7.2)	(7.9)	(8.3)	(0.4)	(62.5)	(63.9)	(64.5)	(0.6)	(93.2)	(95.3)	(97.0)	(1.6)
Planned Care and Surgery	(13.0)	(13.2)	(13.1)	0.1	(102.3)	(106.4)	(107.8)	(1.4)	(153.0)	(158.7)	(160.3)	(1.6)
Corporate	(4.1)	(4.4)	(4.3)	0.1	(33.3)	(35.7)	(34.8)	0.9	(50.1)	(51.8)	(52.5)	(0.7)
Workplace (Estates)	(2.5)	(2.5)	(2.5)	0.0	(20.8)	(20.9)	(20.3)	0.6	(30.8)	(31.0)	(30.7)	0.2
Reserves & Other Income (Inc Fin Costs)	40.2	47.6	45.1	(2.5)	350.0	374.7	369.6	(5.1)	513.5	565.2	571.1	5.9
Adult Social Care – Torbay	(8.0)	(8.0)	(8.3)	(0.3)	(62.6)	(66.1)	(67.3)	(1.2)	(94.3)	(97.9)	(101.2)	(3.3)
Surplus / (Deficit) Total	**(4.5)**	**0.2**	**(2.4)**	**(2.6)**	**(15.3)**	**(11.1)**	**(16.2)**	**(5.1)**	**(33.2)**	**(8.0)**	**(8.0)**	**0.0**

CFHD: YTD £1.0m 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 £1.3m.

Families and Communities: YTD £0.7m lower than plan due to over delivery of CIP (non-recurrent). Forecast £0.2m higher than plan due to CHC growth pressures, partially offset by forecast over delivery of CIP.

Adult Social Care (Torbay): YTD £1.2m higher than plan due to growth in client numbers in Residential & Nursing based settings and increases in Dom care 'client complexity', partially offset by an accrual benefit (£0.8m). Full year effect of cost pressures above is forecast to be £3.3m higher than plan.

Medicine & Urgent Care: YTD £0.6m higher than plan due to ED Medical staffing £0.3m, Cardiology consumables £0.3m, Industrial action £0.4m partially offset with Medicine wards. Forecast higher than plan £1.6m due to Escalation costs £0.7m, ED Medical staffing costs £0.5m,Cardiology consumables £0.5m and Industrial action £0.4m partially offset by underspend in Medicine wards.

Planned Care: YTD £1.4m higher than plan due to medical pay £0.9m, theatre and lab consumables £0.5m, industrial action £0.4m and drugs £0.4m, offset by releasing deferred income £0.6m and pay savings to over deliver CIP £0.2m. Forecast £1.6m higher than plan due to consumables £0.9m, medical pay £0.6m, industrial action £0.4m and additional ERF spend £0.2m, offset by income release £0.6m.

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 £0.2m lower than plan, due to a £0.5m under-delivery of CIP offset with estates vacancies and utilities costs.

Corporate: YTD £0.9m lower than plan due to £0.4m R&D surplus income offset in reserves and £0.9m over delivery of CIP largely attributable to vacancies and overachieved income. £0.4m offset by cost pressures relating to insurance, procurement transformation, people digital and NHP. Forecast £0.7m higher than plan, due to £0.4m under-delivery of CIP and £0.9m cost pressures described YTD. Pressures partially mitigated by £0.5m R&D surplus offset in reserves, £0.4m vacancy slippage and £0.4m underspend across medical records and international recruitment.

Reserves & Other Income (inc Finance costs) : YTD is £5.1m higher than plan due to the trust having not received the deficit support funding in October or November. Forecast £5.9m lower than plan being reserves £6.4m (including delivery of further mitigating run rate improvements from recovery plan), finance costs £1.1m, offset with lower than plan income £1.6m

Workforce

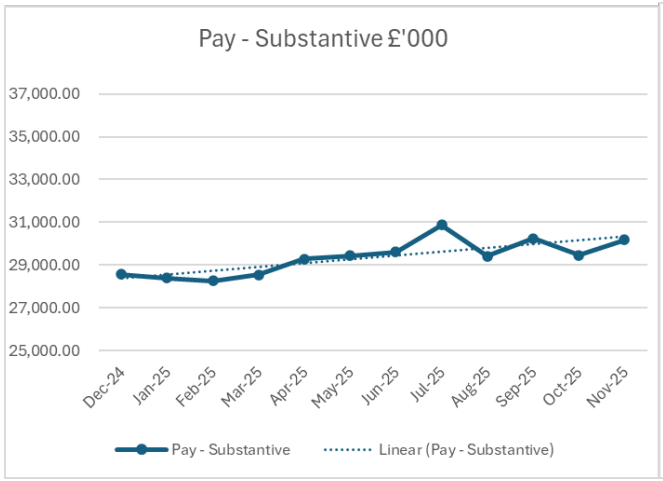
Torbay and South Devon NHS Foundation Trust

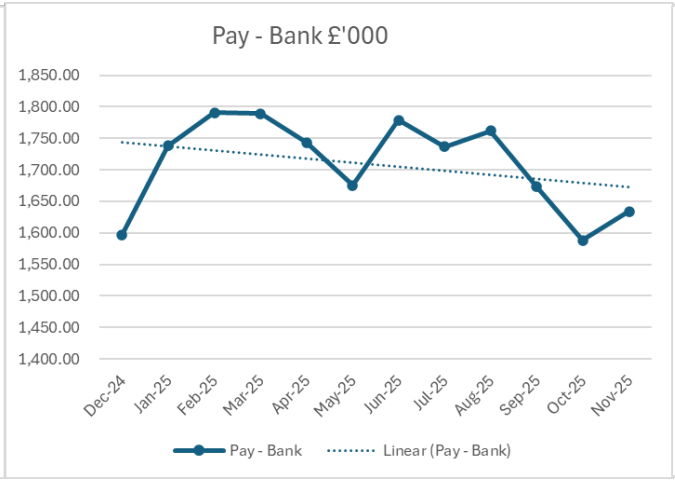
	Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Class	Plan £m	Actual £m	Var +/(-) £m	Full Year Plan £m	Forecast £m	Var +/(-) £m	WTE Plan	WTE Worked	Var +/(-)
Pay - substantive	(235.6)	(238.5)	(2.9)	(349.3)	(355.9)	(6.6)	6,068	6,263	(195)
Pay - bank	(12.9)	(13.6)	(0.7)	(19.3)	(19.1)	0.1	301	302	(1)
Pay - agency	(4.8)	(4.4)	0.4	(7.1)	(6.2)	0.9	63	86	(23)
Grand Total	**(253.3)**	**(256.4)**	**(3.1)**	**(375.6)**	**(381.3)**	**(5.6)**	**6,432**	**6,651**	**(219)**

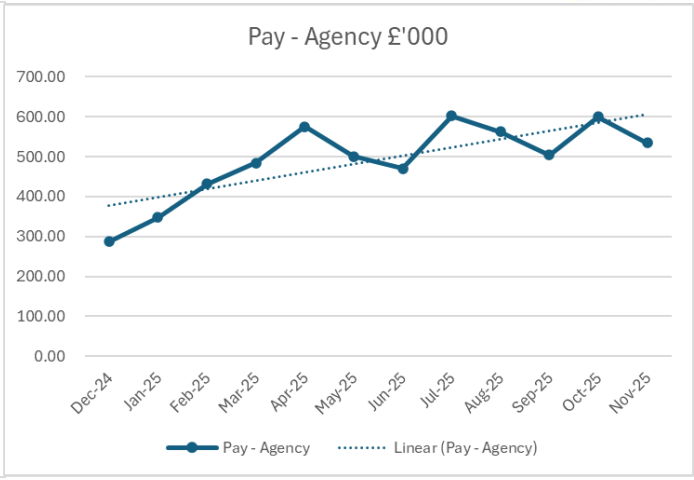
- As at end of November there are 219WTE higher than plan. This is due to the phasing of an additional 230 WTE reduction in the CIP plan from M7. The CIP delivery expectation has however been revised with an estimated reduction of c107WTE estimated via workforce controls. There are however additional efficiencies expected above plan in other areas of non pay and income, also as part of the revised recovery actions, to ensure the overall delivery CIP plan,
- The YTD financial position £3.1m higher than plan for overall pay costs, mainly with substantive posts higher than plan, £2.9m due to efficiency programme phasing, industrial action and medical staffing pressures.
- Forecasted year end over expenditure of £5.6m is due mainly to efficiency programme phasing and continuing medical staffing pressures and industrial action.
- There is a WTE review in month 9 being carried out to reconcile WTE figures to costs and ensure consistency.

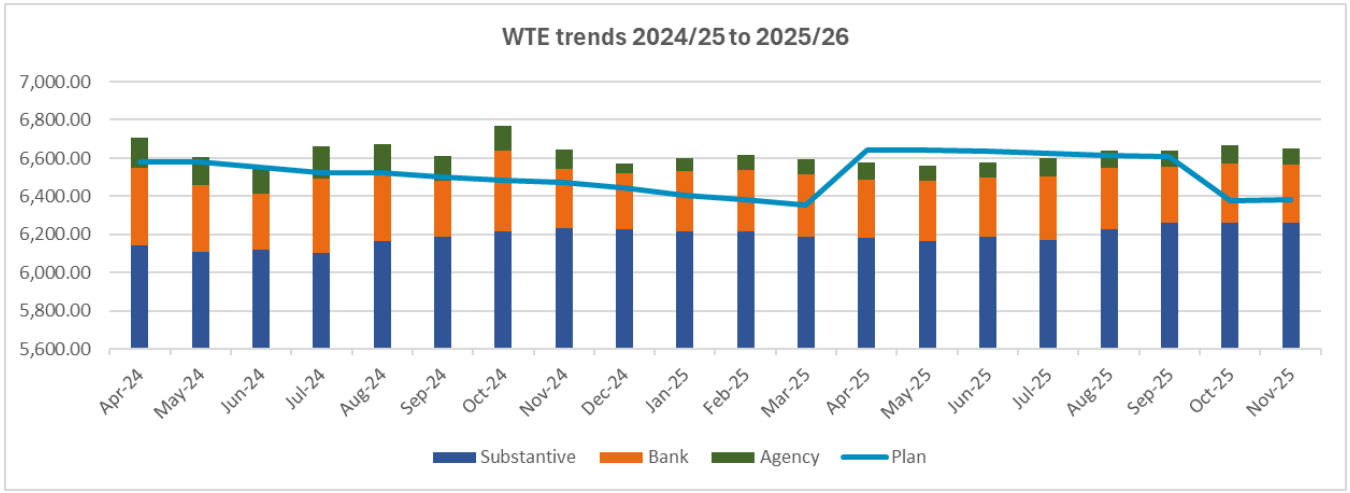
Month 8 – Rolling Worked WTE and Pay Run Rate Trends

Torbay and South Devon NHS Foundation Trust









Non-Pay Summary

Torbay and South Devon NHS Foundation Trust

Description	M8				YTD M8 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	(0.7)	(0.8)	(0.8)	0.0	(6.2)	(6.6)	(6.5)	0.1	(9.1)	(9.9)	(9.8)	0.2
Drugs costs	(4.3)	(4.0)	(4.2)	(0.3)	(32.7)	(32.4)	(35.4)	(3.1)	(50.0)	(48.0)	(52.6)	(4.6)
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	(6.2)	(6.2)	(5.3)	0.9	(44.4)	(49.8)	(47.5)	2.4	(70.6)	(73.4)	(69.7)	3.7
Procurement	(11.9)	(11.1)	(11.2)	(0.1)	(87.3)	(90.4)	(92.1)	(1.7)	(132.8)	(134.7)	(136.1)	(1.4)
Purchase of social care	(9.6)	(9.2)	(9.9)	(0.6)	(73.6)	(76.5)	(77.9)	(1.4)	(110.6)	(113.4)	(116.8)	(3.3)
Financing Costs	0.0	(0.2)	(0.1)	0.1	(0.2)	(1.3)	(0.8)	0.6	(0.1)	(2.1)	(1.2)	0.9
Operating Expenditure Non-Pay and Financing Costs	**(32.7)**	**(31.6)**	**(31.5)**	**0.1**	**(244.4)**	**(257.2)**	**(260.2)**	**(3.0)**	**(373.5)**	**(381.8)**	**(386.3)**	**(4.5)**

Non-pay YTD **£3.0m** higher than plan:

- Pass through drug costs **£2.1m** offset with income, other drugs **£1.0m** (rheumatology, general surgery, outpatients, labs)
- Procurement and Other Non-Pay Operating costs **£0.7m net** lower than plan comprising of:-
  - Recovery plan actions **£1.4m,** planned care over delivery of CIP **£0.9m** (offset under delivery income), ERF **£0.5m** (costs are in pay), CFHD **£0.5m**, workplace utilities **£0.2m,** offset with higher than plan EPR costs **£1.3m** and pass through devices **£0.5m** (both offset with income), Corporate costs **£0.8m** (insurance, procurement transformation, people digital and NHP)
- Purchase of social care **£1.4m** higher than plan due to an accrual benefit **£0.9m,** offset by growth in client numbers and complexity **£2.3m**
- Finance costs lower than plan **£0.6m,** CNST **£0.1m**

Non pay forecast is **£4.5m** higher than plan after expected run rate improvements from the recovery plan **£4.8m.** The underlying position of **£9.3m** higher than plan relates to:-

- Pass through drug costs **£2.7m** (offset with income), other drugs **£1.8m** (rheumatology, general surgery, outpatients, labs)
- Procurement and Other Non-Pay Operating costs **£2.5m net** higher than plan excluding **£4.8m** recovery plan run rate improvements:-
  - EPR costs **£1.9m** and pass through devices **£0.8m** higher than plan (both offset with income)
  - Corporate - under delivery CIP **£1.8m,** non pay costs **£1.5m** higher than plan (insurance, procurement transformation, people digital and NHP). Care Group other non pay costs higher than plan **£0.4m** (supplies, services, consumables)
  - Planned Care lower than plan **£2.9m** being over delivery non pay CIP **£1.4m** (offset with under delivery CIP income), ERF **£1.5m** (offset with ERF pay costs)
  - CFHD & risk share **£1.1m** lower than plan
- Purchase of Social Care **£3.3m** higher than plan due to growth in client numbers and complexity.
- Finance costs lower than plan **£0.9m,** CNST **£0.2m**

Torbay and South Devon NHS Foundation Trust

ERF Income Position against 19/20 Baseline

Care Group	M8 Income 19/20 £m	M8 Income 25/26 £m	M8 Income Variance £m	M8 Income Variance %
Planned Care and Surgery	37.3	40.6	3.4	109%
Medicine and Urgent Care	7.3	10.7	3.4	147%
Families and Communities	4.5	5.7	1.1	125%
Grand Total	**49.1**	**57.0**	**7.9**	**116%**

- The table shows the M8 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

M5	M5 2526	Movement vs M5 2425
Inflation adj. expenditure growth	2.3%	0.0%
Cost weighted activity growth	1.9%	-0.1%
Implied productivity growth	-0.4%	-0.2%

- 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 5, implied productivity is worse than 24/25 by 0.2% (M4 0.4% worse).

Implied productivity metric indicates significant opportunity and a challenge to return to pre-covid levels of productivity. Reasonableness of the challenge to be tested. 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. It will be necessary to consider the impact of the new EPR on counting and coding of activity as the productivity work progresses.

A productivity workstream is proposed as part of the refresh of the Trusts Improvement plan (Our Plan for Better Care). This will increase focus on productivity and improve governance arrangements.

Cash Position – Month 8

	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	(6.5)	(12.0)	(5.5)	(1.7)
Capital Non-Cash movements (depr&amort)	15.2	15.2	(0.0)	23.6
Working Capital Movement	14.9	(12.5)	(27.3)	(21.1)
Net cash generated from / (used in) operations	**26.9**	**17.4**	**(9.5)**	**27.5**
Net Capital Expenditure (Purchase/Disposals)	(39.8)	(13.4)	26.4	(59.4)
Interest Received	0.7	1.1	0.4	1.6
Net cash generated from/(used in) investing activities	**(39.0)**	**(12.3)**	**26.8**	**(57.8)**
PDC paid/received	21.6	12.5	(9.1)	42.1
Loans paid/received	(1.4)	(1.4)	0.0	(2.0)
Capital on finance leases and PFI	(3.4)	(2.9)	0.5	(5.1)
Interest element on loans, finance lease and PFI	(1.6)	(1.5)	0.1	(2.1)
Net cash generated from/(used in) financing activities	**15.2**	**6.7**	**(8.5)**	**32.9**
Closing cash balance	**3.1**	**11.9**	**8.8**	**2.6**

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	**(12.0)**
Finance income	1.1
Finance expense	(2.3)
PDC dividend expense	(3.8)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	**(17.0)**
Capital donations/grants/peppercorn lease I&E impact	0.5
PFI revenue costs on an IFRS 16 basis	2.5
PFI revenue costs on a UK GAAP basis	(2.2)
TOTAL Provider Surplus/(Deficit) - System performance	**(16.2)**

Torbay and South Devon NHS Foundation Trust

The closing cash balance for M8 is £8.8m higher than plan, explained by;

- Opening cash balance at the start of the year was £23.4m was been utilised to make supplier payments in M1-2.
- Net cash generated from operations is £9.5m below plan, mainly due to the withholding Q2/Q3 DSF.
- Investing activities show a £26.8m variance, reflecting re-phasing of the capital plan and some delay in National Schemes programmes.
- Financing activities show £8.5m variance primarily due to lower than planned capital 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/Q4 has been withdrawn (£15.4m). It is now anticipated that this will be received in M12, however this is still to be confirmed.
- There is also a risk of non-delivery of CIP impacting on cash.
- Potential industrial action may also impact on a cash balance later on in the year.

Torbay and South Devon NHS Foundation Trust

Cashflow Forecast – Month 8

	Dec-25	Jan-26	Feb-26	Mar-26
Start Date 01.12.2025	**£m**	**£m**	**£m**	**£m**
Cash Balance B/F	12.8	1.2	2.2	2.2
Total Receipts	61.6	74.0	68.7	80.6
Total Payments	(73.2)	(73.1)	(68.7)	(80.2)
Net Movement	(11.6)	1.0	0.0	0.4
Cash Balance C/F	**1.2**	**2.2**	**2.2**	**2.6**

The Month 8 cashflow forecast has been prepared based on the following basis:

- £4.5m additional Revenue PDC Cash Support has been requested to mitigate the withdrawal of Q3/Q4 DSF (Non-recurrent Deficit Support Funding), and this will be drawn down in M10 & M11.
- Withheld Q3/Q4 DSF of £15.5m is presumed to be received in M12, net of the £4.5m additional Revenue PDC Cash Support.
- The capital plan and associated funding sources remain as per the M8 capital plan including £3.4m of system capital PDC.
- There may be a requirement for non-cash balance sheet adjustments to support the position in M09-M12, which would impact cash.
- If the Q3/Q4 DSF is permanently withheld, there will be a requirement to apply for further Revenue PDC Cash Support in M12.

Balance Sheet – Month 8

Torbay and South Devon NHS Foundation Trust

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	294.0	266.4	(27.6)
Other Non-Current Assets (Receivables)	4.0	4.1	0.0
Cash & Cash Equivalents	3.1	11.9	8.8
Working Capital (excl cash)	(24.2)	(45.0)	(20.8)
Non-Current Liabilities (Loans/Leases/Other)	(53.8)	(51.0)	2.8
Total Assets Employed (Assets + Liabilities)	**223.2**	**186.4**	**(36.7)**
Public Dividend Capital	303.7	292.8	(10.9)
Revaluation	61.0	60.7	(0.3)
Surplus / (Deficit) Sub Total	(11.9)	(17.0)	(5.1)
I&E reserves	(129.6)	(150.0)	(20.4)
Reserves Total	**223.2**	**186.4**	**(36.7)**

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	**(12.0)**
Finance income	1.1
Finance expense	(2.3)
PDC dividend expense	(3.8)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	**(17.0)**
Capital donations/grants/peppercorn lease I&E impact	0.5
PFI revenue costs on an IFRS 16 basis	2.5
PFI revenue costs on a UK GAAP basis	(2.2)
TOTAL Provider Surplus/(Deficit) - System performance	**(16.2)**

- Fixed Assets are lower than plan **£27.6m** due to re-phasing of the Capital Plan. However, it is expected that the year-end position will still align closely with the agreed full-year plan and be slightly above due to additional funding received. There were also some movements in the opening balances in relation to impairments and revaluations at the time of the planning process.
- Cash is **£8.8m** higher than plan, explained in detail in cashflow report.
- Working Capital (excl cash) variance of **£20.8m** is mainly explained by a £6.3m variance in deferred income, related to timing differences, and £9m reduction in receivables, and an increase of £5.6m in trade and other payables.
- Loans and Leases liabilities are **£2.8m** lower than plan, due to a reduction of leasing in favour of outright purchase.
- PDC capital drawdown to the end of M8 is **£6.4m**, £12.8m behind the plan due to schemes' dependencies on other Trusts and re-profiling between organisations and delayed approvals. PDC revenue drawdown is £8m, £2.9m ahead of plan.
- Year-to-date capital expenditure stands at **£15.3m**, (plan £24.9m, delay due to National Schemes spend).

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

Torbay and South Devon NHS Foundation Trust

As at month 7 the Devon ICS is reporting a year to date £32.3m deficit, £24.8m higher than plan. The forecast for the year end is to breakeven at system level.

Description	Month 7			Forecast Outturn		
	Plan £m	Actual £m	Var +/(-) £m	Plan £m	Forecast £m	Var +/(-) £m
Devon ICB	4.7	9.4	4.7	8.0	8.0	0.0
Devon Partnership NHS Trust	0.1	0.1	0.0	0.0	0.0	0.0
Royal Devon University NHS FT	1.2	(23.9)	(25.1)	0.0	0.0	0.0
Torbay and South Devon NHS FT	(11.3)	(13.8)	(2.5)	(8.0)	(8.0)	0.0
University Hospitals Plymouth NHS FT	(2.2)	(4.1)	(1.9)	0.0	0.0	0.0
Total	**(7.5)**	**(32.3)**	**(24.8)**	**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 7 is as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Not assured**	**No change**
Financial performance	No assurance	No change
Savings and efficiencies	No assurance	No change
Financial risks	No assurance	No change
Workforce	No assurance	Deterioration

Devon Financial Escalation Framework – TSDFT Assessment

Torbay and South Devon NHS Foundation Trust

Dimension	Measure	RAG thresholds	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
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%	-4.0%	0.0%	0.0%	0.0%	0.0%	-0.6%	-1.0%
	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%	0%	0%	0.0%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%
	Forecast net unmitigated risk as a percentage of plan operating expenditure	Red rating where more than 0.5% of operating expenditure Green rating where no unmitigated risk	NULL	NULL	0.0%	0.9%	0.0%	0.6%	0.5%	0.5%
	Recurrent forecast variance to planned underlying position	Red rating where variance more than 0.5% of operating expenditure Green rating where ULP equals or favourable to plan	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	-2.3%	-2.3%
Efficiency Programme	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	30%	30%	32%	25%	22%	7%	2%	1%
	Percentage efficiency delivery against plan year to date	Red rating where less than 95% Green rating where plan value achieved or exceeded	98%	107%	108%	116%	116%	116%	107%	99%
	Percentage forecast recurrent efficiency delivery against plan	Red rating where less than 95% Green rating where plan value achieved or exceeded	100%	100%	98%	93%	93%	75%	76%	75%
Cash Management	Forecast cash support required from the System	Green rating where none Red rating where required	Permanent	Permanent	Permanent	Permanent	Permanent	Permanent	None	None
Capital	Year to date charge against CDEL as a percentage of forecast CDEL expenditure	Green rating where reported YTD expenditure is more than 85% of calculated forecast straight-line profile. Red rating where YTD expenditure is less than 70% of forecast straight-line profile	13%	10%	13%	20%	26%	32%	33%	38%
	Funding approval status of schemes in forecast	Green rating where >90% of forecast has funding approved. Red rating where <70% of forecast has funding approved	47%	47%	47%	60%	60%	60%	72%	63%
	Forecast capital spend as a percentage of allocated system capital	Red rating where spend is either 10% more or 10% less than allocation Green rating where allocation fully utilised	0%	0%	0%	0%	0%	0%	0%	0%

Key indicators

- Assessment identifies high risk indicators, in consecutive months, in three of the four dimensions.

Revenue plan delivery

- TSD ytd position adverse to plan by the value of the withheld DSF funding for month 7 and 8. With DSF funding as planned, the TSD position would be in line with plan.
- Forecast outturn ULP was reassessed in month 7 to indicate net underlying expenditure adverse to plan by £17.7m (move to £99.5m)
- DSF assumed to be received in full in forecast position

Efficiency programme

- Year-to-date achievement of efficiencies is marginally below the planned phasing in month 8.
- The forecast achievement of recurrent savings at 75% of plan.

Capital plan

- Funding approval status of schemes has declined to 63% with funding approval, but there is no significant increase to the forecast value of the programme.
- Capital expenditure profile ytd remains low at 33% of plan
- Plans are in place to deliver capital spend in full.

Torbay and South Devon NHS Foundation Trust

Board of Directors

Information: Legal and Regulatory Updates

Date of meeting	Date report produced
8 January 2026	2 January 2026

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	**Name and title:**	Sarah Fox Corporate Governance Manager
Phone:		**Date:**	2 January 2026
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: **November** Consultation: Advanced Foundation Trust Programme: guide for applicants - NHS England - Citizen Space Chancellor to double down on drive to cut NHS waiting times and rollout of new Neighbourhood Health Centres - GOV.UK Intellectual property (IP) guidance for the NHS in England - GOV.UK **December** NHS England » NHS maternity signal system will spot and stop emerging safety concerns Engagement insight report: 10 Year Health Plan for England - GOV.UK Fuller inquiry: government interim update on phase 2 recommendations - GOV.UK NHS England » NHS oversight framework – NHS trust performance league tables process and results

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 2026/27

	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	Committee Annual Reports		Annual Plan 2024/25		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 Finance Report Our Plan for Better Care Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR Finance Report Our Plan for Better Care Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR Finance Report Our Plan for Better Care Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR Finance Report Our Plan for Better Care Trust Strategy Update Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR Finance Report Our Plan for Better Care 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 Finance Report Our Plan for Better Care Legal and Regulatory Updates
Information Items	**Committee Chairs' Report** Audit F&OC QPC	**Committee Chairs' Report** Audit Charity F&OC QPC	**Committee Chairs' Report** Audit Charity F&OC QPC	**Committee Chairs' Report** Audit F&OC QPC	**Committee Chairs' Report** Charity F&OC QPC	**Committee Chairs' Report** Charity F&OC QPC
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						
Requested Reports						
Future Items	Well Led Update Board Effectiveness					

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: Thursday 8 January 2026

Time: 12.30 pm - 2.30 pm

The Boardroom, Hengrave House,
Torbay Hospital

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Working with you, for you

TSDFT Public Board of Directors - Information Pack

Board Room, Hengrave House

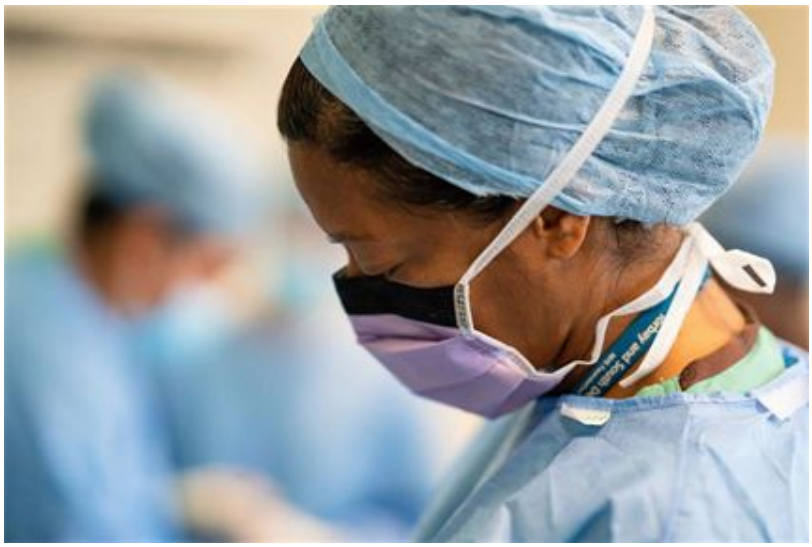
Torbay and South Devon NHS Foundation Trust

08/01/2026 12:30 - 14:30

NHS
Torbay and South Devon
NHS Foundation Trust

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 and People Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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 form 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. Internl/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 and People Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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:**
1. Frontline operational teams managing patient flow to meet performance standards 2. Clinical teams implementing harm stratification for long waiting patients and escalating risks 3. Local ward leadership monitoring performance and addressing bottlenecks 4. Daily ward huddles and twice daily board rounds	1. Safety and Flow meetings3 times a day 2. Risk escalation committees ensuring long wait patients with potential harm are prioritised 3. Regular reporting to ExCo 4. CMO and CNO leadership	1. Internal audit reviewing operational processes 2. CQC/NHS assess access standards and safety of long waits 3. Independent harm reviews associated with delayed care 4. Benchmarking against national standards for waiting times and elective and urgent care 5. Board level scrutiny via Audit committee 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 and People Committee**	
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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 and People Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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 and People Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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 and People Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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 and People Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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: Quality and People Committee**	
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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 (December 2025)	**Previous assessment: Limited (November 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 Mach 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 (December 2025)	**Previous assessment: Limited (November 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: Quality and People Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Satisfactory (November 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, Quality and 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 Quality and 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 Operations Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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, despite ongoing work, there is limited assurance that sufficient demand management will be in place for winter • UEC improvement plan refocussed to deliver intended benefits Complete interventions designed and overseen by UEC group • Elective Care Improvement Group and performance processes strengthened, led by DCOO. • Winter plan testing complete, November 2025, mitigating actions regarding known risks, are now concluded • Workforce v demand reviews to be undertaken in ED and medical wards and presented to executives – Work completed business case to Exec December 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: Finance and Operations Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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:**
Buildings: • Substantial area of trust estate is in poor condition and life expired and does not meet HTM for fire safety in buildings. • Insufficient capital to undertake required remediation and replacement of infrastructure • Lack of technical resource to deliver fire engineering maintenance to required standards. Lack of equipment storage results in item in corridors and lobbies • Implementation of EPR will introduce additional devices that will require storage and charging areas •	• Fire Safety Policy in place • Fire Safety audit completed in August 25 New Daily Ward Checks have been introduced in Wards in Tower Primary and secondary Fire Risks Assessment on the Tower being completed by Fire Safety Partnership by 31st January 2025 • 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 January 2026) • 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.	• Further Meeting with DSFRS (Fire service) underway Monday 15th December 2025. This will specifically review Tower Risk. • Fire Strategy for Tower • Commissioned to start February 2026. • Quality Design Review Meetings set up for 16th and 17th December to sign off fire improvement plans for the Tower. • 6 facet survey to provide up-to-date estate condition report underway Due to complete end of January 2026 • NHS E, DSFRS and Authorising Engineer attending site 17th December for a fire safety review of the Tower.

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: Finance and Operations Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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. . 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.	

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). • Disruption risk to clinical services during project delivery works.	• 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.
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.	• 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	• 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.

• 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.	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.	• 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 Operations Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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 • Workforce capacity in order to drive review of service as indicated in the objective and drive delivery	• Agree KPI Specification to build a KPI report to aid reporting and review. • PMO support for the substantive project lines remains outstanding – will be escalated.	• A draft KPI specification has been shared with key stakeholders. This has been 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 Operations Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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: Finance and Operations Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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	• 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.	• 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)

• 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	• 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.	• 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: Quality and People Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Satisfactory (November 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, Quality and 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 Quality 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 Quality and 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: Quality and People Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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.	• 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	• ICB/NHSE • NHSE Senior Leader Visit (annual). • NHSE and CQC visits and or reports.

• Individual team and service reviews as part of management and team meetings. • NHSE and HEI reporting.	Executive Operational Group (EOG) • Corporate Risk register • Bi-monthly reviews at Quality and 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: Quality and People Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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	• Monthly flash report submitted to the Oversight Group • Monthly review by the People & Education Leadership Team (PELT).	• ICB/NHS • NHSE Senior Leader Visit (annual). • NHSE and CQC visits and or reports.

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 review of Care Group and EOG	• Regular review at the ICB Workforce Delivery Management Group (Tactical and Strategic Cells)

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: Quality and People Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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	• Quality and People Committee receive a monthly update on this objective, including a review of progress and outstanding risks.	• NHSE Oversight Framework monitoring: Starting Autumn 2025, NHS England will publish trust-level metrics on key aspects (availability of basic

actions and resolve operational issues as they arise. • Exception reporting by junior doctors is actively monitored. • Resident Doctors' Representative Committee (RDRC).	• Executive oversight is maintained via the Executive Committee and internal performance reviews. A dedicated progress report on resident doctors working lives is scheduled at the Executive Committee in October 2025 for assurance	facilities, compliance with advance rota notice, incidence of payroll errors, etc. Regulatory reviews: Periodic NHSE Senior Leadership visits (annual) and CQC well-led inspections include evaluation of workforce wellbeing and organisational culture • Educational oversight: External bodies like the General Medical Council (GMC) and Health Education England (Deanery) conduct annual surveys (e.g. GMC National Training Survey) and quality assurance visits that gauge junior doctor satisfaction and training conditions..

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: Board of Directors**	
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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: Quality and People Committee**	
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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: Finance and Operations Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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:	Gaps in control & associated actions:
• 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.	• N/A

Three lines of defence:

First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
• Continued engagement with partners and checking alignment with emerging strategies and plans (e.g. from NHS Devon).	• Regular briefings to task-and-finish group, BBF Committee and Trust Board.	• External strategy expert is currently supporting development of our strategy, and progress will be shared with commissioners/regulators as appropriate.

SUPPORTING OBJECTIVE: To work with stakeholders to deliver services in our community where it is both sustainable for our Trust and we are best placed to do so, supporting the population we serve to live well; one of the pillars of the strategy will be integrated neighbourhood teams which will provide proactive, joined up care in the communities in which people live.	
Executive lead: Chief Planning and Strategy Officer	**Board oversight Committee: Quality and People Committee**
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 2025)**

Overarching comment & rationale for assessment:
Our strategy-in-development heavily emphasises the role of integrated neighbourhood teams and community hubs as physical spaces to bring complementary services together form across our services, primary care, local authority, mental health and VCSE community support. A key enabler will be the development of a framework for sharing ownership for health and care services with our local community which will describe the roles and relationships of different partners as well as facilitating improved engagement, involvement and collaborative decision-making.
Early implementation of our strategy is expected to involve:
• Exploring options that are likely to be easier to implement quickly – for instance where GP services are already located adjacent to our community facilities (e.g. Ashburton or Dawlish).

• Targeting opportunities where we have identified potential benefits with primary care partners, such as putting in place “interface services” like phlebotomy, assessment and triage. • Working with primary care, VCSE, mental health and Council partners to consider co-location of other complementary services within a framework that we can evaluate and adjust or build on accordingly.		
Risk to delivery:		
Aggravating factors:	**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 and People Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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:	**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.

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: Finance and Operations Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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: Finance and Operations Committee**	
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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 (forecast to complete mid 2026). 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.
		  ○ 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.
		  ○ 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.
		  ○ 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 and People Committee**	
Current assessment: Improving – Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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 and People 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 Operations Committee**	
Current assessment: Satisfactory (December 2025)	**Previous assessment: Satisfactory (November 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 January 2026. • 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 December • Care Groups to either identify recurrent pay savings or agree to a recurrent vacancy factor being applied to their budgets by end of December • 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 December • Further work required to identify all changes with timescales and estimate financial impact by end of 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:**
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 Operations Committee**
Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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 December • Business cases submitted for national PDC to support critical infrastructure and constitutional standards awaiting national approval by end of 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:**
• 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 Operations Committee**

Current assessment: Limited (December 2025)	**Previous assessment: Limited (November 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	Development of a collective group of provider Executives (DCEO, CFO, COO, CMO's) meeting weekly to design a strengthened collaborative plan, in order to improve confidence in system benefits – commenced Nov 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**
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.

Finance and Performance Committee

Items for Information

REPORTS PRESENTED TO THE BOARD FOR INFORMATION

The following reports are provided to the Board of Directors for information:

- Integrated Performance Focus Report
- Electronic Patient Record Progress Report

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

December 2025: Reporting period November 2025 (Month 8)

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.

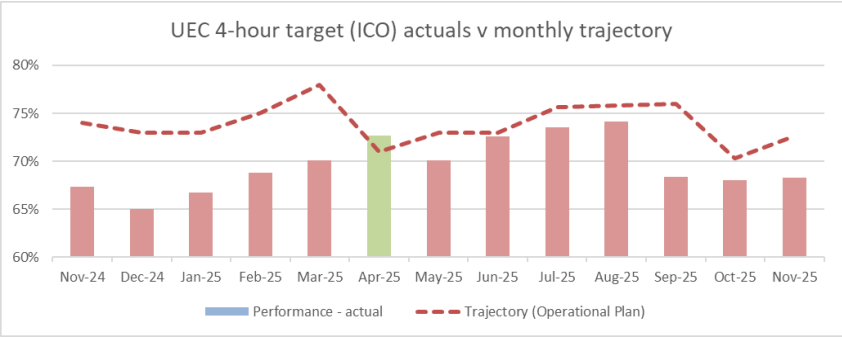
National Oversight Framework– Urgent and Emergency Care Performance Summary

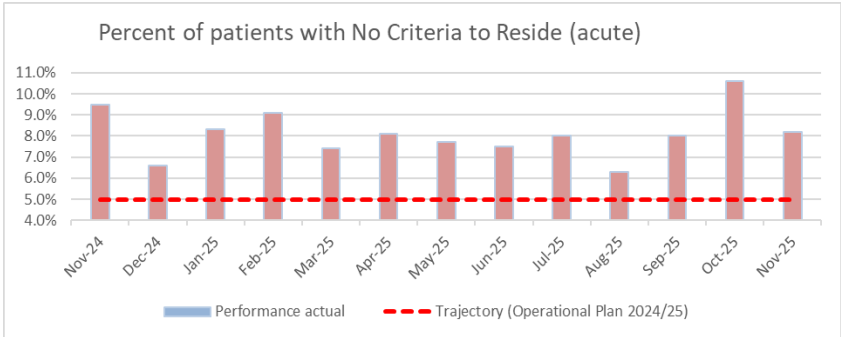
Torbay and South Devon NHS Foundation Trust

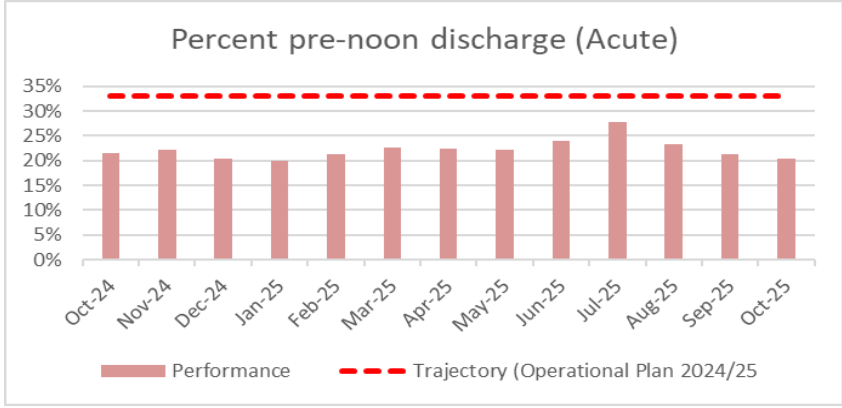
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Operational Plan trajectory
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			3275	3108	2532	1625	1268	839	1530	1159	725	943	1823	810	624	1821
Average handover time (mins)	45 mins		109	95	84	62	47	36	52	45	32	38	60	33	29	42mins
Total average time in ED (hours/minutes)			06:18	06:17	06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		854	793	818	677	615	415	688	494	457	426	655	585	549	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		12.6%	12.8%	13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.8%	8.4%
UEC 4-hour target (RAG against local trajectory to national target)	78%		67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	72.6%
% patient discharges pre-noon	33%		22.3%	20.4%	19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		9.5%	6.6%	8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	5%

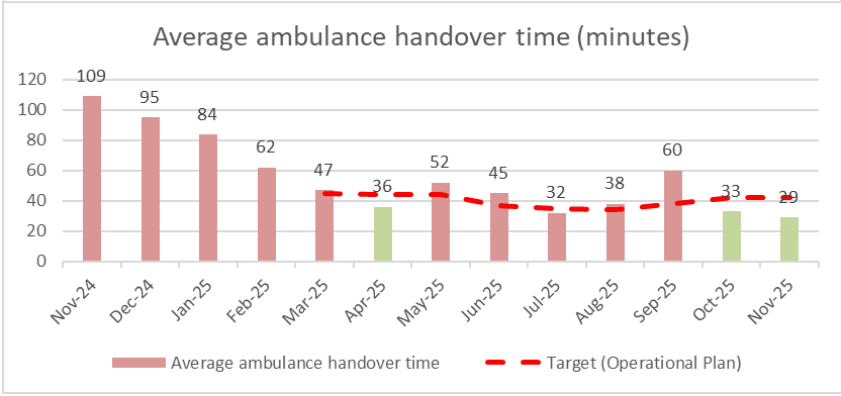
RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

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.







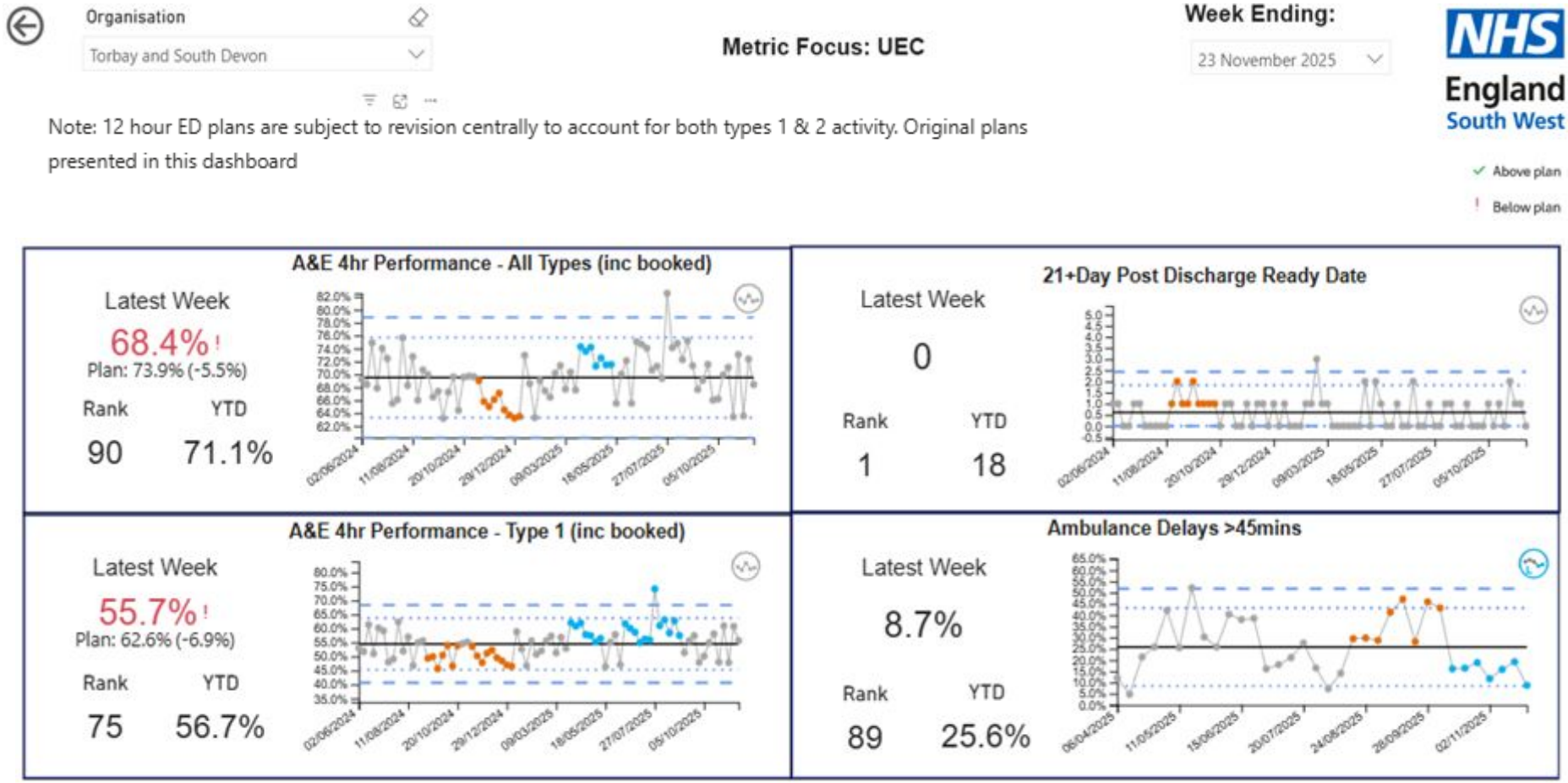


Urgent and Emergency Care Performance Summary - NHS England monitoring report

Torbay and South Devon NHS Foundation Trust

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 shows ambulance handover delays over 45 minutes and the recent weekly ranking of 89 out of 123 trusts (as of 23 November 2025) from rank 83 last month.



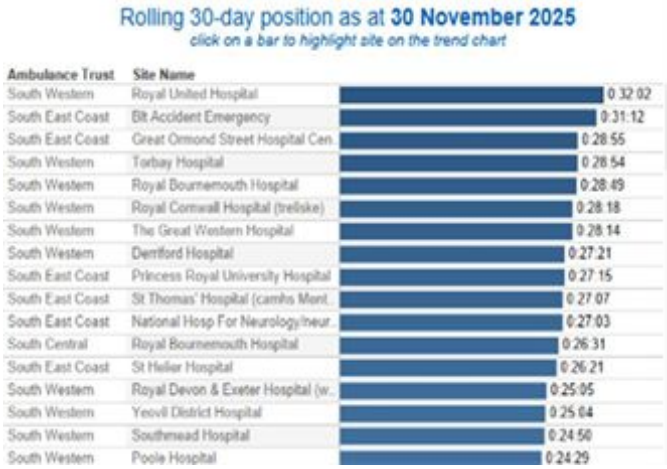
Exception report: Average Ambulance Handovers time: Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

The total number of ambulance conveyances to the ED in November was 2604, which is the highest number of conveyances by SWAST the organisation has seen in a month period.
November's handover average was 28 mins 34 sec and was 1hr 26 sec in September and 33 mins 15 sec in October.

Average handover time – rolling 30 day (as at 30 November 2025)



Operational update

Ambulance handovers remain a key focus for the Trust and Timely Handover Process (THP@45) was 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 414 in November. November's average ambulance handover time is the best seen in the last five years.

Average ambulance handover time

Actions to complete next month

- Following Improvement and Innovation (I&I) support, post ECIST, the main workstreams have now been developed into operationally led programmes of work:
  - ED Demand and Capacity Recovery and Improvement
  - ED Demand Management
  - 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.
- Sustained increase in demand above historical trend.
- Changes to the flow and heightened escalation due to increased demand and the THP@45 24/7 process on the wider organisation: demand vs capacity and responsive flow meaning boarding on the assessment areas and into the ED corridor/airlock, and the use of ward-based day rooms.

5

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

Torbay and South Devon NHS Foundation Trust

Performance

	Nov 2024	Nov 2025
MIU/UTC attendances	3187	3067
MIU/UTC performance	99.4%	99.5%
ED (type 1) attendances	6614	7075
ED (type 1) performance	51.8%	54.8%
ICO attendances	9801	10159
ICO performance	67.3%	68.3%

Opel score

November 2024

Mon	Tue	Wed	Thu	Fri	Sat	Sun
				1 L3	2 L2	3 L3
4 L2	5 L4	6 L4	7 L4	8 L3	9 L3	10 L3
11 L4	12 L4	13 L3	14 L4	15 L3	16 L3	17 L4
18 L4	19 L3	20 L3	21 L3	22 L4	23 L4	24 L3
25 L4	26 L4	27 L4	28 L4	29 L4	30 L3	

November 2025

Mon	Tue	Wed	Thu	Fri	Sat	Sun
					1 L3	2 L3
3 L3	4 L3	5 L3	6 L3	7 L3	8 L3	9 L3
10 L3	11 L3	12 L4	13 L4	14 L4	15 L3	16 L3
17 L2	18 L3	19 L3	20 L3	21 L3	22 L3	23 L3
24 L4	25 L3	26 L3	27 L4	28 L4	29 L3	30 L3

Operational update

4hr performance for the month stands at 68.35% against a trajectory of 72.6%, meaning a slight improvement on October of 0.34% but 4.25% below trajectory.
The ICO had 10,159 attendances, the Emergency Department recorded 7,075 attendances (7th consecutive month in excess of 7000).
November has seen a daily high of 276 patients in the ED department; this level of daily attendance in normally seen in the busy summer months.
Resus is still seeing more than 280 patients a month denoting the acuity and complexity. Along with a rise in mental health and infection-based attendances requiring IPCC management.
Patient experience, safety, and risk metrics - ED 12-hour Length of Stay continues to improve at 549 from 568 in October.
November paediatric 4-hour target is 84.5% against a target of 95%

Actions to complete next month

We remain committed to improving the two main causes of patient flow imbalance and improving performance by:

- Increasing the number of patient discharges before noon and;
- Increasing the number of patient weekend discharges.

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 continues, which also supports operational escalation throughout the year.
- EPIC GLRA120 commences on 09/12/25- active planning to support is ongoing.

Risks/issues

- 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.

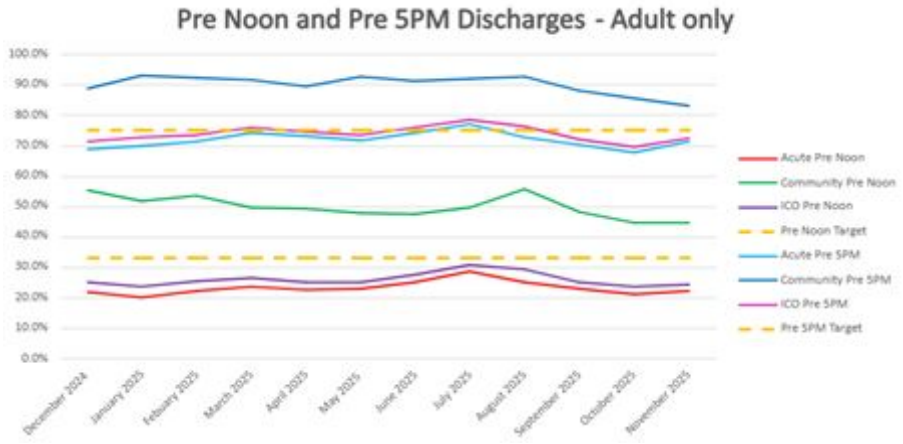
Exception report: Percent of pre-noon discharges: NOF 4 Exit Criteria - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

Performance Analysis: October vs November 2025

- November shows a slight improvement compared to October.
- Pre-Noon discharges remain below the 33% target, while Pre-5PM is close but still slightly under the 75% target.



Operational update

Throughout November, 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 November, the Discharge Lounge supported 747 patients. 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.

Actions to complete next month

- Review how we capture AMU Level 2 >1 Day LOS cohort into our discharge number.

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.

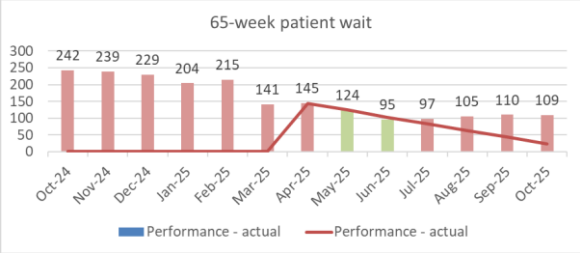
National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

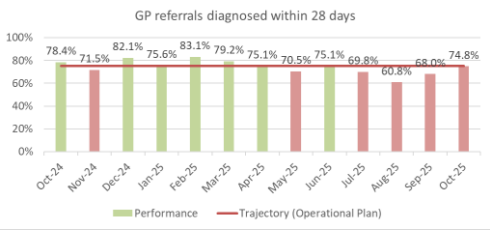
Torbay and South Devon NHS Foundation Trust

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Operational Plan trajectory Nov 2025
Oversight Framework																
Elective recovery																
RTT 78 week wait incomplete pathway	0		6	0	12	14	7	4	8	8	9	16	13	16	9	0
RTT 65 week wait incomplete pathway	0		239	229	204	215	141	145	126	95	97	105	110	109	84	3
RTT 52 week wait incomplete pathway	268		1276	1265	1238	1209	931	914	805	740	615	618	615	647	607	505
RTT % Incomplete pathways <18 wks	66.8%		61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	65.1%
RTT Wait for first appointment <18 weeks	70.3%		65.3%	64.6%	63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	68.8%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		71.5%	82.1%	75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	75.0%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	76.7%
Cancer: No of patients waiting >62 days to start treatment	138		77	110	95	94	111	133	225	223	220	257	176	132	91	138
Cancer: % of patients > 62 days to start treatment	tbc		5.0%	7.0%	6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	tbc

RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

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; 4 of the 7 trajectories in Month 8 have been met.





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

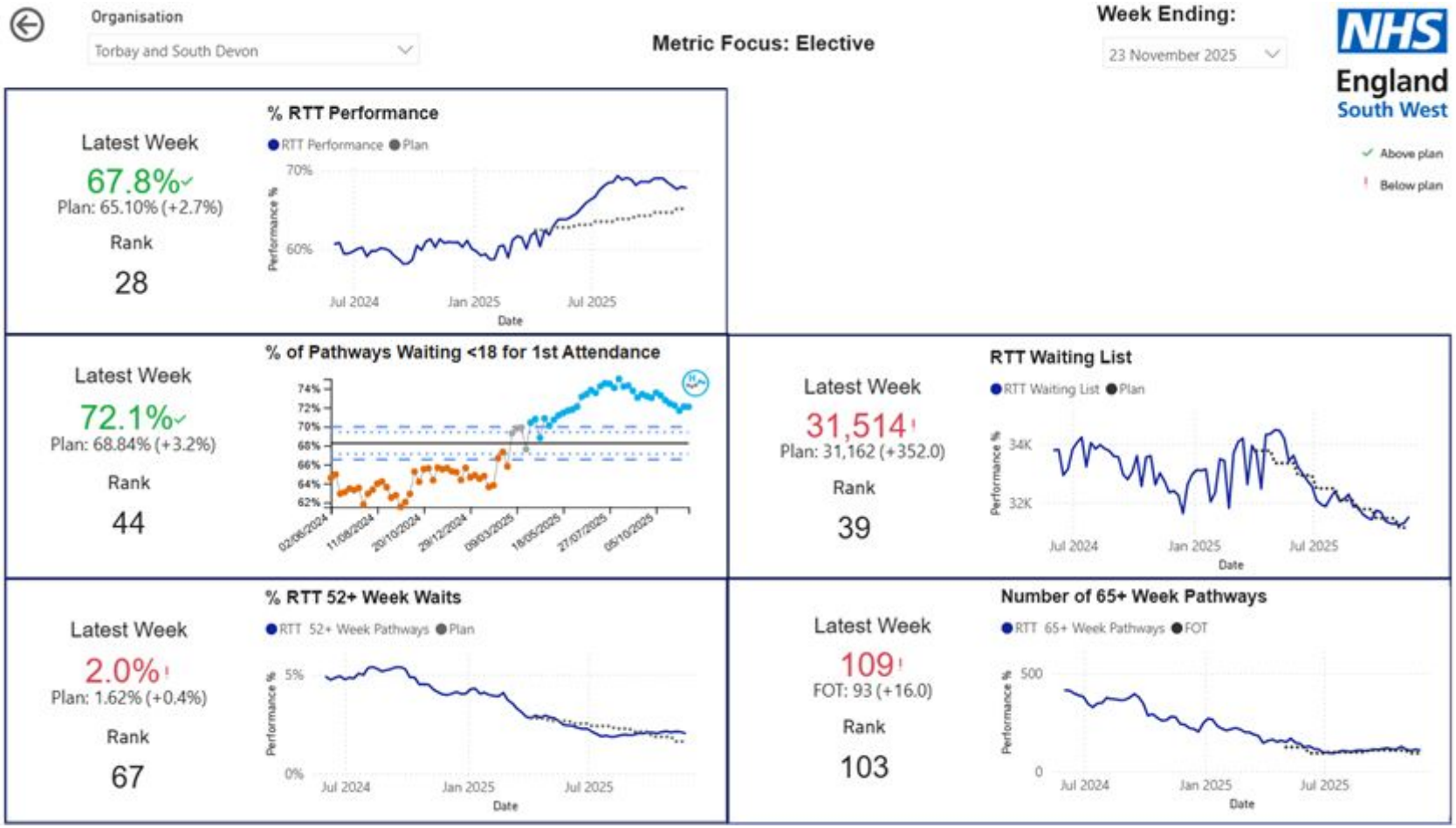
- Workforce – enough surgeons and anaesthetists to meet demand (hip and knee). Admin (secretary / booking) to cope with additional demand.
- Balance of recovery of cancer/urgent/long waits continues to pose pressure on long-waiters. Growth in Dermatology referrals (14% growth year-to-date).
- Trauma and anaesthetics capacity – impact on T&O lists. Particularly for 65-week waits.

Elective Care Performance Summary - NHS England monitoring report

Torbay and South Devon NHS Foundation Trust

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



The Published reports showing latest performance and trust ranking (134 Trusts) against the RTT waiting time metrics and our submitted operational planning trajectories confirm the good performance seen to date this year.
Significant ongoing risk with hip and knee orthopaedics in the 65-week cohort. Struggling to achieve reductions in clearance rates against tip-ins. Wider workforce pressures as well as significant trauma impacts.

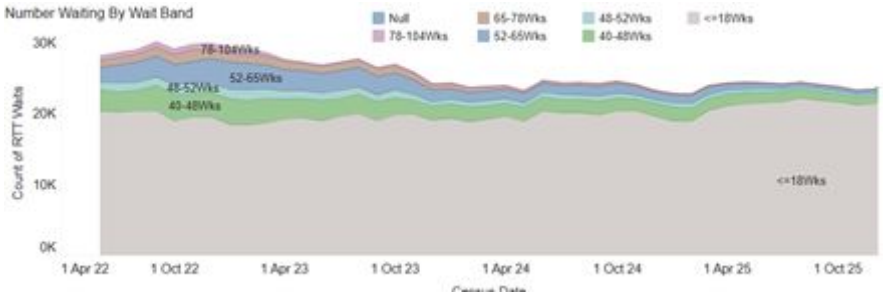
Exception report: 78-Week and 65-Week Clearance: NOF 4 Exit Criteria – Elective Recovery

Torbay and South Devon NHS Foundation Trust

Performance

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

	November 2024	November 2025
78 weeks	6	9
65 weeks	239	84
52 weeks	1276	607



Operational update

78 week: At the end of November (provisional figures) there are 9 breaches - 8 admitted orthopaedic patients (due to specialty capacity for hip and knee surgery). And 1 Upper GI admitted – There are ZERO non-admitted

65 week: In November (provisional figures) there were 84 breaches - Gynaecology (4), Ophthalmology (2), Oral Surgery (1), Orthodontics (1), Pain Management (2), T&O (68), UPGI (2) and Urology (1) ENT (2), Interventional Radiology (1). Most of which will be cleared December, outside of T&O.

Weekly Trauma and Orthopaedic huddles are 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

- Continued insourcing in key areas.
- To recruit locum to manage the transition to approved substantive posts in T&O.
- Theatre recovery programme.
- Start recruiting agreed posts to exit insourcing reliance as part of business planning.
- Implement outpatient improvement programme with detailed plan milestones agreed by service area.

Risks/issues

- Trauma and cancer impacting long-wait elective capacity.
- Admin pressures impacting additional insourcing.
- Lost operational capacity due to estate failure e.g. theatre breakdown.
- Risk of delays to recruitment against agreed posts to deliver additional capacity and transition away from insourcing.
- 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

Torbay and South Devon NHS Foundation Trust

STAGE OF TREATMENT WAITING LISTS | NEW OP & PENDING

New Outpatient & Pending List as at All (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	1,554	536	842	16	17	14	2,979
130 - OPHTHALMOLOGY	1,411	402	281	15	7	7	2,123
140 - ORAL SURGERY	935	230	549	24	2	1	1,741
110 - TRAUMA & ORTHOPAEDICS	1,001	274	315	48	11	43	1,692
330 - DERMATOLOGY	1,225	186	175	2			1,588
302 - ENDOCRINOLOGY	608	169	418	213	162	6	1,576
340 - RESPIRATORY MEDICINE	834	77	207	85	68	153	1,424
101 - UROLOGY	855	227	63	1			1,146
650 - PHYSIOTHERAPY	844	75	175	6	1		1,101
320 - CARDIOLOGY	864	60	54	11	8	23	1,020
420 - PAEDIATRICS	808	100	97	5	1	2	1,013
410 - RHEUMATOLOGY	712	74	166	48	1		1,001
104 - COLORECTAL SURGERY	571	145	144	1			861
400 - NEUROLOGY	558	143	108	30	15		854
301 - GASTROENTEROLOGY	722	77	41				840
191 - PAIN MANAGEMENT	529	109	138	8	1		785
502 - GYNAECOLOGY	619	44	13	1		1	678
840 - AUDIOLOGY	613	18	26	4			661
430 - GERIATRIC MEDICINE	177	46	65	3	1		292
106 - UPPER GASTROINTESTINAL SURGERY	256	6	14	4	1	1	282
655 - ORTHOPTICS	210	23	37	2	1		273
401 - CLINICAL NEUROPHYSIOLOGY	262	2	1				265
103 - BREAST SURGERY	222					1	223
143 - ORTHODONTICS	65	14	46	25	2	1	153

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 November position is 67.7% against trajectory of 65.1%.

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

Baseline	WLMDS	Target
Nov-24	w/e 23-Nov-25	Mar-26
65.3%	72.1%	70.3%

Torbay & S Devon: Wait to first by specialty

Specialty	0-18 weeks	First activity	Wait to first	% point change Baseline	% point change Target
ENT	1,263	2,345	53.9%	-11.4%	-16.4%
Oral Surgery	940	1,726	54.5%	-10.8%	-15.8%
Trauma & Orthopaedics	757	1,236	61.2%	-4.0%	-9.0%
Elderly Medicine	189	306	61.8%	-3.5%	-8.5%
General Medicine	11	17	64.7%	-0.6%	-5.6%
Neurology	522	749	69.7%	4.4%	-0.6%
Other - Other Services	38	54	70.4%	5.1%	0.1%
Ophthalmology	1,985	2,731	72.7%	7.4%	2.4%
Plastic Surgery	20	27	74.1%	8.8%	3.8%
Other - Medical Services	1,142	1,526	74.8%	9.6%	4.6%
Other - Surgical Services	1,037	1,361	76.2%	10.9%	5.9%
Urology	860	1,110	77.5%	12.2%	7.2%
Rheumatology	541	684	79.1%	13.8%	8.8%
Dermatology	1,246	1,565	79.6%	14.3%	9.3%
Cardiology	1,197	1,415	84.6%	19.3%	14.3%
Gastroenterology	701	790	88.7%	23.5%	18.5%
Gynaecology	734	823	89.2%	23.9%	18.9%
Respiratory Medicine	538	578	93.1%	27.8%	22.8%
Cardiothoracic Surgery	2	2	100.0%	34.7%	29.7%
Other	14	14	100.0%	34.7%	29.7%
Total pathways	**13,737**	**19,059**	**72.1%**	**6.8%**	**1.8%**

Data Source: WLMDS for w/e 23-Nov-25
Baseline is the WLMDS w/e 01-Dec-24
Below baseline | Above target

The Trust is achieving 71.8% 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.

Exception report: Cancer Waiting Time Standards

Torbay and South Devon NHS Foundation Trust

Performance

	August 2025	September 2025	October 2025	November 2025
28-day FDS	62.1%	67.3%	74.8%*	76.3%*
31-day treatment	87.1%	91.8%	91.1%*	93.1%*
62-day cancer RTT	65.7%	63.3%	72.4%*	73.5%*
62-day backlog	257 (9.2%)	170 (7.1%)	152* (6.8%)	91 (4.5%)

** 2025 provisional data*

Faster Diagnosis Standard (FDS): The Trust is currently reporting 76.3% against the 75% FDS target. This position is undergoing validation ahead of submission at month end.

62-day Cancer Referral to Treatment: October's provisional performance is 73.5%, meeting the 70% interim target.

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 03/12/2025, the backlog is 4.5%.

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.

Actions to complete next month

Dermatology

- Performance has further improved to 87% in November 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.

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.

Quality and Safety Indicators – dashboard of key metrics

Torbay and South Devon NHS Foundation Trust

Key		
↑ = Performance improved from previous month	↓ = Performance deteriorated from previous month	↔ = No change

	Not achieved		Under-achieved		Achieved		No target set		Data not available

Reported Incidents – Severe (<6)		↓
Reported Incidents – Death (<1)		↓
Medication errors resulting in moderate harm (<1)		↓
Medication errors - Total reported incidents (No target set)		
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 7	↑
Stroke patients spending 90% of time on a stroke ward (>80%) - one month in arrears	Month 7	↑
Mixed sex accommodation breaches (0)		↑
Follow-ups 6 weeks past to be seen		↓

13

Quality and Patient Safety Summary -

Areas of deterioration and risk

Stroke care

Performance in stroke remains inconsistent with reductions in the percentage of patients admitted to the stroke unit with 4 hours, percentage of patients scanned with 20 minute, and rates of thrombolysis. The proportion of patients receiving a formal swallow assessment within 24 hours remains very low and significantly below the national average.

Feedback and engagement

There is a significant backlog of email and telephone contacts to the Feedback and Engagement team which has not yet been heard. A recovery plan is in place and numbers of unread feedback will be monitored closely moving forwards.

Follow-ups past 6 weeks to be seen date

There has been a deterioration in patients awaiting follow up past 6 weeks, and trends over the past year have not improved. The Executive Operations Group are requesting targeted recovery plans for the services with most significant backlogs.

Maternity

In November there was one neonatal death and one late fetal loss. Other maternity metrics were stable.

Patient safety incidents

Blood transfusion reports to the Medicines Healthcare products Regulatory Agency are significantly delayed over the 21-day timescale and some reports have been rejected. The central safety team have met with the relevant Care Group to discuss a plan for improvement.
There are no never events reported in November.

Infection Control

Rates of MSSA and e-coli are about target thresholds. The Infection, Prevention and Control (IPC) team is implementing an improvement plan.
Trust flu vaccination rate is just over 50.9% (against regional performance of 47.5% and national performance of 40.0%)

Areas of stable or improving performance

Safer Staffing

October data is within the NHSE suggested tolerance of 80-120% and also within the TSDFT tolerance of 90-110% fill rates; a stable trend from September.

Mortality

HSMR, HSMR+ and SHMI are all statistically as expected in the latest report presented in October 2025

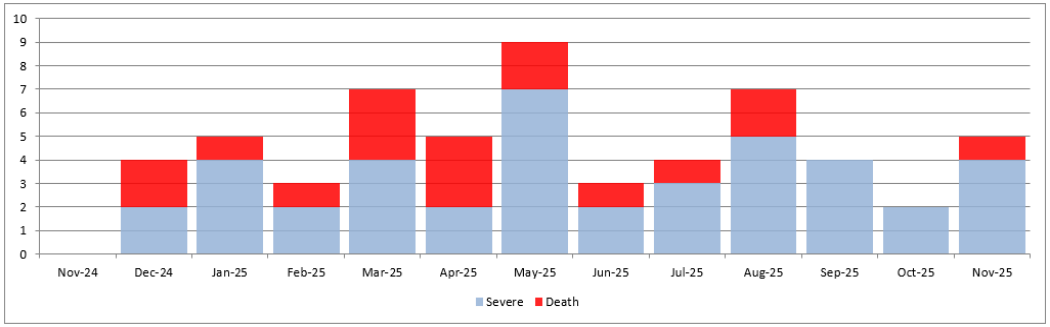
CQC and regulatory compliance: We are working to test future CQC readiness using a service and ward accreditation process which Audit South West will be reviewing.

Quality and Safety exception reports – Reported incidents

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

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



Incidents reported as severe harm or death

In November 2025 there were 2 incidents of death reported, and 3 severe harm incidents reported:

[Death] - Neonatal death at 39+5 weeks gestation

[Death] - Late fetal loss at 22+0 weeks gestation

[Severe] - Patient with challenging behaviour noted to be on hospital roof

[Severe] - Unwitnessed fall, subdural haematoma; for AAR

[Severe] - Fall, head injury & #NoF sustained

Patient Safety Incident Response Framework (PSIRF) and remaining serious incidents:

There are currently 11 ongoing patient safety incident investigations (PSII) underway and open on the STEIS (national reporting system). *Some reviews have been completed but remain open on DCIQ (local reporting system), pending additional focus, e.g. actions

PSII's underway

PSII criteria	National: Maternal death	National: Child death	National: Never Event	National: MNSI	National: Death contributed to by incident	Local criteria
No of PSII's underway	1 being led by ICB (early gestation)	1 (2024 case)	1 (misplaced NG tube)	1 (November case)	2	5

Completed PSII/Equivalent Reviews – November 2025:

- 1x Child death (PSII-National)
- 1 x ED delayed medications (PSII-Local)
- 1 x Maternity (baby) (MNSI-National)
- 3 PMRT cases are awaiting completion (these have not been raised as PSII's)
- 1 Serious incident remains open –this is a 2023 maternal death case being led by the ICB

Areas to escalate:

Themes identified within maternity regarding escalation following neonatal death cases. 2 PSII's have been commissioned one of which is a thematic review of 3 cases.

Blood transfusion reports to the Medicines Healthcare products Regulatory Agency are significantly delayed over the 21-day timescale, some reports have been rejected as they do not demonstrate required an understanding of the systemic issues and are focused on individuals. Work is underway to support the blood transfusion team and the Senior Specialist Practitioner of Transfusion.

CQC Update

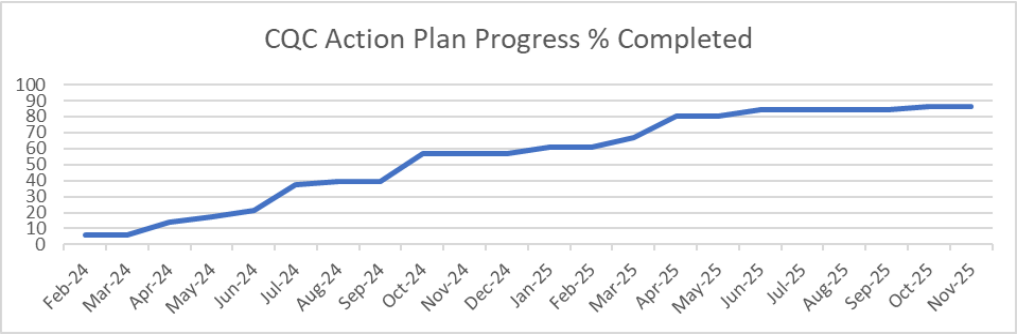
Torbay and South Devon NHS Foundation Trust

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					11th December 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	6	2	1
Urgent and Emergency	2	6	2	6	2	2
Medical Care	3	6	3	6	3	3
OPD	1	10		6	1	0
Diagnostics Imaging	7	7	7	7	7	7
TOTAL	15	36	13	31	15	13
Total MDSD Actions	51				% Closed	86.67%
Total MDSD Actions Closed	44					
Percentage MDSD Actions Closed	86.27%	11/12/2025				



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.

Regulatory Compliance and readiness

Looking forward, this slide will also include other aspects of regulatory compliance and not just CQC oversight. This will include but not limited to MHRA, HTA and external accreditations.

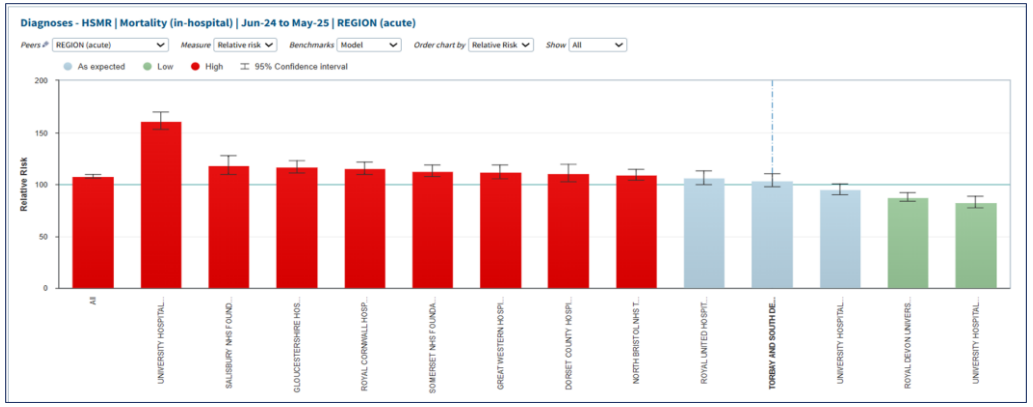
The External Review Oversight Group (previously CQCCAG) is moving towards oversight of CQC and service readiness for inspections. Audit Southwest are currently undertaking a review of current processes which includes the ward and AHP accreditations. Local service accreditation information will be included here going forward.

Quality and Safety exception reports – Hospital Standardised Mortality Ratio HSMR

Torbay and South Devon NHS Foundation Trust

No update on data since 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 HMSR 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:
    - Occlusion or stenosis of precerebral arteries
    - Respiratory failure, insufficiency, arrest (adult)
    - Gastrointestinal haemorrhage
    - Acute and unspecified renal failure

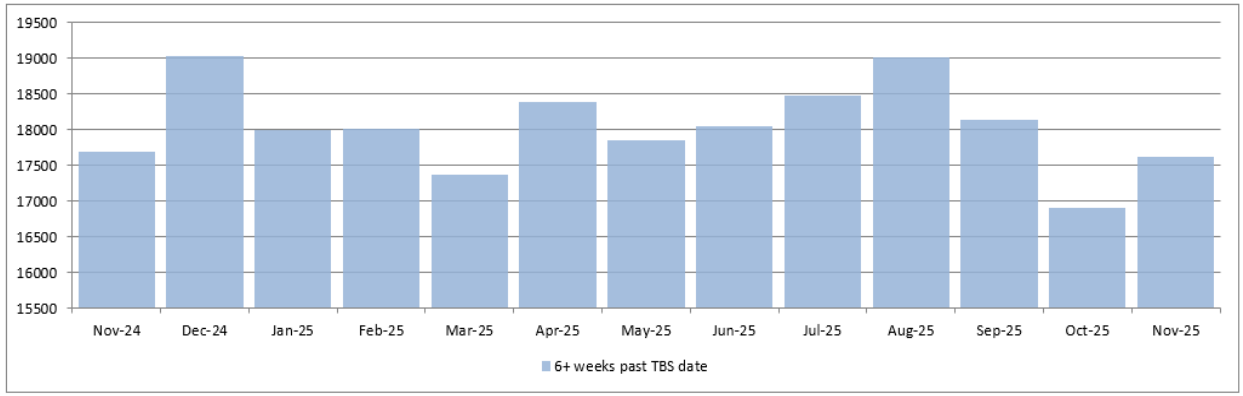
Alerts will be monitored by the Mortality Surveillance Group.

Quality and Safety exception reports – follow-ups past to be seen by date/fractured neck of femur

Torbay and South Devon NHS Foundation Trust

Follow ups 6 weeks past to be seen by date

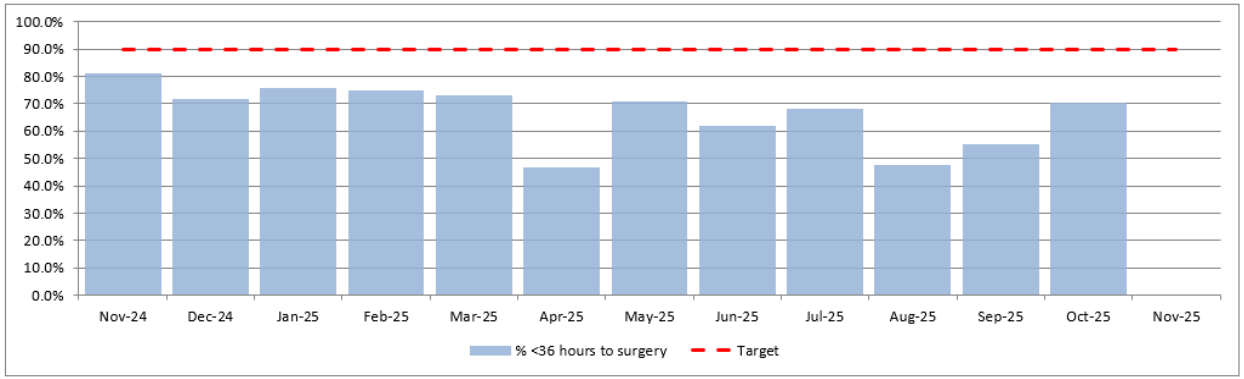
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
6+ weeks past TBS date	17689	19036	17997	18005	17361	18380	17843	18040	18486	19016	18135	16900	17610



Follow-ups past 6 weeks to be seen
We have seen an overall increase in the number of patients waiting longer that 6 weeks past their to be seen by date - 87% (621) of the total increase of 721 is within Ophthalmology due to consultant sickness, and sickness and vacancy in the Patient Access Centre.

Fractured neck of femur - <36 hours to surgery

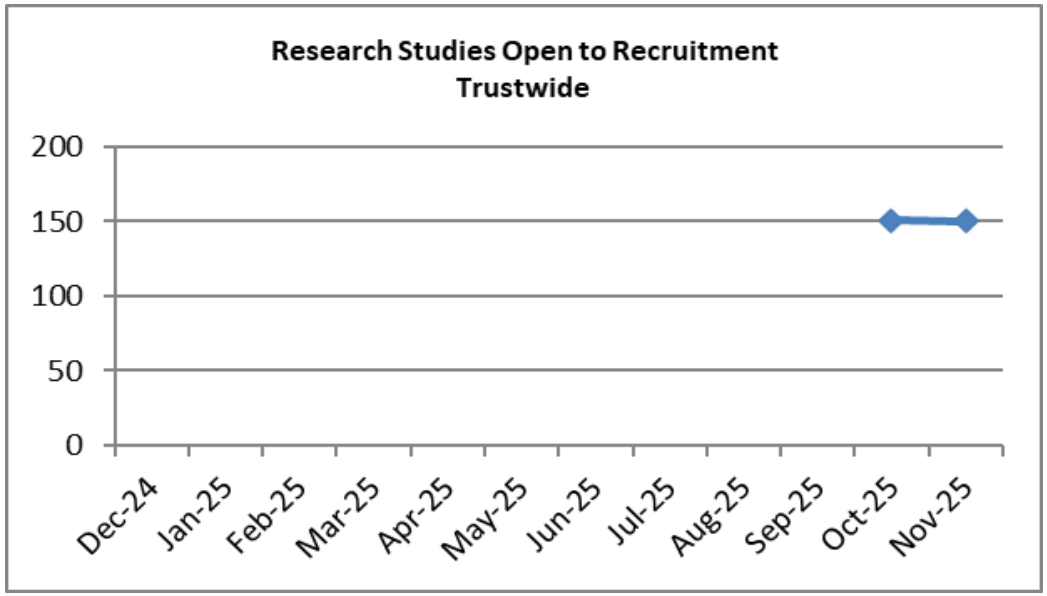
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
% <36 hours to surgery	81.1%	71.9%	75.6%	75.0%	73.2%	46.5%	70.7%	61.8%	68.1%	47.4%	55.0%	70.3%	N/A
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



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

November data shows 36 hip fractures plus 5 other femoral fractures admitted. This will include the complex periprosthetic fractures. Average time to theatre for the hip fractures was 33.30 hours which is a increase on October. This is impacted by only having 2 trauma lists on 9 days in month (due to industrial action and Gaps in Consultant rota). This led to cancellation of elective cases for trauma

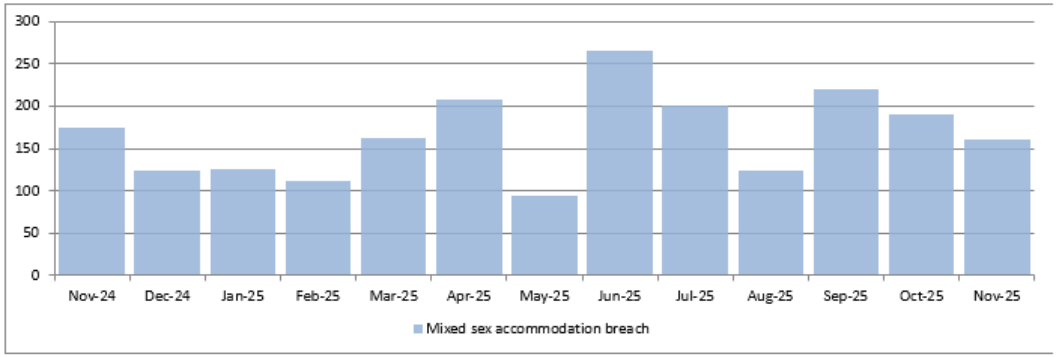
Quality and Safety exception report – Research involvement / Mixed Sex Accommodation



Research involvement
Numbers of research studies open remains steady at 150 studies

Mixed sex accommodation breach

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Breaches - actual	174	123	125	112	163	208	94	265	200	124	220	190	160
Target	0	0	0	0	0	0	0	0	0	0	0	0	0

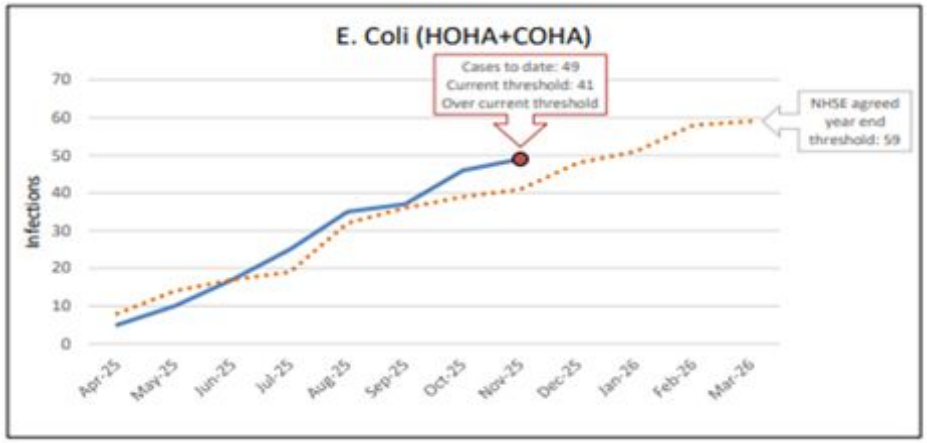


Mixed Sex Accommodation
All reported breaches related to mixed-sex accommodation when patients remain on the Surgical Receiving Unit (SRU) without transfer to an inpatient ward within four hours of a decision to admit, or when patients are transferred to the SRU from the Emergency Department following 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 November we recorded 160 breaches, 30 breaches less then October 2025.

From Jan 2026 we will be adopting guidance where we operate a 'clock stop' on breaches between 10pm and 7am in line with NHSE guidance.

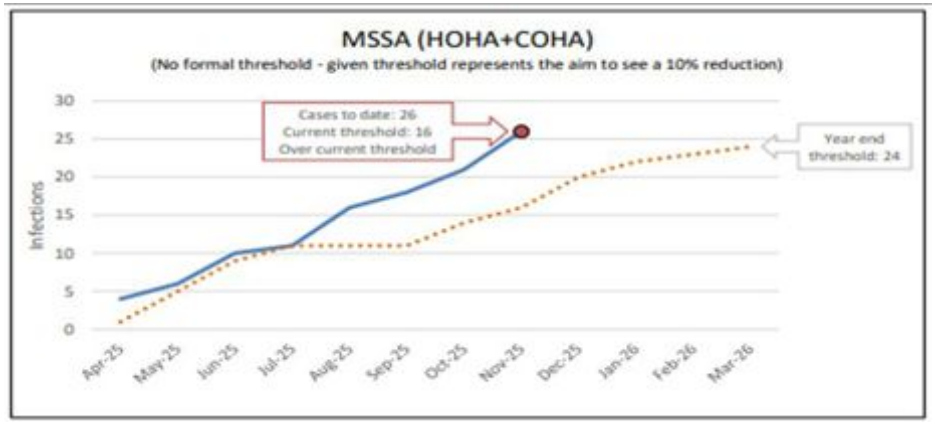
Quality and Safety exception report - Infection control



Rates of Klebsiella, C-Difficile and pseudomonas are all below out target levels.
However, rates of e-coli and MSSA are both above the target level.
Increased infection rates may be a consequence of:

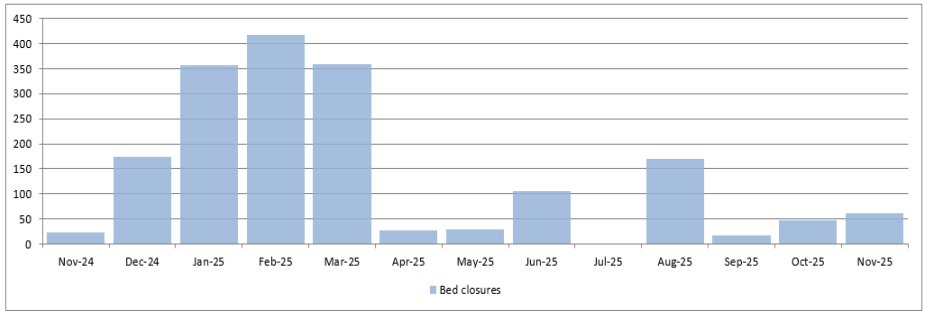
- Increased patient acuity and complexity
- Reduced infection control compliance
- High bed occupancy

The IPC team are supporting an improvement plan and education.



Infection control - Bed days lost (Acute)

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Bed closures	24	174	358	418	360	28	29	105	0	170	18	47	61



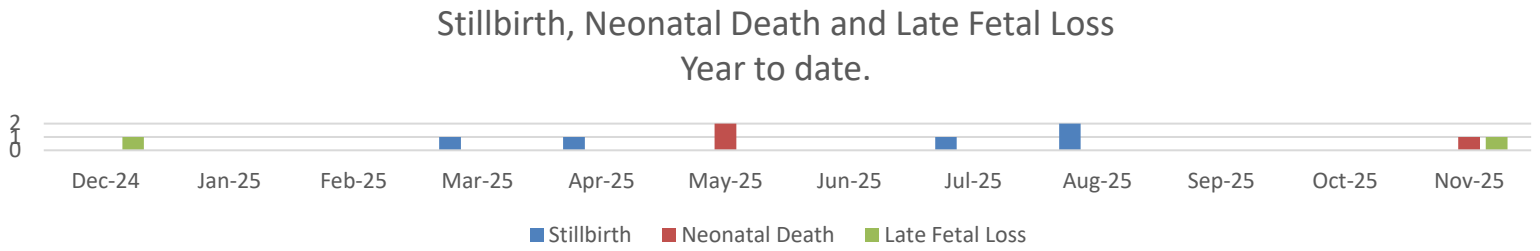
There were eleven bed days lost in November due to IPC related issues.
These were:

- Brixham- 4 days (in total) lost due to Covid at the beginning on November and Diarrhoea and Vomiting (D&V) at the end of the month
- Allerton – 3 days lost due to Covid
- Simpson - 4 days lost due to Flu A

Side room usage continues to be reviewed daily across all in-patient areas working with the site team and wards to ensure appropriate usage.
The updated Isolation Policy has been ratified at IPCG to support a standardised approach to bed closures on a trust wide basis. IPC 7 day working continues with attendance at all control meetings to advise/support with bed closures

Quality and Safety- Perinatal Clinical Quality Surveillance December (November 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:

- **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.
- **November 2025** - 1 x Late Fetal Loss - Spontaneous Labourer with probable infection. 1 x Neonatal Death at 39+5 weeks gestation, baby born 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.

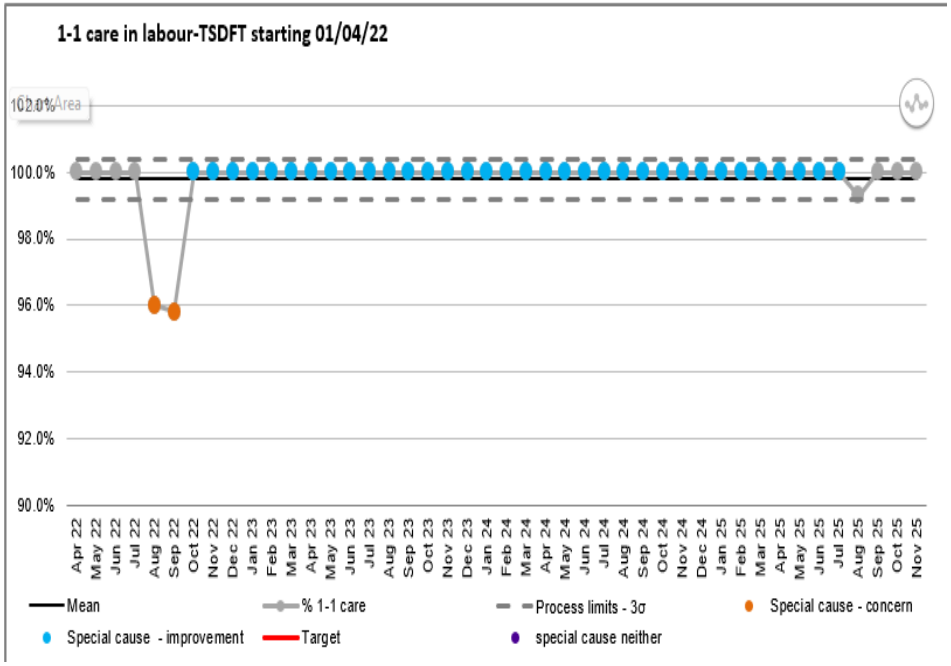
Incidents moderate and above = 2

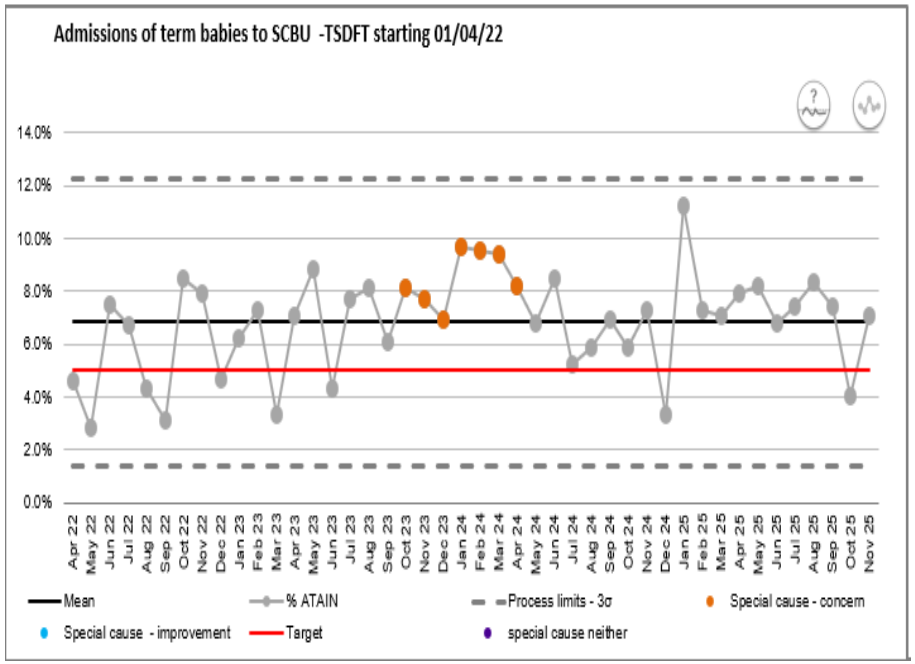
- 2 x Death Caused by the incident - 1 x Late Fetal Loss - Spontaneous Labourer with probable infection. 1 x Neonatal Death at 39+5 weeks gestation, baby born with severe Hypoxic Ischaemic Encephalopathy (HIE), transferred to Level 3 Neonatal Unit for therapeutic cooling, care withdrawn on day 5 of life and baby passed away.

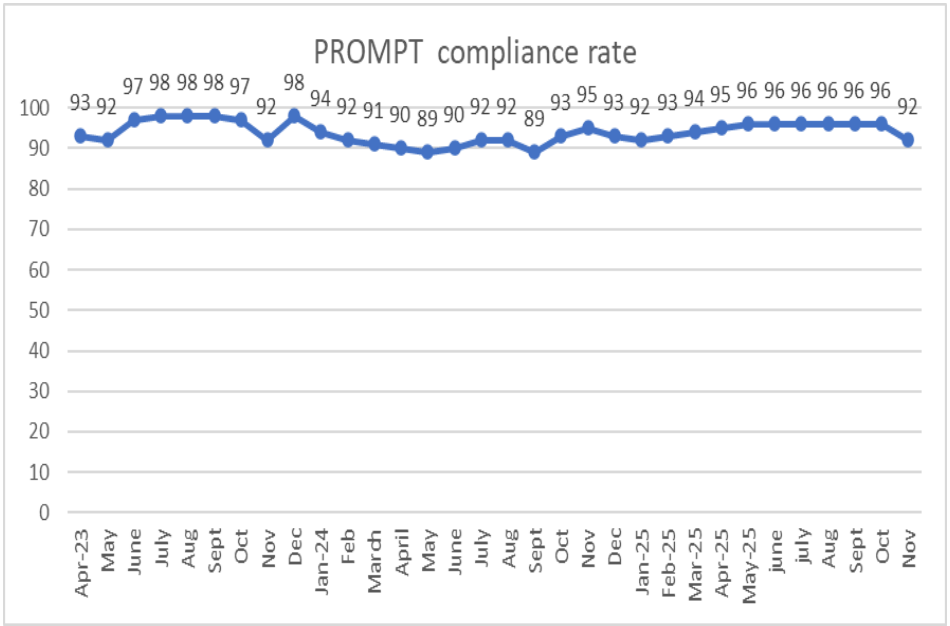
MNSI – 1 Referral Initially for HIE, then subsequently Neonatal Death in higher level unit.
CQC – None
Coroner referral – Baby referred to in above MNSI case referred to the coroner by higher level unit.

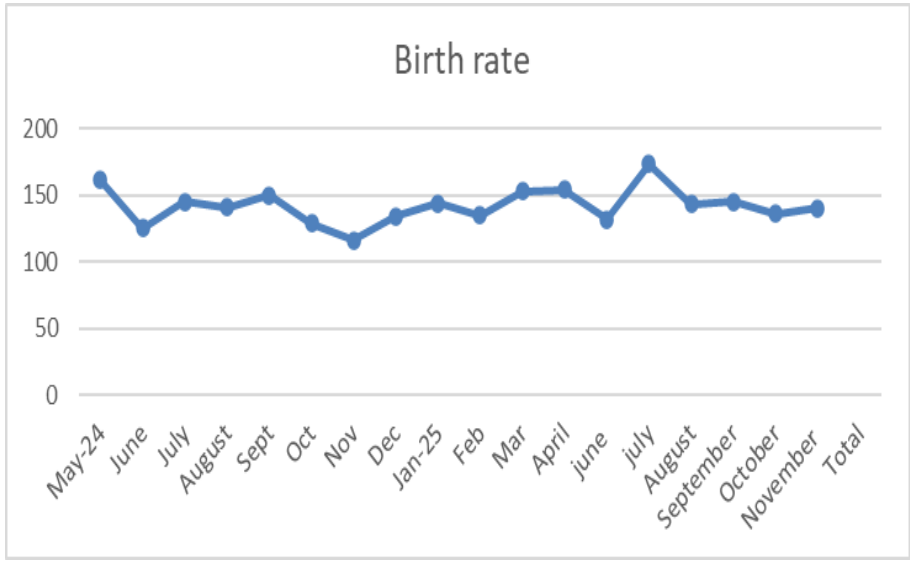
Quality and Safety exception report - Metrics relating to the provision of quality maternity care

Torbay and South Devon NHS Foundation Trust

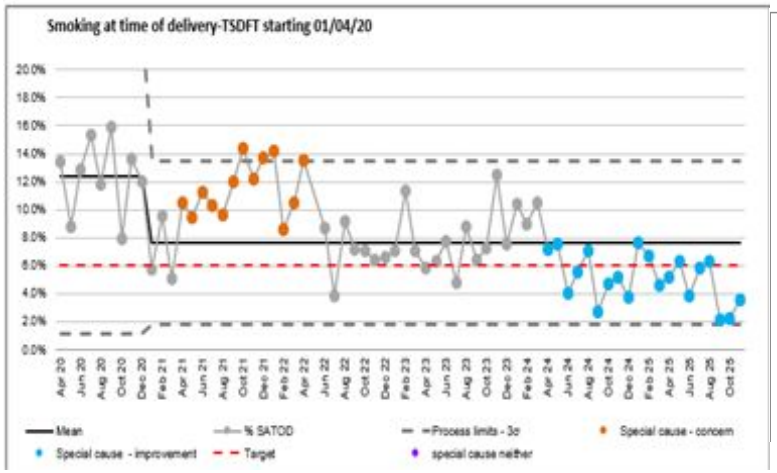


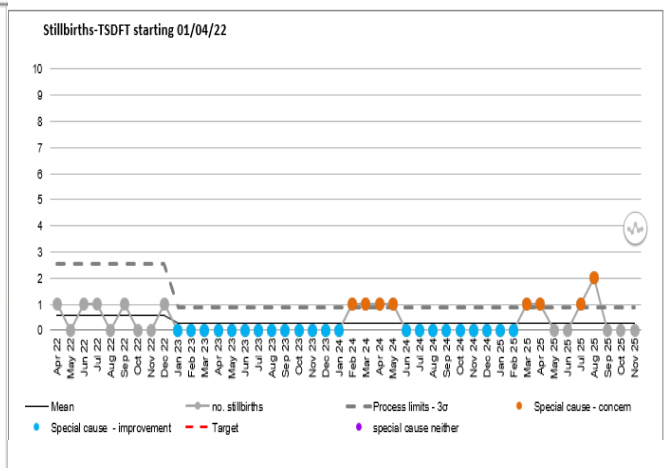


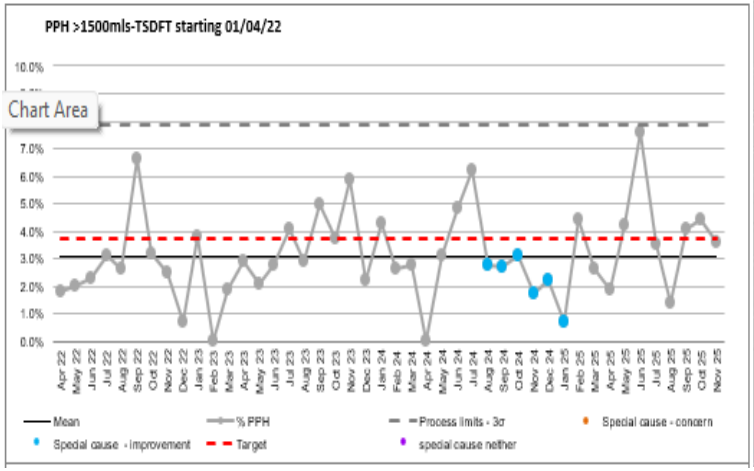


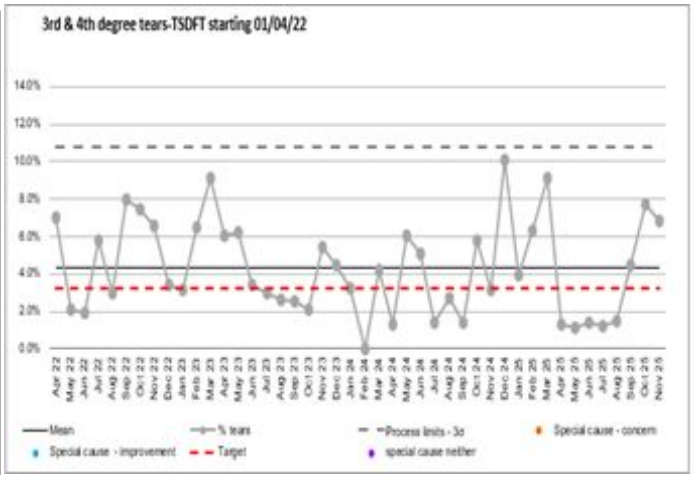


Quality and Safety exception report - Metrics relating to the provision of quality maternity care









- Births in November: 140
- Marginal increase for the month of November in smoking at delivery 3.6%; quarterly average of 2.7% well below the national average of 6%.
- Zero Stillbirths in the month of November.
- One Neonatal death and late fetal loss
- Decrease in the number of 3rd/4th degree to 6.8% % in November; quarterly average of 6.3%. NMPA target average is 3.2%
- PPH>1500mls down to 3.6% for November, quarterly average 4% marginally above the national target the national target of 3.7%.
- An increase in term baby admissions to SCBU to 7%; quarterly average of 6.17%; NMPA target is 5%. QI work in place to reduce rate- Screen and Treat at bedside.

Quality and Safety exception report – Stroke care

Torbay and South Devon NHS Foundation Trust

Data for October 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	Oct-25
Number of patients (N)		**42**	**50**	**46**	**50**	**46**	**56**	**55**	**62**	**54**	**50**	**58**	**53**	**54**
% 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%	27.3%
% 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%	49.1%
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	03:45
% 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%	88.9%
% 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%	5.50%
% (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)	10.9% (6)
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	00:58

In October:

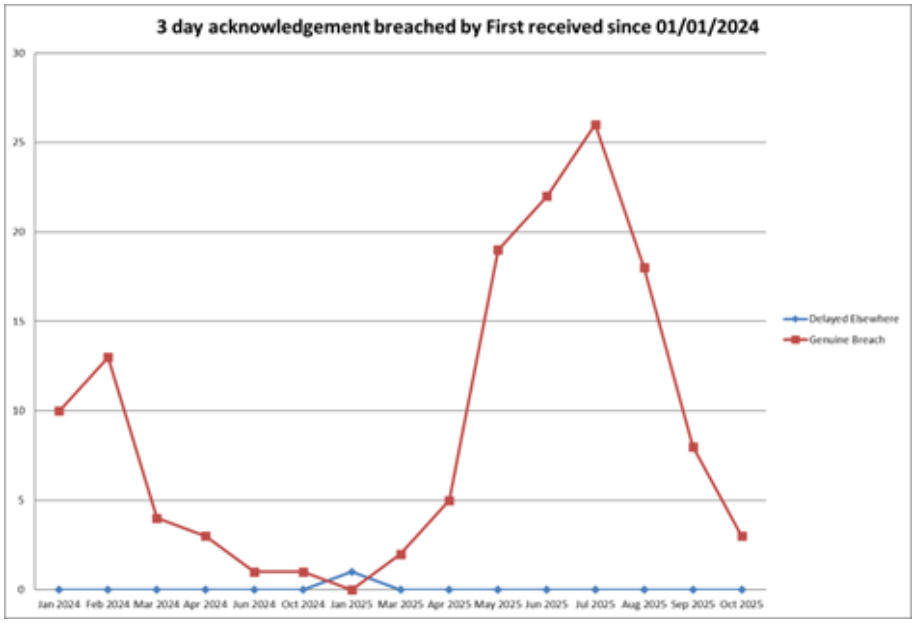
1. The proportion of patients being scanned in 20 minutes deteriorated and is below the national average.
2. The proportion of patients admitted to the Stroke Unit in 4 hours decreased slightly but remained broadly in line with the national average.
3. The median time to get to the stroke unit worsened by 5 minutes; 7 minutes faster than the national average.
4. Proportion of patients spending 90% of their time on a dedicated stroke unit improved and is above the national average.
5. Thrombolysis rate dipped and remains below the national average; 6 patients receiving this treatment in September.
6. The proportion of patients receiving a formal swallow assessment within 24 hours remains very low and significantly below the national average.

In the last month:

1. A Pathway mapping event was held on 21st November. Very well attended; output is being reviewed and next steps agreed.
2. Tenecteplase has been used for thrombolysis instead of Alteplase since 3rd November; this will support reduced time in ED.
3. CT Perfusion will be offered – during restricted hours initially – for extended window thrombectomy patients from 15th December
4. All the above are positive steps and in line with Dr David Hargroves' recommendations for change

Next month: Distilling information from pathway mapping event and meeting to be held to discuss how to improve the 4-hour to the stroke unit target.

Quality and Safety exception report – Feedback and engagement



Top complaint themes Nov 2025
Clinical treatment
Access to Treatment/ Service

Top compliment themes Nov 2025:
Clinical treatment

Complaint Metrics

The Trust is required to report on two complaint standard metrics;

- Acknowledge complaint within 3 working days
- Formal response within 6 months (internal deadline 12 weeks)

The Trust cannot accurately report on the quality standard for acknowledgement of complaints due to current the large volume of unactioned correspondence within the mailbox.

There are currently 605 emails within the Feedback mailbox (this includes email and telephone contacts.
156 are as considered duplicate contacts.
Approximately 70% of the mailbox content has not yet been processed.

A recovery plan has been produced to manage the existing backlog.

New oversight metrics to follow next month.

****Data collected 11.12.2025 – all data subject to change due to recategorisation and delayed processing**

Quality and Safety – Safer Staffing – Dashboard October 2025

Torbay and South Devon NHS Foundation Trust

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

Beds		Staffing Fill Rates				Actual Staffing Split				Care Hours Per Patient Day (CHPPD)										HR Metrics			Temporary Staffing	
		Days		Nights		Days		Nights		Days						Nights								
										RN / Midwives		Care Staff		Overall Day		RN / Midwives		Care Staff		Overall Night				
Establ. Beds	Bed Occ.	RN / Midwives	Care Staff	RN / Midwives	Care Staff	% RN / Midwives Hours	% Care Staff Hours	% RN / Midwives Hours	% Care Staff Hours	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Sickness Rate (Sep-25)	Turnover Rate	Vacancy Rate	Prop. Bank Hours	Prop. Agency Hours
518	95.3%	90.2%	96.8%	95.3%	103.2%	53.6%	46.4%	54.7%	45.3%	2.4	2.2 (–0.2)	2.0	1.9 (–0.1)	4.4	4.1 (–0.3)	1.9	1.8 (–0.1)	1.4	1.5 (+0.0)	3.3	3.3 (–0.0)	5.6%	8.7%	2.6%	12.2%	3.6%

CHPPD- Satisfactory Assurance

The Trust overall actual CHPPD for RN/Midwives in October 2025 is 4.0. This is slightly under the overall planned of 4.3. The overall Trust actual CHPPD for HCSW is 3.4. This matches the planned requirement of 3.4 this is a slight reduction on use from September due to reduced availability to support Enhanced Therapeutic Observations of Care. Work is underway to review the current ETOC provision and how this can be supported through SNCT establishments.

Octobers' data is within the NHSE suggested tolerance of 80-120% and within the TSDFT tolerance of 90-110% fill rates. RN numbers are at the lower end for the days at 90.2% but for the nights 95.3% both static with September's figures. Care staff fill rates on day shifts are 96.8% and nights are at 103.2%, night figures static with September whilst day has seen a slight improvement. Fill rates have been better through the month of October.

The last 5 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 and 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.

Community and Social Care Indicators - Summary of key metrics

Torbay and South Devon NHS Foundation Trust

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

Opiate users - % successful completions of treatment (quarterly - 1 quarter in arrears)		
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		
Community Hospital - Admissions (non-stroke)		
Community Hospital average Length of Stay (days)		⬆
Community Hospital patient discharges pre-noon		⬆
Urgent Community Response 2 hours		⬆
Domiciliary Care hours per week – total demand		
Domiciliary Care hours per week – % outstanding	Month 7	⬇
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

Torbay and South Devon NHS Foundation Trust

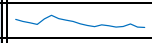
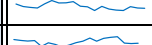
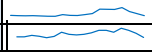
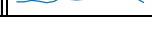
Key									
↑ = Performance improved from previous month ↓ = performance deteriorated from previous month ↔ = no change									
	Not achieved		Under-achieved		Achieved		No target set		Data not available		NHSI Indicator

Cancer – 2 week wait from referral to date first seen – regional reporting		↑
Cancer – 28-day faster diagnosis standard		↑
Cancer - 31-day wait from decision to treat to treatment - national reporting		↑
Cancer - 62-day wait for treatment - national reporting		↑
Cancer - Patient waiting longer than 104 days from 2 week wait		↔
Referral to treatment - % Incomplete pathways less than 18 weeks		↓
RTT 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		↑

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Torbay and South Devon NHS
NHS Foundation Trust

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Operational Plan trajectory Nov 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			3275	3108	2532	1625	1268	839	1530	1159	725	943	1823	810	624	1821
Average handover time (mins)	45 mins		109	95	84	62	47	36	52	45	32	38	60	33	29	42mins
Total average time in ED (hours/minutes)			06:18	06:17	06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		854	793	818	677	615	415	688	494	457	426	655	585	549	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		12.6%	12.8%	13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.8%	8.4%
UEC 4-hour target (RAG against local trajectory to national target)	78%		67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	72.6%
% patient discharges pre-noon	33%		22.3%	20.4%	19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		9.5%	6.6%	8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	5%
Elective recovery																
RTT 78 week wait incomplete pathway	0		6	0	12	14	7	4	8	8	9	16	13	16	9	0
RTT 65 week wait incomplete pathway	0		239	229	204	215	141	145	126	95	97	105	110	109	84	3
RTT 52 week wait incomplete pathway	268		1276	1265	1238	1209	931	914	805	740	615	618	615	647	607	505
RTT % Incomplete pathways <18 wks	66.8%		61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	65.1%
RTT Wait for first appointment <18 weeks	70.3%		65.3%	64.6%	63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	68.8%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		71.5%	82.1%	75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	75.0%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	76.7%
Cancer: No of patients waiting >62 days to start treatment	138		77	110	95	94	111	133	225	223	220	257	176	132	91	138
Cancer: % of patients > 62 days to start treatment	tbc		5.0%	7.0%	6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	tbc

RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory

Torbay and South Devon NHS Foundation Trust

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Performance Report - November 2025

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Severe	Trustwide	<6		0	2	4	2	4	2	7	2	3	5	4	2	4	29
Reported Incidents - Death	Trustwide	<1		0	2	1	1	3	3	2	1	1	2	0	0	1	10
Medication errors resulting in moderate harm	Trustwide	<1		0	0	0	0	0	2	1	0	0	0	0	1	2	6
Medication errors - Total reported incidents	Trustwide	N/A		50	47	57	45	55	42	43	61	63	53	44	56	45	407
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)	Trustwide				28	27	25	24	24	36	26	29	20	27	30	22	
Never Events	Trustwide	<1		0	0	1	0	0	1	0	0	0	0	0	0	0	1
Strategic Executive Information System (STEIS) (PSII)	Trustwide	<1		0	0	1	0	2	4	2	0	0	1	3	1	0	11
QUEST (Quality Effectiveness Safety Trigger Tool Red rated areas / teams	Trustwide	<1		0	0	0	0	1	1	0	1	0	0	0	0	1	3
Formal complaints - Number received	Trustwide	20		18	13	18	11	20	20	30	33	45	27	15	17	4	191
VTE - Risk Assessment on Admission (acute)	Trustwide	>95%		95.6%	93.1%	95.1%	94.7%	94.0%	95.7%	96.0%	95.6%	96.2%	93.3%	95.8%	95.4%	94.2%	95.4%
VTE - Risk Assessment on Admission (Community)	Trustwide	>95%		84.8%	82.7%	97.5%	98.6%	87.3%	87.5%	100.0%	90.0%	95.5%	90.5%	83.9%	81.0%	83.9%	91.5%
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		106.1	105.7	106.2	106.5	104.7	104.6	103.7	104	103.6					
Safer staffing - ICO - Day time	Trustwide	90% - 110%		90.4%	89.3%	88.2%	87.8%	89.6%	93.6%	91.5%	92.4%	93.0%	90.9%	91.2%	90.2%		
Safer staffing - ICO - Night time	Trustwide	90% - 110%		93.0%	91.5%	91.5%	93.1%	94.1%	93.2%	91.8%	94.0%	94.6%	94.4%	95.1%	95.3%		
Bed capacity impacted by Infection Control (Acute beds closed in month)	Trustwide	<100		24	174	358	418	360	28	29	105	0	170	18	47	61	458
Hand Hygiene	Trustwide	>95%		95.6%	96.0%	97.3%	96.4%	95.0%	93.0%	94.3%	92.7%	94.3%	96.5%	92.8%	96.2%	97.5%	
Number of Clostridium Difficile cases (COHA+HOHA)	Trustwide	<3		9	7	1	2	6	10	7	2	3	12	4	8	4	50
CDiff - Hospital Onset Healthcare Associated (HOHA)	Trustwide			9	4	1	2	4	5	4	1	2	7	4	3	3	29
CDiff - Community Onset Healthcare Associated (COHA)	Trustwide			0	3	0	0	2	5	3	1	1	5	0	5	1	21
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		81.1%	71.9%	75.6%	75.0%	73.2%	46.5%	70.7%	61.8%	68.1%	47.4%	55.0%	70.3%		
Stroke patients spending 90% of time on a stroke ward	Trustwide	>80%		71.0%	59.0%	71.4%	69.0%	83.6%	69.1%	77.4%	81.0%	78.9%	81.0%	81.0%	88.9%		
Mixed Sex Accommodation breaches	Trustwide	0		174	123	125	112	163	208	94	265	200	124	220	190	160	1461
Follow ups 6 weeks past to be seen date	Trustwide	6400		17689	19036	17997	18005	17361	18380	17843	18040	18486	19016	18135	16900	17610	
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.1%	5.1%	5.1%			
Appraisal Completeness	Trustwide	>90%		78.6%	78.8%	78.8%	78.5%	79.6%	78.9%	79.8%	79.5%	80.2%	80.5%	80.5%	80.5%		
Mandatory Training Compliance	Trustwide	>85%		88.8%	88.8%	88.6%	88.7%	89.0%	89.0%	84.7%	85.3%	85.0%	85.4%	85.5%	86.2%		
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.8%	11.0%	10.9%	11.2%	11.1%	11.3%	11.0%	11.0%	10.9%	10.9%	10.8%	10.8%		
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		18.2%	17.9%	17.9%	18.1%	18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.2%
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%			6.4%						5.7%			6.9%			
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET							642	658	631	612	568	526	515	503	

Torbay and South Devon NHS Foundation Trust

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Performance Report - November 2025

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Year to date
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		266	266	329	270	273	239	240	223	235	199	215	264	229	1844
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		186	201	194	193	221	204	202	204	211	168	190	241	208	1628
Community Hospital Length of Stay (days) - (general)	Community Hospital	NONE SET		14.9	13.4	14.8	14.0	13.2	13.9	14.2	13.4	14.3	15.5	15.7	13.9	12.9	14.2
Community Hospital % patient discharges pre-noon	Community Hospital	33%		57.0%	56.0%	52.0%	55.0%	50.0%	50.0%	47.0%	47.0%	49.0%	50.0%	48.0%	45.0%	47.0%	
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	80% ICB target		88.0%	88.6%	91.5%	89.5%	87.4%	87.7%	88.8%	87.8%	89.9%	85.8%	90.0%	91.3%	92.7%	88.9%
Urgent Community Reponse (2 hour) - Number of referrals	Trustwide	157		249	202	236	181	215	219	197	172	227	232	251	299	220	1817
Domiciliary hours per week - total demand (Health and Social Care) (one month in arrears)	Community	NONE SET		15198	14801	14794	15261	16860	15626	15205	14883	14122	13836	13575	13227		
Domiciliary hours per week - % outstanding (Health and Social Care) (one month in arrears)	Community	NONE SET		0.4%	0.4%	0.1%	0.9%	0.3%	0.1%	0.2%	0.5%	0.0%	0.3%	0.6%	1.0%		
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		31.3	30.0	28.7	28.7	30.0	26.1	23.5	20.9	31.1	24.6	24.6	24.6	24.6	24.6
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		870.4	862.5	820.3	830.8	907.3	772.8	778.1	783.4	750.6	721.9	687.9	737.6	742.8	742.8
Proportion of clients receiving direct payments	Trustwide	25%		18.2%	17.9%	17.9%	18.1%	18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.2%
% reablement episodes not followed by long term SC support	Trustwide	83%		86.9%	86.8%	87.0%	86.6%	86.2%	86.1%	86.9%	88.3%	89.1%	88.8%	88.9%	88.6%	88.9%	88.9%
PERFORMANCE FRAMEWORK																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		42.7%	38.5%	59.4%	65.4%	62.6%	38.5%	33.5%	31.7%	31.7%	24.9%	30.9%	38.0%	38.9%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		96.7%	94.2%	92.3%	91.1%	91.7%	89.9%	93.3%	90.7%	91.4%	88.9%	91.4%	91.1%	93.1%	
Cancer - 62-day wait for treatment - national reporting (2024/25 target 70%) (2025/26 target 75%)	Trustwide	75%		81.3%	77.3%	74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		7	11	18	17	19	26	22	52	24	28	29	21	21	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		61.6%	61.6%	61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	
On the day cancellations for elective operations	Trustwide	<0.8%		0.8%	0.6%	0.9%	1.4%	0.8%	0.9%	0.8%	1.3%	1.3%	1.1%	0.7%	0.8%	0.7%	
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		10	3	1	0	3	3	5	11	21	11	11	17	17	
Theatre Utilisation	Trustwide	85%		69.2%	81.9%	80.7%	84.6%	83.1%	82.7%	83.2%	81.1%	76.7%	82.3%	82.7%	83.2%	81.8%	
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		16.9%	17.3%	17.5%	16.5%	16.3%	17.0%	15.7%	16.2%	15.9%	16.7%	15.9%	14.6%	15.6%	
Bed Occupancy	Acute	90%		97.4%	95.0%	96.7%	96.0%	95.8%	95.2%	95.9%	96.1%	96.0%	95.3%	96.8%	96.7%	96.5%	
% patient discharges pre-5pm	Acute	75%		73.8%	66.5%	69.9%	70.4%	73.0%	71.8%	71.0%	72.6%	75.3%	71.4%	68.3%	66.0%	68.8%	
Percentage of inpatients with No Criteria to Reside (Torbay GP registered patients)	Acute	<5%		10.0%	7.2%	7.7%	10.9%	6.9%	7.8%	8.7%	7.6%	8.8%	6.5%	9.3%	11.9%	7.8%	
Percentage of inpatients with No Criteria to Reside (South Devon GP registered patients)	Acute	<5%		12.3%	9.7%	12.6%	10.8%	10.0%	10.4%	8.4%	9.9%	9.7%	8.3%	10.0%	12.8%	10.6%	
Average length of stay (days) - discharges from main acute wards	Acute			6.5	6.5	6.3	6.5	5.8	6.0	5.9	5.9	5.9	5.9	6.1	5.3	5.0	
Number of patients >7 days LoS (daily average)	Acute	153		169.9	150.0	160.6	161.4	139.2	151.5	144.2	148.0	149.2	149.2	159.6	158.3	161.9	
Number of extended stay patients >21 days (daily average)	Acute	35		43.2	31.3	38.2	34.0	32.3	35.7	32.5	31.5	28.4	38.8	42.5	39.3	43.7	
Ambulance handover delays > 30 minutes	Acute			1235	1387	1243	1098	966	720	1122	951	716	804	1250	933	957	7453
Ambulance handover delays > 60 minutes	Acute	0		934	1001	850	679	521	307	601	531	302	390	764	203	121	3219
UEC - patients seen within 4 hours (2025/26 plan target 78%)	Trustwide	78%		67.3%	65.0%	66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	71.0%

Torbay and South Devon NHS Foundation Trust

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Performance Report - November 2025

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Year to date
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute			63.3%	62.6%	66.7%	67.6%	60.0%	63.3%	58.0%	58.7%	60.9%	63.7%	60.4%	65.3%	65.2%	
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute			25.0%	22.9%	27.6%	26.2%	24.2%	25.7%	28.3%	23.6%	22.0%	19.7%	25.6%	21.8%	21.3%	
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute			04:22	04:27	04:19	04:01	04:00	03:52	04:10	03:54	03:48	03:50	04:07	04:10	04:03	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute			10:22	10:13	10:12	09:51	08:25	07:12	08:59	08:04	07:08	07:05	08:58	08:15	08:05	
Diagnostic tests longer than the 6 week standard	Trustwide	5%		32.3%	37.3%	40.0%	31.7%	31.8%	32.4%	37.8%	34.0%	37.0%	37.0%	37.0%	29.0%	28.0%	
Dementia - Find - monthly report	Trustwide	>90%		n/a	86.6%	95.7%	97.2%	97.3%	96.2%	96.5%			97.7%	95.1%	94.9%	96.9%	95.9%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		81.5%	76.3%	83.0%	76.5%	77.5%	83.6%	81.9%	75.7%	80.0%	77.5%	77.8%	77.5%	71.4%	78.2%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		59.7%	65.9%	69.6%	64.0%	65.2%	67.5%	61.0%	64.6%	62.5%	60.8%	58.0%	60.6%	67.2%	62.9%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		70.7%	63.6%	75.4%	76.5%	65.6%	71.9%	68.1%	74.9%	76.0%	79.3%	72.2%	72.1%	74.4%	
ERF activity 2025/26 vs 2019/20 baseline																	
Day cases										116%	111%	117%	112%	120%	108%	100%	112%
Elective inpatient admissions										85%	80%	79%	94%	86%	87%	72%	86%
Admitted Patient Care Total										112%	108%	112%	110%	116%	106%	97%	109%
Outpatient - first appointment										98%	98%	97%	99%	114%	108%	106%	103%
Outpatient - first appointment with procedure										161%	146%	155%	172%	131%	130%	128%	146%
Outpatient - follow-up with procedure										151%	129%	136%	120%	117%	126%	135%	135%
Outpatient Appointment Total										121%	114%	117%	114%	117%	117%	118%	119%
ERF Income Grand Total (% above 2019/20)		114%								120%	114%	113%	112%	124%	113%	105%	116%
Non-ERF activity 2025/26 vs 2024/25																	
Non-elective admissions											106%	107%	102%	110%	110%	104%	105%
UEC attendances (Type 1 and 3)											103%	104%	105%	105%	106%	109%	105%
NHS I - FINANCE AND USE OF RESOURCES																	
Year-to-date revenue variance to plan	Trustwide												0.0%	0.0%	0.6%	-1.0%	
Year-to-date revenue variance to plan,excluding the impact of loss of DSF	Trustwide												0%	0%	0%		
Forecast revenue variance to plan	Trustwide												0.0%	0.0%	0.0%	0.0%	
Forecast revenue variance to plan, excluding the impact of loss of DSF	Trustwide												0%	0%	0%		
Forecast net unmitigated risk as a percentage of plan operating expenditure	Trustwide												0.0%	0.6%	0.5%	0.5%	
Recurrent forecast variance to planned underlying position	Trustwide												0.2%	0.0%	-2.3%	-2.3%	
Percentage of efficiency schems assessed as high risk	Trustwide												22%	7%	2%	1%	
Percentage efficiency delivey against plan year to date	Trustwide												116%	116%	107%	99%	
Percentage forecast recurrent efficiency delivery against plan	Trustwide												93%	75%	76%	75%	
Forecast cash support required from the system	Trustwide												Permanent	Permanent	None	None	
Year-to-date charge against CDEL as a percentage of forecast CDEL expenditure	Trustwide												26%	32%	33%	38%	
Funding approval status of schemes in forecast	Trustwide												60%	60%	72%	63%	
Forecast capital spend as a percentage of allocated system capital	Trustwide												0%	0%	0%	0%	

Torbay and South Devon NHS Foundation Trust

Board of Directors
Electronic Patient Record (EPR) Progress Report

Date of meeting	Date report produced
8th January 2026	29th December 2025

Author(s)		Report approved by	
Name and title:	Kevin Pirie EPR Lead	**Name and title:**	Adel Jones, Chief Operating Officer
Phone:	07901696807	**Date:**	29th December 2025
Email:	Kevin.pirie2@nhs.net		

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

Executive summary

This report summarises the progress of the One Devon EPR program.

At the 12th December the overall program status has been maintained at “Watch”, measured as 7/10 compared to an average Epic customer score of 6.7 / 10 at this stage of the program.

Progress of the electronic patient record (EPR) implementation:

Progress against Phase 2 of the program is assessed as “Watch” providing a Satisfactory level of assurance.

The programme remains at a status of *watch*. Although we are in a strong position with overall configuration, data migration and super user identification, we are behind with training registration and are at risk of decreasing scope or delaying the Beacon go-live for Torbay & South Devon NHS Foundation Trust (TSD) and Royal Devon University Healthcare NHS Foundation Trust (RDUH) due to delays with Oncology Protocol validation. See additional details in the December Progress Report Executive Summary - *Issues Needing Executive Intervention and Oversight*. (Appendix 1)

Beacon

Validation of the 718 chemotherapy regimens is off track for the 23rd February cutover, putting the 3 April Beacon go-live at RDUH and TSD at risk, this has been escalated to SRO's and a meeting is arranged with CMO's to secure immediate solutions.

Training Registration

TSD End User training registration is 45% complete against 80% expected, risking under filled classes for the 2 February start and jeopardising the ability to train all users before go live.

TSD Blood Transfusion

TSD Blood Transfusion LIMS integrations is at risk for go-live due to delays in validation and technical feasibility concerns.

Progress against other risks / issues / events.

120 Day Go Live Readiness Assessment (GLRA)

This event took place at TSD on Tuesday 9th December. It was the first in a series of 4 Readiness Assessments and the first opportunity for many of our Operational and Clinical teams to experience the GLRA process. The event went really well, senior Epic colleagues compared it very favourably with other 120-day GLRA at other organisations. The engagement of our Care Groups and Corporate areas was excellent and most importantly very open and honest about the challenges they are facing. A strong attendance from our Executive Team gave a very important message about our organisational ownership of the Epic program. We are now planning the 90-day event on the 13th January 2026..

Device Integration

Device Integration (DI) has improved to watch as TSD device scope has been finalised, Mindray delivered devices, and a device deployment plan is in place.

Staffing

Staffing and Certification decreases to watch as several configuration teams (Cadence, Springboard, Beaker, Stork, and TSD Change) are facing pressures of unexpected analyst team outages and only 18 of the 24 net new application roles have completed certification. To increase to good, our 1 Devon Configuration Lead will work with the Lead Configuration Managers to confirm suitable support plans for the teams with analyst outages.

Key Decisions

Decisions around End User Devices scope in the tower may be necessary when the Estates work on electrical load is completed.

Key Program risks

- Current recruitment controls may impact programme activity.
- 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:

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

Appendices

1.One Devon Monthly Progress Executive Summary report

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

Key recommendations and actions requested

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

It is recommended the Trust Board take significant assurance that progress is good and that strong foundations have been created. Two independent NHSE (FLD) assessments have described the program as “exemplar” This level of assurance is also based on the risks identified and the work being undertaken to mitigate these.

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

The EPR is the key enabler of clinical transformation in Torbay and South Devon. Using a single instance of the Epic EPR, transformation will take place across the entire Devon footprint strengthening our clinical and operational capacity and ability to deliver high quality care in line with “Our Plan for Better Care”. Epic will also allow the people of Devon to take more control of their healthcare pathways by providing digital access to their clinical pathway information.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	The EPR will support self-managed care and care closer to home.
Quality of services provided	The networked EPR enables standardisation of pathways based on best practice.
Sustainable and efficient use of resources	Providing efficient and best value services

Impact on BAF Objectives	
BAF Objective	**Impact**
Provision of Community and Care Services Delivered in Partnership	The networked EPR enables standardisation of pathways based on best practice and promotes and supports partnership working
Quality, Safety and Patient Experience	The networked EPR enables standardisation of pathways across Devon based on best practice.
Leadership and Governance	
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 variation. Reduced footprint of multiple paper based systems will enable better use of space Appropriate digital systems and supporting infrastructure ensures clinical and service delivery provided to the community by the Trust are not compromised Significantly reduces digital and cyber related risks associated with aging technology Use of hosted datacentres to the highest standards reduces the carbon footprint by between 3 and 5 times that of the legacy on-premise facilities)

Risk: Risk ID (as appropriate)	
Risk	**Risk ID**
Current IT systems and infrastructure will not meet future demands Computer hardware risks Computer infrastructure risks - Datacentres Failure to meet cybersecurity and information governance standards	1159, on Datix, no escalation 2830, on Datix, no escalation 2831, on Datix, no escalation 2838, on Datix, no escalation

External Standards affected by this report and associated risks

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

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

One Devon Monthly Progress Report

17 November – 12 December 2025

OVERALL PROJECT STATUS	OVERALL SCORE: **7.0/10.0**	
Watch	AVERAGE EPIC CUSTOMER SCORE FOR PHASE 2: **6.7/10.0**	GO-LIVE DATES: 3 April 2026 (TSD) & 23 July 2026 (UHP)

Appendix 1

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 *watch*. Although we are in a strong position with overall configuration, data migration and super user identification, we are behind with training registration, do not have a Blood LIMS plan for UHP, and are at risk of decreasing scope or delaying the Beacon go-live for TSD and RDUH due to delays with Oncology Protocol validation. See additional details below in *Issues Needing Executive Intervention and Oversight*.

Configuration teams completed 83% of an expected 92% of Build Waves 1–6, 98% of application testing, passed 100% of integrated testing scripts for Round 1 & 2 and are on track to complete Round 3 by 5 January. Integration and data migration teams continued full-scale validation with strong engagement from clinicians and operations to ensure staff will be able to access the historical information needed to provide safe and efficient care at go-live.

Super user training started this month and 298 super users have completed training as of 12 December. Registration for end user training began on 10 November, with 45% of an expected 80% complete. It is critical to stay on track with registration to ensure initial classes are filled, maximising classroom and trainer capacity and avoiding the need to add additional sessions later in the training phase.

We held our first enterprise Go-Live Readiness Assessment on 9 December at TSD. This was attended by 44 clinical and operational leaders from across the trust and provided a venue to focus on risk mitigation and service readiness for the organisation.

Next month, the configuration team will complete specialty build and finish integrated testing. Training will continue for trainers and super users and the change teams will engaged with the organisation to start implementing high risk change plans. 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 increase to a good status, One Devon must complete the actions identified in Issues Needing Executive Intervention and Oversight and:

1. Complete 80% of Round 1 of Submission Patient Management Testing (SPMT) to ensure we are on track to test our reporting submissions ahead of the 3 April go-live.
2. Schedule TSD core readiness activities for all core areas and users by 9 January.

Issues Needing Executive Intervention

Validation of the 718 chemotherapy regimens is off track for the 23 February cutover, putting the 3 April Beacon go-live at RDUH and TSD at risk. Consultant prescribers have validated 150 of an expected 224 protocols and pharmacists have completed second sign-off on 1 of an expected 58 protocols. These delays are a result of consultant availability and pharmacists refusing to commence with second checks due to guidelines not being signed off by individual trusts. To mitigate risks and ensure validation is completed prior to cutover, Adrian Harris will work with CMOs to create a plan that ensures capacity is released for consultants to complete 57 validations per week and each trust must validate guidelines by 19 December or agree to proceed with second checks prior to validation. CMOs must also agree that if consultant validation is below 50% or second-check below 40% by 9 January, regimens prescribed fewer than five times in 2025 will be removed from scope.

Epic

One Devon Monthly Progress Report

17 November – 12 December 2025

One Devon EPR
Transforming care together

Issues Needing Executive Oversight

TSD End User training registration is 45% complete against 80% expected, risking under filled classes for the 2 February start and jeopardising the ability to train all users before go live. The delay is primarily due to inaccurate staffing roles identified during manager validation, which impacted training maps and slowed user registration. Helen Vigne and Guy Boosey are working with managers to correct role data and drive uptake through simplified training maps, drop-ins, and increased booking support via Hive, aiming to reach 80% by December 19. Richard Collins will escalate to Adel Jones by December 22 for additional intervention if training registration remains below target.

UHP has identified core functionality concerns with Haemonetics SafeTrace that cannot be mitigated without a system upgrade, which is not feasible before the planned July go live. These limitations pose risk specifically for UHP because the system does not support UHP's required ABO compatibility and sample validity workflows, and the operational changes needed to work around these gaps have been reviewed but are not clinically or operationally viable for UHP. To address this, UHP is exploring remaining on the current APEX LIMS. while the integration team simultaneously investigates a reduced or non integrated approach. Tim McLean will work with the Anjula Mehta and clinical teams to confirm by 19 December whether UHP will move away from SafeTrace for go live, after which John Flippance and Steph Reynolds will begin interface configuration, scope analysis, and testing by 9 January to progress the selected alternative solution.

TSD Blood Transfusion LIMS integrations is at risk for go-live due to delays in validation and technical feasibility concerns. Steve Mills, Alistair Penny and Julia Pinder began Haemonetics-Epic validation, currently at 12% of expected 25%. By 19 January, Steve Mills and Julia Pinder must complete 50% validation, including with BloodTrack, otherwise TSD will reduce integration scope to ADT-only for go-live.

Epic

One Devon Monthly Progress Report

17 November – 12 December 2025

One Devon EPR
Transforming care together

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	Clinical Specialty Review
Benefits Realisation	Business Continuity Planning	Interoperability	Cutover
Admin Specialty Review			

STATUS KEY							
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
●	◐	▲	◆	◆	N/A	↑	↓

Epic

One Devon Monthly Progress Report

17 November – 12 December 2025

One Devon EPR
Transforming care together

PROJECT ASSESSMENT – AREAS OFF TRACK		
CROSS APPLICATION AREAS		
Admin Specialty Review	↓◆	Admin specialty review returns to serious as the team completed 70% of critical template build (81% non AHP, 12% AHP) by the 19 December deadline, but the unexpected loss of a key analyst has created significant delivery risk. Mitigations are in place, including weekly turbo rooms, workload reassignment, recruitment of a replacement and escalation of engagement blockers with IO teams, though handover time remains a major constraint. To improve, the team must complete 100% of non AHP and 25% of AHP critical template build by 19 December.
Materials Management	◆	Materials Management remains serious as procurement will not be able to load the required supply data into the TSD and RDUH Genesis environments by go-live, requiring an import from Nexus. To increase to watch, Pete Sewell and Debra Nicholson will map data points from Nexus to Epic by 22 December. Sarah Rundle, Deborah Vale, and David Brown will complete supply clean-up for orthopaedics by 9 January and import TSD orthopaedic supplies by 16 January.
Interoperability	▲	Interoperability remains at watch as the EpicCare Link legal agreements did not go to Compliance Advisory Council, although they need to be updated to reflect the recent change in Epic-Care Link scope to include referral functionality for Livewell. These agreements are necessary to provision non trust users access to Epic-Care Link, so Simon Hasnip cannot begin onboarding site administrators in January until they go to the Advisory Council. Dan Bristow will determine plan to update the agreements with Simon, James Fellows, and Hanna Kruisbrink by 19 December.
Testing	▲	Testing remains at watch, with application testing 98 percent complete (17 scripts outstanding) and integrated testing 81 percent complete (11 scripts remaining). Mapped Record Testing has improved but is still off track, with only 13 percent of unique interfaces and 47 percent of records tested against the 65 percent target. To increase to good, all application teams must complete 100 percent of application scripts and 80 percent of Mapped Record Testing, as well as all round three TSD integrated scripts, by 30 December.
Day Cases	▲	Day Cases remains at watch, as; 18 of 48 departments passed testing. 30 departments are ready to retest as the day case functional area leads did outstanding data collection and build for previously failed departments. To improve to good, the team must test an average of 10 departments a week to complete testing by 19 December. Zoe Barbeary, Roxana Pristavu, and Matthew Hamlyn should complete the 10 remaining build wave 6 day case tasks by 23 January.
Benefits	▲	Benefits realisation remains at watch as the team has not yet completed its review of at risk benefits or assessed impacts on first year post live delivery. The team has consolidated all cash releasing benefit profiles into a single tracker and application managers are reviewing expected trajectories and the effort required to recover those at risk. To return to good, the team will complete its initial CRB review and escalate concerns by 17 December, finalise benefit quantification with Finance by 19 December, and define measurement and reporting approaches for go live by the same date.
Interfaces	▲	Interfaces remains at watch. With 216 interface test scripts still incomplete for the April go-live, testing will extend into Q1 2026. This creates bandwidth constraints for teams

STATUS KEY							
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
●	◐	▲	◆	◆	N/A	↑	↓

		responsible for managing testing, cutover planning, and production readiness updates in Epic and the integration engines (TIEs) during the three-month ramp-up to go-live. Additionally, suppliers cannot complete their PRD readiness preparations until the system's interface testing and MRT are complete, increasing the risk of third-parties not having PRD readiness complete in time for go-live. The team will prioritise completing testing required for the April go-live by 30 January. See issues needing executive oversight for more on Haemonetics.
Technical	▲	Technical remains at watch, with several areas off track. Device ordering is over six weeks behind schedule, with only 63 percent of expected TSD orders and none of the expected 50 percent for UHP completed, and deployment is significantly delayed, with 71 percent of TDR critical devices deployed against a 90 percent target. Hosting also remains at watch due to unresolved network concerns at UHP, and these delays collectively put timely deployment ahead of TDR at risk. Ada will work with Kathleen to complete all ordering for fixed devices at TSD and 50% of TDR-critical devices at UHP, and Jordan Goss will complete all TDR-critical deployment by 31 December to allow Pilot TDR to begin on 5 January. Jedidiah Heathcote will complete a plan for ISCV testing without the originally scoped domain trust by 2 January.
Business Intelligence	▲	Business Intelligence remains at watch as TSD and UHP teams still cannot access the shared out of Epic data warehouse, preventing development of key Tableau reporting content. ARLs have completed 89 percent of required end user reporting build against an expected 100 percent, and go live essential Caboodle and Clarity development is also behind plan at 71 percent versus 81 percent expected. In addition, lack of agreement across RDUH, TSD and UHP on how to treat AHP activity in Community and Outpatient datasets has stalled required CSDS build. To get back to good, the programme must restore data warehouse access, complete outstanding reporting and platform build, and reach agreement on the CSDS approach.
Clinical Specialty Review	▲	Clinical Specialty Review remains at watch as wave two specialty data collection is overdue, and analysts have completed 43% of an expected 80% of functional build and 55% of an expected 70% of assessment and questionnaire build. To increase to good, UHP and TSD IOs must finalise all specialty review wave two data collection by 5 January, and analysts must complete 100% of functional build and 90% or assessment and questionnaire build by 19 December.
Staffing	↓▲	Staffing and Certification decreases to watch as several configuration teams (Cadence, Springboard, Beaker, Stork, and TSD Change) are facing pressures of unexpected analyst team outages and only 18 of the 24 net new application roles have completed certification. To increase to good, Jason Scott will work with the Lead Configuration Managers to confirm suitable support plans for the teams with analyst outages.
Device Integration	↑▲	Device Integration (DI) increases to watch as TSD device scope was finalised, Mindray delivered devices, and a device deployment plan is in place. Variable testing is at 51% of an expected 84% complete and device build is at 61% of an expected 100%. To improve to good, Harrison Kirwin will complete anaesthesia variable testing by 18 December. Amy Johnson will complete 50% ED variable testing by 22 December. Harrison, Amy, and Claire-Marie Hunt will build patient monitor and anaesthetic carts by 15 December. Gary Price and Darren Russell will deploy 100% of new TSD Mindray devices by 6 January.

STATUS KEY							
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
●	◐	▲	◆	◆	N/A	↑	↓

Epic

One Devon Monthly Progress Report

17 November – 12 December 2025

One Devon EPR
Transforming care together

Application Areas		
Beacon Protocol Build & Validation	◆	*See issues needing executive intervention for more.*
Patient Letters Content Collection	◆	Patient Access/Springboard remain serious, as admin letters build has yet to be started by Synertec due to outstanding information required from both trusts. To increase to good, Mia Jones and Gemma Taylor will ensure their trusts have completed all returned information required by Synertec to begin their admin letter build in earnest by 19 December to ensure that Syndertec has time to build the content on agreed, but already reduced timeline of 4 weeks. This allows then time for testing ahead of the April go-live.
Clin Doc & Stork Testing	▲	Clin Doc and Stork remains at watch due to outstanding testing. Stork has been unable to progress mapped record testing for Viewpoint ultrasounds, key workflows remain untested because of incomplete order question and scheduling build, and code testing is at 0 percent against a 100 percent target. To get back to good, the team must complete application and mapped record testing, resolve blocking build issues, and progress code testing and workflow build to planned levels.
Same Day Emergency Care (SDEC Build)	▲	ASAP remains at watch as Same Day Emergency Care (SDEC) configuration is at 49% of an expected 100% complete. This has resulted in delays to application testing, and delays in the creation of SDEC training materials. To remain at watch, Francis Mimmack will work with the configuration team to complete SDEC workflow build by 18 December.
Beaker	▲	Beaker remains at watch as the GP/Community Collect workflow for TSD is undefined, impacting clarity on process for GPs to collect bloods on behalf of the Trust at go-live. Additionally, UHP Instrument Manager MRT and clinical content validation (CCV) testing are off track, risking completion by February and shortening time available for readiness activities. UHP ICE build is off track due to delays in Clinisys test imports, shortening timeline for manual build and risking 8 January planned MRT start date. To improve to good, the labs, pathology IT, and Beaker teams should complete 80% of IM MRT by 9 January. Clive Keys will work with Michelle Collins, Tony Lowe, and Claire Stacey to outline all options for GP/Community Collect by 9 January and bring options to Joanne Watson and Mike Green by 16 January for a final decision.
Chemotherapy Mixture Validation	▲	Willow remains at watch as chemotherapy mixture and worksheet validation are off-track to complete validation due to pharmacy resource constraints at TSD and RDUH. Aseptic validation timelines moved back to 30 January, as a result 44% of an expected 66% medications have been approved. General mixture medication validation is now at 40% of an expected 48% of medications validated and the team is confident they will be able to meet the new revised timelines. To increase to good, the Willow and pharmacy teams will validate 77% of mixture medications and worksheets, by 19 December.
Cupid Third Parties & Data Quality Concerns	▲	Cupid remains at watch due to unresolved vendor support for ISCV and ECGs for the April go-live and the lack of agreement for a UHP domain trust, which is required for ISCV access. Data quality issues in TSD appointment records hinder mapping from discrete procedure values, risking failed automatic conversions and substantial manual effort, while limited cardiologist engagement at RDUH delays structured reporting and content validation. To increase to good, the Cupid team will work with Josh Langdon and Richard Collins to establish agreement for domain trust between UHP and

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Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
●	◐	▲	◆	◆	N/A	↑	↓

		RDUH/TSD and finalise plans for third-party vendor support for the April go-live by 15 December.
TSD & UHP Compass Rose Build & Testing	⚠	Dorothy and Compass Rose remain at watch. The team is behind on build and training for TSD and UHP, but plans are in place to get back on track. To increase to good, the team will complete 100% of build wave 6 by 17 December.
OpTime Build and Training	⚠	OpTime and Anaesthesia remains at watch, as POA content build is not complete, MRT progress is behind schedule, and proceduralist authorisations and resource types have not been assigned in Production. To improve to good, Hugo Silva, Ali Phillips, and Mel Edwards will complete outstanding POA Triage Scoring build and reporting updates by 22 December.

STATUS KEY							
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
●	◐	⚠	◆	◆	N/A	↑	↓