Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors

Date: Thursday 5 March 2026

Time: 11.15 am -1.15 pm

The Boardroom, Hengrave House,
Torbay Hospital

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TSDFT Public Board of Directors

The Board Room - Hengrave House

05/03/2026 11:15 - 13:15

Torbay and South Devon NHS Foundation Trust

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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 12.30 PM ON THURSDAY 8TH JANUARY 2026

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
	Mrs N McMinn	Chief Nursing Officer
	Ms A Jones	Deputy Chief Executive/Chief Operating Officer
	Mr P Richards	Non-Executive Director
	Mr S Tapley	Chief Strategy and Planning Officer
	Mr R Williams	Non-Executive Director
In Attendance:	Mrs Val Browning	Governor
	Ms Becky Chown	Fundraising Manager (for item 04/01/26)
	Mrs S Fox	Corporate Governance Manager
	Mrs Annie Hall	Member of the Public
	Ms J Harris	Associate Director for Communications and Partnership (for item 04/01/26)
	Mr Mike Joyce	Governor
	Mrs J Piper	Acting Chief People Officer
	Mr Andrew Postlethwaite	Governor
	Mrs Alison Ramon	Governor
	Mrs A Williams	System Improvement Director
	Mr Vincent Williams	Governor

WELCOME AND INTRODUCTIONS

01/01/26 The Chairman welcomed all those in attendance.

PRELIMINARY MATTERS

02/01/26 **Apologies for Absence, Quoracy and Declarations of Interest**

An apology for absence was received from Chris Saxby, Non-Executive Director and Emily Long, Director of Corporate Governance and Trust Secretary. The Chair confirmed the meeting as quorate.

03/01/26 **Unconfirmed Minutes of the Meeting held on 24 September 2025**

The Board received the minutes of the meeting held on 26 November 2025, circulated with the agenda pack. The action log was reviewed, and updates were received on outstanding actions.

One amendment was noted in the minutes, in the last bullet point of page 4: 'Concern was raised around the time it was taking to make a decision in respect of the future of Dawlish Hospital' to be amended to read: 'Concern was raised around the time it was taking to make a decision in respect of the future of Dawlish Hospital MIU'. *(post meeting note – actioned)*

The Board APPROVED the Unconfirmed Minutes from the Public Board meeting held on 26 November 2025 as a true and correct record, noting the amendment agreed detailed above.

04/01/26 **Patient Story**

The patient story was a video that detailed the work of the Trust's Charity during 2024/25 and presentation of the Charity Impact Report for 2024/25. The following was discussed:

- In 2026 the Charity would have been in existence for 30 years.
- In 2024/25 the Charity had raised over £383,000 enabling a wide range of improvements to be provided for patients, families and staff.
- Improvements included refurbishment of the maternity bereavement room; installation of light boxes in windowless clinical assessment rooms; and partnerships with local artists and the Trust's HeArts team.
- Other impacts included the opening of the Organ Donation Memorial, which was partly funded by the Charity, and the transformation of the Lousia Cary Ward.
- More recently a bid had been submitted to NHS Charities Together for a work-based wellbeing grant to create wellbeing spaces for teams.
- The speed at which charitable funds were spent was queried. It was noted that some monies were spent very quickly, however for some projects that required, for example, a competitive process, it could take longer, or where there was a revenue consequence attached to the spend.
- It was noted that the Leagues of Friends (LoFs) had stated in the past that there had been frustration at the slow pace of procurement and JH was asked if she had experienced similar issues. JH said that she worked closely with the Procurement Team to navigate the system to ensure that projects were taken forward as quickly as possible. She also provided support to the LOFs in this respect.

In respect of the Charity's 2024/25 Annual Report and Accounts, the following was discussed:

- In the last year the Charity had exceeded its fundraising target and thanks were placed on recorded to Jane Harris and the Charity Team for their work to achieve this.
- Thanks were also placed on record to Siân Walker-McAlliser, the previous chair of the Charity Committee, for her work and support.

- The Board was reminded that much of the donations received by the Charity were personal donations and it was important this was reflected, alongside support from partners who donated, for example, to support the annual People Awards.
- The Charity also worked with charity partners outside of the Trust, for example to provide activities and respite for adult carers.
- The Board recognised the positive impact the work of the Charity has had on staff wellbeing and patient experience.
- The reach of the Charity was discussed. It was noted that, historically, it was used primarily as a mechanism to manage donations rather than actively seek donations or bid for funds. More recently funding had been used to publicise the Charity to support increased donations.
- The funding of staff supporting the Charity was queried. It was noted that the Charity Team costs were charged to the Charity, but other individuals' time, such as the Associate Director for Communications and Partnership, was not.
- It was suggested it would be helpful for the Board to understand those members of staff who were paid by the Charity compared to the funds raised.

05/01/26 **Report from the Chairman**

The Chair briefed the Board on the following:

- The Chair had made several visits since the last meeting including to the Digital Futures Team, where he had learnt that Epic would provide live monitoring to patients at home who were being overseen by the Virtual Ward. He asked if this was something that would be available to wards. KL confirmed that it was.
- A meeting of the Charity Committee with the Trust's LoFs had taken place. This had proved to be a positive meeting which noted many of the Leagues were struggling for members and might need to think differently about their structure in the future to continue to be able to fundraise.
- The Chair had visited the Pharmacy Team and seen the new robot in operation. The visit had highlighted the challenge some teams had when working out of spaces that were not fit for purpose, but needed to meet statutory requirements, for example the aseptic team.
- Other visits included to the security team; deep cleaning team; porters, a number of wards on Christmas day; dermatology team; and the switchboard team, noting their frustration when dealing with people who were not able to get hold of members of staff due to phones being on answerphone.
- Following the changes to the Board Sub-Committee structure, changes had been made to the Non-Executive membership of those committees, as follows:

Audit and Risk Committee

- Mark Greaves (Chair)
- Martin Beaman
- Liz Edwards-Smith
- Robert Williams

Finance and Operations Committee

- Robert Williams (Chair)
- Mark Greaves
- Paul Richards
- Chris Saxby

Quality and People Committee

- Martin Beaman (Chair)
- Liz Edwards-Smith
- Ashish Ghadiali
- Chris Saxby

Charity Committee

- Liz Edwards-Smith (Chair)
- Ashish Ghadiali
- Robert Williams

Non-Executive Director Nominations and Remuneration Committee

- Chris Balch (Chair)
- Martin Beaman
- Liz Edwards-Smith
- Paul Richards

The Board received and noted the Chairman's report.

06/01/26 **Chief Executive's Report**

The Board received the Chief Executive's report, circulated with the agenda pack.

Recovery Support Programme

Work continued to move towards exiting from the Recovery Support Programme (RSP). NHS England would be meeting on 24 February to consider those Trusts seeking to exit the RSP process. Before that meeting the Trust would be meeting with system and regional teams to review its progress and evidence. It was noted that although the Trust was not meeting all of the RSP exit criteria, it was performing better than many other Trusts who were part of the RSP process. It was not yet known how this might affect the decision made, however it was unlikely NHS England would want too many Trusts being part of the new performance programme and requiring intensive support.

Financial Challenge

The Devon system was facing a significant financial challenge moving into 2026/27 of c£300m. It would require system transformation to deliver the scale of savings required to meet the financial gap. It was not yet understood what level of intervention might be imposed on Trusts and systems that could not deliver a balanced financial plan.

Adult Social Care

The Chief Executive's report stated the cost of delivering service was £30m more than funding received, however this was understood to be £35m. It was noted that the final sum was impacted by some variation, however it was around £35m.

New Emergency Department

The Board was reminded that Governors had expressed concern around the proposed seating as part of the Emergency Department works, in that they felt the seats were too close together. RW informed the Board that he had visited the new department and the seating was comfortable and spacious.

The Board noted the report of the Chief Executive.

07/01/26 **Board Assurance Framework**

The Board received the Board Assurance Framework (BAF), circulated with the agenda pack and agreed to review it at the end of meeting to consider if any risks discussed needed to be reflected in the BAF.

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

FOR REVIEW

08/01/26 **Our Plan for Better Care**

The Board received the Our Plan for Better Care Report, circulated with the agenda pack. The following was discussed:

Leadership Programme

- This was on track noting the recent changes to the Board governance framework, in line with the well-led recommendations.

Strategy Programme

- The Strategy due to be presented to the Board in February.
- Epic go live was in c90 days.
- The Peninsula Acute Sustainability Programme (PASP) was currently on hold due to key members of the team leaving and moving to different roles.
- Discussions were underway to agree a way of continuing the important work of PASP.
- The Continuing Health Care contract negotiations were underway and the ICB would take over from 1st April 2026.
- The transfer of Child and Family Health Devon was being progressed and continued to be on plan to be delivered by the 31st March 2026.

Performance Programme

- Separate reports to the Board detailed the Trust's current performance and future trajectories.

Finance Programme

- The Board would receive the Finance Report later in the meeting, but was reminded of the financial risk it was holding and the mitigations in place.
- The procurement element of the programme was currently assessed as being red. As part of the outsourcing arrangements the Trust had not yet had sight of some of the contractual arrangements. ST and JC were working with an external advisor to understand the benefits that would be delivered and when.

People Programme

- This was being overseen by the People Committee and was on track to deliver its targets.
- The Epic implementation was discussed, the readiness for go live; performance management following go live; and tracking of benefits realisation. AJ informed the Board that a mechanism was in place to assess readiness for go live and Epic had well-defined criteria for success that the Trust would need to meet. A readiness assessment meeting with Epic was taking place later in the month to confirm the Trust's readiness. Operational teams were owning the readiness of their services and detailed plans from teams were provided to provide assurance for areas such as training.

- In respect of training, Epic recommended a need of 10% of users to be trained as 'super users'. The Trust has c19% which would offset the risk of attrition. Currently 95% of super users had either completed training or had training booked.
- 83% of end users had at least one session booked.
- Training information was provided on a regular basis and tested through the go live readiness assessment.
- In respect of performance management, the Trust had applied learning from those Trusts that had 'bounced back' quickly following implementation, and this would be discussed at the readiness meeting later in the month. One piece of learning was the importance of 'at the elbow' support to users when using the new system.
- It was recognised there would need to be other plans in place in case performance did not return to normal levels within the expected timeframes.
- Some teams were not used to using data to inform decision making as it had not been available in the past, work was therefore taking place to ensure they had support on how it would be expected to be used.
- Work was taking place around benefits realisation and in particular to ensure benefits were not double counted. At present the Trust was trying to hold, for example, administration vacancies as those posts would not be required post-implementation, but the impact of this was that in some cases clinics were not being booked quickly enough. There was currently less granularity around how bigger strategic benefits would be delivered and assurance was provided that this work was taking place.
- The biggest impact on benefits realisation was the removal of variation across pathways noting that reaching agreement across three organisations in this respect could be difficult.
- Concern was raised around the need for a robust infrastructure to support Epic, such as cybersecurity and the need for focus on these areas so that they were in place post-implementation. It was suggested the Board needed to have better oversight of these areas so that it could assure itself that arrangements were robust. AJ stated that she shared these concerns and that a business as usual workshop was taking place in the near future to address these issues and to ensure plans were aligned to the Epic programme. It had also been agreed more frequent presentations would be provided to the Executive Committee on this issue.
- The Board was informed that the Trust's cybersecurity lead had been asked to work with the national cybersecurity team to obtain external advice to support the decision making across the three trusts. It was agreed further assurance on this issue would be provided to the Board. **Action: AJ**
- The increase in headcount as stated in the report was queried. Work had taken place to understand the drivers impacting on the headcount increase, noting that it included staff who had transferred to the Epic team but not removed from the Trust's teams, also in some cases headcount had increased but costs reduced. It was recognised that there was a need to decide how to report workforce numbers to ensure the drivers were

understood. The Workforce and Finance teams were currently working on a dashboard to provide this information.

- It was recognised that this information needed to be finalised before the Trust submitted the Medium-Term Finance Plan in February.

The Board:

- **Noted the progress made during the reporting period;**
- **Acknowledged the risks to delivery and ongoing work required to improve the Trust's 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.**

REPORTS FROM BOARD SUB COMMITTEES, CHARITY AND SUBSIDIARIES

09/01/26 **Charity Committee**

The Committee received the Charity Committee Chair's report noting work taking place to consider the option of transferring the Charity's cash holdings to a liquidity fund to maximise short term returns and the work to review the Charity's governance documents. The positive returns from the Charity's investment portfolio were noted.

10/01/26 **People Committee**

The Board received the People Committee Chair's report noting concern that the Trust's workforce controls did not seem to be effective, evidenced by the Break Glass panel approving 525 of the 586 reviewed roles.

Planned compulsory redundancies had not been able to be enacted due to lack of assumed external funding.

The positive work of the workforce team was noted, in particular around the re-establishment of staff networks and positive GMC national training report. There were, however concerns around the grip and control of workforce numbers.

JT reported that learning over the last year had shown that a vacancy freeze was almost impossible to safely enact and this had impacted on, for example, the resource available to book clinics. It was recognised that there needed to be different solutions to reduce headcount. Teams needed to be given a headcount number and provide the service within that envelope. Following Epic implementation a review of the workforce would take place.

11/01/26 **Finance and Performance Committee**

The Board was briefed on the need to ensure there was robust oversight and governance attached to the CIP programme, with the suggestion the Star Chamber process was reinstated.

12/01/26 **Operational Performance Report**

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

Urgent and Emergency Care

- In December four hour performance was 70.9%, with 9% of patients waiting over 23 hours which was below the target of 10%.
- In January the four hour performance was currently 68.84% reflecting the current challenging operational environment due to high levels of patients

being admitted with infections; bank holidays and high patient acuity. This was a national picture.

- In December Ambulance Handover times had reduced to an average of 27 minutes, despite a 12% increase in conveyances. This was the best performance since 2020. In January, however, the average had increased to 53 minutes, reflecting increased demand.
- Staff shortages in the new frailty unit had resulted in an unexpected impact on the Trust. Work was taking place to ensure the impact of any future staff sickness in the unit was mitigated.

Elective

- In December there were 76 patients waiting 65 weeks for treatment. By the end of the month this had increased to 88. This was particularly a challenge for Trauma and Orthopaedics.
- 52 week wait performance was currently rated as amber.
- Turnaround intervention in planned care had been agreed to improve performance.

Cancer

- The faster diagnostic standard had been met in December meaning the Trust should be able to exit Tier 2 oversight.

Diagnostics

- Performance remained challenging and work continued to improve the position.

The following was discussed:

- Noting the Trust had, for a period of time, been either in Opel 4 or a critical incident in terms of demand, performance in the community, particularly over the Christmas and New Year period was queried. AJ reported that it had been difficult to obtain a single version of the truth so a deep dive was taking place on this issue. She said that it was recognised domiciliary and nursing care places reduced over the Christmas and New Year period. There was a significant peak in assessment over the period, but also the Trust had a reduced number of staff to undertake referrals. It was agreed the outcome of the deep dive be reported to the Quality and People Committee. **Action: AJ**
- Frustration around simple discharges was discussed, noting there was evidence that showed the Trust placed too many people in social care which was a result of custom and practice and also accessed social care ways that other organisations did not. Work to change this practice was part of the Better Care Plan and Ward Optimisation Programme. It was noted that ideally, discharges would be criteria led, but this was something that Trusts had not been able to implement.
- It was agreed a report would be produced on the challenges faced by the Trust in terms of discharges, its patient mix, and benchmarking information and this be presented to the Quality and People Committee. **Action: AJ**

The Board received the report and agreed the recommended assurance ratings.

13/01/26 **Month 8 Finance Report**

The Board received the Month 8 Finance Report, circulated with the agenda pack. The following was discussed:

- It was noted the report contained an error in that the current gap to delivery of the end of year target was £2.9m not £1.9m.
- The Trust was reporting a year to date deficit of £16.2m which was a £5.1m variance to plan, due to the withdrawal of deficit support funding. It was expected this would be earned back in month 12.
- The gross risk to delivery had reduced from £18.9m to £13.9m due to the impact of recovery actions. Following other plans the current net risk to delivering the forecast outturn was £5.6m
- £21.7m of CIP savings had been delivered.
- An application for cash had been made to the national team. It was expected a decision would be made in the near future. If the Trust's application was not approved, it could make a further application in February.
- It was understood that University Hospitals Plymouth were likely to be reporting they were off plan which, alongside the difficulties being experienced by Royal Devon University Hospital Trust, could impact on the availability of deficit support funding in quarter 4.
- The deficit support funding the Trust expected to receive totalled £15m. The need for the Trust to be clear in its communications with the system and region that this was due to factors outside of its control was acknowledged. JC provided assurance that region fully understood the Trust's position and the drivers impacting on it.
- It was agreed the Chief Executive would formally write to the region to escalate the impact the lack of deficit support funding was having on its cash position, through no fault of its own, and the Board's concern around this position. **Action: JT**
  It was also suggested the Board start to report delivery of the financial plan with and without deficit support funding and this be escalated to region. **Action: JC**
- The use of service line reporting (SLR) was discussed, noting that it had started to be used, but there was currently a lack of data to support this work. An SLR pack had been produced which detailed the top six outliers with cost vs income, but more work needed to be undertaken to ensure the data were correct and validated.
- The importance of understanding those services that were currently running at a loss or profit was recognised and was a key part of business planning.
- The need for the current payment framework to allow for Trust to be paid for the work they undertook was also recognised. JC informed the meeting that in 2026/27 there was a move to better recompense Trusts for the work they undertook.
- It was agreed SLR would be the subject of a future Board Development Session.
- Given the risks attached to delivery of the forecast end of year position due to the withholding of deficit support funding, it was suggested the assurance level of the BAF objective be considered. **Action: JC**

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 Trust financial performance was off plan by £5.1m year to date due to deficit support funding (DSF); and**
- **Forecast Outturn to 30th November 2025 was on plan as the Trust had been advised by the ICB to assume full deficit support would be earned back in Quarter 4.**

	FOR INFORMATION
14/01/26	**Legal/Regulatory Report** The Board received the Legal/Regulatory report, circulated with the agenda pack.
	CLOSING MATTERS
15/01/26	**Any Other Business and Review of Meeting** A number of reports had been discussed with enough time on the agenda to allow a full discussion.
16/01/26	**Board Assurance Framework (matters for review or escalation)** The Board welcomed the in-depth discussion on the Our Plan for Better Care and EPR implementation. It was suggested the need for the right level of capacity to deliver the Our Plan for Better Care could be reviewed in the near future.
17/01/26	**Board Workplan** The Board received and noted the Board Workplan.
18/01/26	**Date and Time of Next Meeting:** The next Board meeting in public is scheduled to take place at 12.30 pm on Thursday 5th March 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
121/09/25	**Board Assurance Framework** – heat map to be provided in future reports.	**EL**	**February Update:** the highlight report, included, shows movement month on month but due to the change in scoring methodology from numerical to assurance statements makes the use of the heat map less effective.	**Closed**
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.	**Closed**
08/01/26	**Our Plan for Better Care** – further assurance be provided to the Board around cybersecurity.	**ST**	**February Update:** completed – paper presented to Finance and Operations Committee in January.	**Closed**
12/01/26	**Operational Performance Report** – outcome of deep dive into community performance over the Christmas period to be reported to Quality and People Committee.	**AJ**	**March Update:** to be presented to March Quality and People Committee.	**Open**
12/01/26	**Operational Performance Report** – discharge deep dive to be presented to Quality and People Committee.	**AJ**		**Open**
13/01/06	**Month 8 Finance Report** – letter to be sent to Region highlighting the Board's concern at the withdrawal of deficit support funding and impact on its cash position.	**JT**	**February Update:** letter sent to region on 26 January outlining the risk to our cash position due to withdrawal of deficit support funding.	**Closed**
13/01/06	**Month 8 Finance Report** – delivery of the finance plan to be reported both with the assumption that deficit support funding was provided and if it was not.	**JC**	**February Update** – included in report to Finance and Operations Committee.	**Closed**

13/01/06	**Month 8 Finance Report** – given the impact of the lack of deficit support funding on delivery of the end of year target, consider the BAF assurance rating.	**JC**	**February Update:** assurance rating amended to 'Limited'	**Closed**

Torbay and South Devon NHS Foundation Trust

Board of Directors

Chief Executive's report

Date of meeting	Date report produced
05.03.2026	24.02.2026

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:**	26.02.2026
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. It is clear how much pride our people take in the care they provide and how strongly they want to play a part in shaping our future. Colleagues continue to bring forward ideas, insight and a real commitment to improving services for patients and communities. Their feedback has highlighted the value colleagues place on clear priorities, consistent messages and a shared understanding of where we are focusing our efforts. At a time of significant pressure, there is reassurance in knowing what matters most and confidence that change will be followed through. This reinforces the importance of leadership at every level that is visible, open and supportive – creating space for people to speak up, listening carefully to feedback, and enabling teams to act with confidence within clear expectations. Getting the balance right between local flexibility and clear accountability is key to maintaining trust, sustaining momentum and delivering meaningful improvement.

3. My twice-monthly Meet Joe sessions continue to provide a valuable opportunity to hear directly from colleagues and in the past two months I have appreciated being able to hear directly from colleagues at Ashburton Health and Wellbeing Centre, Shrublands and Torbay Hospital as well as hearing from colleagues across the organisation and remote workers in my quarterly Meet Joe online. I also joined, participated in and/or hosted our corporate induction, Trust Talk (our monthly staff briefing) and Medical Staffing Committee in the past two months. I have attended our Council of Governors meeting as well as our Partnership Forum and hosted our quarterly Our People Awards winner breakfast.

4. Since my January report I have spent time with our drug and alcohol service, our medical devices team, our diabetic foot service, our cashiers' team and our chaplaincy team. I was privileged to join labour ward colleagues for a shift and have also visited our orthoptics and optometry teams and visited our Cheetham Hill, New Forrest, George Earle and Simpson wards. I have also co-hosted several listening events with colleagues in adult social care and pathology services.

5. I joined colleagues from Torbay Council at a public meeting on 08 January 2026 hosted by the Heart Campaign to clearly set out our position on the future of Adult Social Care in Torbay and our commitment to ensuring that local people’s voices are heard as the cardiology case for change is developed by the Devon Integrated Care Board.

6. I also attended the Torbay Council Adult Social Care and Health Overview and Scrutiny Sub-Board on 04 February 2026 to share with the Sub-Board our position on the future of Adult Social Care in Torbay.

7. It has been a particular pleasure to meet with each of our clinical service leads and allied health professional leads over the past two months. As a Board I know how committed we are to ensuring that the voices and views of our clinicians support us to both address our current challenges and shape our future.

8. 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.

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

Recovery Support Programme (RSP) exit process

10. Our latest assessment against the Recovery Support Programme exit criteria is attached to my report for information. While we remain amber in several areas against the criteria, and we recognise we have a lot to do, we continue to perform comparably with our peers and remain in segment 3 in the 2025/26 NHS Oversight Framework.

Provider capability self-assessment

11. NHS England provider capability assessments are mandatory, annual self-assessments for NHS trust boards, designed to evaluate leadership capacity to manage challenges and improve performance. These are part of the NHS Oversight Framework 2025/26, these reviews cover six domains – strategy, quality, people, access, productivity and finance.

12. The Board completed the national self-assessment template and submitted this for review at the end of October 2025. Our self-assessment was as follows: -
    - strategy, leadership and planning – partially confirmed
    - quality of care – confirmed
    - people and culture – partially confirmed
    - access and delivery of services – partially confirmed
    - productivity and value for money – partially confirmed
    - financial performance and oversight – partially confirmed

13. Following the conclusion of the national moderation process, the provider capability ratings for all trusts have now been agreed, nationally.

14. Based on our self-assessment Torbay and South Devon NHS Foundation Trust has an overall capability rating of Amber / Red for 2025/26. Provider capability ratings will be published in Q1 26/27 taking account of the implications of Q4 25/26 segmentation and planning outcomes in an updated view of organisations' capability.

15. The definitions provided are as follows:
    "Amber-Green / Amber-red: some concerns of varying seriousness across one or more areas to be addressed. We will work with providers to ensure that appropriate support is in place."

16. Our final ratings are broadly consistent with our own self-assessment reflecting that while we have made some improvements over the last year, we still have a considerable way to go and especially in relation to our finances.

Business Planning 2025/26

17. Our annual financial plan for 2025/26 remains on track at month 10 but will require several one-off savings and actions to be achieved.

18. Notably we have also seen overspends in adult social care and continuing health care in 2025/26 which will both further deteriorate our underlying financial position as we head into 2026/27.

19. At the end of 2025/26 we estimate our underlying financial deficit will be close to £100m.

20. In respect of performance delivery although we have not achieved all the constitutional standards, we have made significant improvements through this year when compared to 2024/25.

Our future – our strategy

21. In 2025/26, we commissioned a refresh of our 3–5-year strategy. This was driven by several critical factors:
    - a material underlying financial deficit.
    - our entry into the National Oversight Framework.
    - concerns that the Peninsula Acute Collaborative Programme was not fully reflecting our position (e.g., pPCI).
    - clinical colleagues asking for a clear and consistent direction from us.

22. Since this time, we have undertaken extensive engagement internally and with the Board and we now have a draft strategy developed that we will be taking forward into an engagement phase.

23. Our current aim is to secure formal Board sign-off in May 2026.

24. Alongside this, year one delivery plans are being developed and will form part of the 2026/27 plan submission, we are also pooling existing resources where we can to establish a transformation unit to support us with our strategy delivery.

The future of Adult Social Care in Torbay

25. As Board members will be aware we were due to make a final decision on the future of the section 75 agreement with Torbay Council at our public meeting of Thursday 05 March 2026.

26. Following constructive discussions with Torbay Council and the Devon Integrated Care Board on Wednesday 25 February, partners have reaffirmed their strong and ongoing commitment to working together, while taking the time needed to consider carefully whether a credible joint proposal for resetting the Section 75 agreement can be developed and agreed.

27. This work will not be considered at the Board of Directors' meeting on 05 March 2026, and no proposals or recommendations are being brought forward at that time.

28. Any future decisions would be taken by the Board through our formal governance processes, informed by the work underway and ongoing engagement with partners.

Successes – our people and teams

Endoscopy service achieves full accreditation

29. The Endoscopy Service at Torbay Hospital has been awarded full accreditation by the Joint Advisory Group for Gastrointestinal Endoscopy (JAG), recognising the high quality of care provided to patients.

30. The accreditation followed a detailed assessment in December 2025 and confirms that the service meets national best-practice standards across safety, patient experience, workforce, leadership and training. Accreditation is awarded for five years, subject to annual review.

31. Assessors highlighted strong multidisciplinary working across medical, nursing, decontamination, administrative and managerial teams, alongside effective leadership, positive team culture, efficient patient flow and high-quality education and training. A small number of recommendations were made to support ongoing improvement, including reviewing job planning following our Electronic Patient Record go-live and further work on inpatient capacity.

32. The Endoscopy Unit carries out around 12,000 procedures each year and this accreditation provides external assurance of the quality, safety and professionalism of the service delivered to patients.

33. I'm really proud of our endoscopy team and the accreditation reflects the professionalism, skill and care they show every single day. What stood out to me in the assessment is exactly what we see all year round — a calm, well run service, great teamwork across all parts of the unit, and a real focus on giving people the best possible experience. This accreditation is well deserved.

Supporting the South West to reduce waiting lists

34. The NHS in the South West has delivered more than one million waiting list operations in a single year for the first time, and we have played an important part in achieving this regional milestone.

35. Over the past year, we have increased day-case surgery, improved theatre productivity and strengthened waiting list management, helping more people receive care sooner and making better use of inpatient beds. Investment in a dedicated in-house waiting list validation team and new digital tools has improved accuracy, reduced delays and helped lower the number of missed appointments.

36. Further improvements are being made for people waiting for outpatient appointments. Through the Getting it Right First Time (GIRFT) programme, services including ENT, Gastroenterology and Cardiology are offering more than 1,000 additional appointments this year. Digital tools, such as the My Recovery app, are also supporting more personalised and efficient pathways for people before and after surgery.

37. These improvements contribute to a 2.6% productivity increase across the South West since April 2025, exceeding the national target. In December 2025, we had

the highest proportion of patients in Devon seen within 18 weeks of referral, with particularly strong performance in Gastroenterology and Respiratory services.

38. Together, these changes mean shorter waits and better experiences for patients and reflect the continued commitment of our teams to improving access to care.

Leading national research into breast cancer treatment

39. Women in Torbay and South Devon who are being treated for breast cancer are taking part in an important new clinical research study that could improve treatment for thousands of people each year.

40. We are the first site in the UK to recruit patients to the Trans-EndoNET study, which is exploring whether insulin levels influence how well people respond to hormone treatments for breast cancer. The study focuses on the most common form of breast cancer and aims to better understand how metabolic health may affect treatment outcomes.

41. Patients receiving care locally are being offered the opportunity to take part in this research, reflecting our strong track record in clinical trials and our commitment to giving people access to innovative research alongside high-quality care. The study is being led by the University of Oxford and is funded by the Medical Research Council and the National Institute for Health and Care Research.

42. This work builds on our position as one of the highest-recruiting organisations to cancer trials nationally and supports our wider role in advancing research that can improve outcomes for patients both locally and nationally.

New automated dispensing system installed in inpatient pharmacy at Torbay Hospital

43. We have installed a new automated medicines dispensing robot in the inpatient pharmacy, replacing the previous system which had been in operation for more than 18 years and dispensed over 3.4 million packs of medicines during that time. The new system, supplied by Becton Dickinson U.K. Limited, has been named Spencer by pharmacy colleagues.

44. The new robot improves the speed, accuracy and reliability of medicines dispensing and has been configured to integrate with our new electronic patient record (EPR), due to go live in April. This will support safer and more efficient medicines workflows across both acute and community services.

45. The installation required a significant transition period, during which pharmacy staff manually processed prescriptions to maintain safe patient care and support timely discharges. The robot is now fully operational and I would like to formally record my sincere appreciation to our pharmacy and capital development teams for the way they managed the installation and maintained safe patient care throughout, particularly over the Christmas and New Year period. Their professionalism ensured continuity for patients while this essential upgrade was completed

National recognition for work experience programme

46. Our work to support people into health and care careers has been recognised nationally with an NHS England Silver Award for Work Experience.

47. The award reflects the commitment of colleagues across the organisation who give their time to welcome work experience learners, explain their roles and help people gain a realistic understanding of careers in health and care. Each year, staff from a wide range of services support school students, young adults and people changing careers, helping to build confidence and open up future pathways.

48. As the largest employer in Torbay and South Devon, we take our role in creating local opportunities seriously, and work experience is an important part of developing the future workforce. The Silver Award also provides helpful feedback to support further improvement of the programme.

49. The submission brought together examples from across services and reflects the collective efforts of colleagues who support learners alongside their day-to-day roles.

Neonatal nurse receives NHS England's Chief Nursing Officer award

50. Our Neonatal Nursery Nurse Jenny King has received NHS England's Chief Nursing Officer Healthcare Support Worker award.

51. Jenny, who works on our Special Care Baby Unit, was nominated for her outstanding compassion, professionalism and advocacy in supporting babies and families, and highlights her ability to build trusting relationships and empower families under her care. It was noted that she consistently delivers high-quality, personalised care that positively impacts both family experience and team culture.

52. Our Chief Nurse, Nicola McMinn, presented Jenny with her award earlier this month.

Priority areas

Cardiology

53. Cardiology services remain a priority for us, reflecting the growing demand for cardiac care and the importance of timely access to high-quality diagnostic and interventional services for local people. Our cardiology teams continue to deliver vital care every day, and their expertise and commitment are highly valued.

54. Across Devon, the Integrated Care Board is developing a case for change for cardiovascular disease, cardiology and cardiac surgery services. As we have said previously, this work does not include proposals for change at this stage. As it progresses, it will be supported by a clear communications and engagement approach to ensure colleagues, partners and local communities are kept informed and have opportunities to share their views.

55. Alongside this system-wide work, we continue to focus on the resilience and sustainability of our local cardiology services. In particular, we have prioritised the refurbishment of our cardiac catheter laboratories as a key clinical and patient safety investment. The cath labs play a critical role in diagnosing and treating heart disease and are central to both emergency and planned cardiac care at Torbay Hospital. Investment in their refurbishment has been confirmed as one of our highest clinical priorities within our capital programme and work is progressing to modernise these facilities and ensure they remain safe, reliable and fit for the future.

Teignmouth Community Hospital – building condition and safety update

56. As previously reported to the Board in public in November 2025, Teignmouth Community Hospital faces significant challenges linked to the age and condition of the estate, including a substantial maintenance backlog and identified safety risks. While parts of the building are not fit for purpose, some areas of the site continue to be assessed as fair or good quality and remain in use.

57. Further to that update, a building fabric conditions report was completed and reported in December 2025, providing additional assurance on the nature of the risks identified and highlighting the need for more detailed assessment to inform prioritisation and future decision-making. Work is now underway to progress a six-facet survey, which will support a clearer understanding of the scale, quantum and prioritisation of key building and asset-related risks and inform longer-term options for the site, as previously committed to the Board.

58. In the interim, and consistent with our duty to maintain a safe environment while the site remains occupied, urgent building safety and maintenance works have been required due to the ongoing degradation of parts of the estate. During February 2026, this has included rebuilding part of the boundary wall, replacement of the pump system to address flooding in the lower basement area, and urgent critical ventilation works within theatres.

59. These actions are necessary to manage immediate safety and operational risks and do not change the position previously set out to the Board regarding the wider challenges facing the site. Work continues through the established governance arrangements to develop and appraise a range of future options, including appropriate engagement with staff and stakeholders, with further updates to be brought back to the Board as this work progresses.

Bone cement supply disruption

60. We were recently affected by a national disruption to the supply of certain bone cement products, used mainly in orthopaedic surgery. This was a UK-wide issue linked to a global manufacturing problem and has been managed nationally by NHS England, with regional coordination across the South West.

61. Throughout the disruption, patient safety has been our priority. In line with national guidance, clinical teams prioritised trauma and urgent cases first, followed by urgent elective procedures where alternatives were not clinically appropriate.

62. Thanks to the swift action and careful planning of our orthopaedic clinical and operational teams, disruption locally has been very limited. To date, only two elective cases were cancelled, both at the very start of the issue.

63. The national position is now improving. Alternative bone cement supplies have been approved, additional stock is entering the NHS supply chain, and training is underway to support their safe introduction into clinical practice. This is enabling providers to plan a phased return to routine activity, supported by continued clinical prioritisation and regional coordination.

64. We are working closely with our clinical teams and regional partners to resume planned activity safely where possible. This includes support to complete

treatment for a group of long-waiting patients by the end of March 2026, which is an important factor in our current improvement forecast for the 65-week wait position.

65. The two patients affected by short-term disruption are being contacted directly by their clinical teams. We will continue to monitor the position closely and keep the Board informed as recovery continues.

Pathology

66. Pathology services continue to be a key area of focus across the south-west peninsula, reflecting rising demand, workforce challenges and the importance of resilient, high-quality diagnostic services to patient care.

67. Alongside partner trusts in Devon, Cornwall and the Isles of Scilly, we are working through the Peninsula Pathology Network to explore options for a more sustainable, joined-up approach to pathology services. This work is part of a wider national move towards collaborative pathology networks and aims to improve quality, resilience and access to modern technology, while supporting patient pathways across the system.

68. In January, Kate Lissett, our Chief Medial Officer and I met with our pathology colleagues to provide an update on this work and to listen directly to their key concerns and questions. This engagement is helping to inform the issues that colleagues would want to see addressed as the work progresses.

69. As set out previously to Board, this work remains at a developmental stage. No final decisions have been taken about future service models and any proposals will be subject to further detailed work, staff engagement and appropriate governance before being brought back for consideration. We continue to keep colleagues informed and involved as the work progresses.

Emergency Department redevelopment – phase two update

70. Phase two of the Emergency Department redevelopment at Torbay Hospital is now progressing, following the successful completion and opening of Phase One, which delivered new reception, waiting and triage facilities, alongside improved staff and training spaces. Early feedback from patients and colleagues on the Phase One areas has been positive.

71. Phase Two focuses on the opening of the new minors area, supporting improved patient flow and care experience within the Emergency Department. This phase is due to be completed in March. As construction activity has progressed, works have moved into the existing minors area, along with associated utility and store spaces, which are temporarily unavailable for clinical use while redevelopment continues.

72. The programme continues to be delivered within a live Emergency Department environment. This requires careful phasing and close coordination between clinical teams, estates colleagues and construction partners to ensure services continue safely and effectively throughout the build. Planning for Phase Two has taken account of operational pressures, with mitigations in place to minimise disruption to patient care.

73. Further updates will be provided as the programme progresses into subsequent phases, including Phase Three, which will complete the redevelopment through improvements to utility and store areas and the provision of additional clinical and patient support spaces.

National, regional and local issues and topics of interest

Agenda for Change pay uplift and a fairer deal for nurses

74. In February 2026, the Government confirmed acceptance of the NHS Pay Review Body (PRB) recommendations for Agenda for Change (AfC) staff for 2026/27, alongside a separate package of measures described as a “fairer deal for nurses”. Together, these changes are intended to address pay, career progression and retention challenges within the nursing workforce, while also beginning longer-term reform of the AfC pay structure.

75. For 2026/27, staff employed on AfC terms and conditions will receive a 3.3% consolidated pay uplift, effective from 01 April 2026. The intent is for this award to be paid in April salaries, avoiding the delays and back-pay issues experienced in previous years. The uplift applies across AfC staff groups, including nurses, midwives, allied health professionals and wider NHS staff covered by AfC.

76. In parallel, the Government has committed to funding reforms to the AfC pay structure, with negotiations to take place through the NHS Staff Council. These reforms are intended to address long-standing concerns about entry-level and graduate pay, progression and pay compression. Any agreed changes would be additional to the headline annual pay award and may result in further uplifts for some staff, backdated to April 2026.

77. Alongside the pay award, the Government and NHS England have announced a package of targeted measures to support nurses, developed following engagement with the Royal College of Nursing and other staff-side organisations.

78. Key commitments include:
    - review of all band 5 nursing roles, to ensure job descriptions and pay bands accurately reflect the work being undertaken
    - prioritising graduate pay, including nursing graduates, as part of wider AfC pay structure reform
    - introduction of a single national nursing preceptorship standard, to improve consistency and quality of support for newly qualified nurses
    - additional national funding to support the band 5 role review process and any resulting pay adjustments, separate from the annual pay award.

79. The focus on band 5 roles reflects their significance as the largest group within the nursing workforce and a critical point for recruitment and retention.

80. Work to deliver the fairer deal for nurses is expected to commence from April 2026, with national timescales, guidance and assurance arrangements to follow from NHS England. Employers will be required to put local plans in place, with Board-level oversight and partnership working with staff-side representatives.

81. These national commitments have potential benefits for nurse recruitment, retention and early-career progression, but will require careful local implementation, including job description reviews, engagement with staff and workforce planning. Further detail on funding flows, reporting requirements and

timescales is awaited. Updates will be brought back to the Board as national guidance is issued and local implementation plans are developed.

National Cancer Plan published

82. In February 2026, the Government and NHS England published a new National Cancer Plan for England, setting out a ten-year strategy to improve cancer outcomes, experiences and survival. The central ambition of the Plan is that by 2035, three in four people diagnosed with cancer will survive for at least five years or live well with cancer.

83. The Plan focuses on earlier diagnosis and prevention, faster access to treatment, improved quality of life and personalised care, expanded research and innovation, and reducing inequalities in outcomes. A key commitment is to meet all NHS cancer waiting time standards by 2029, alongside significant investment in diagnostic capacity, including community diagnostic centres, extended operating hours and greater use of digital and AI-enabled diagnostics. The Plan also places strong emphasis on research, genomics, access to clinical trials and the expansion of advanced treatments, including robot-assisted surgery.

84. Importantly, the Plan recognises cancer as increasingly a long-term condition for many people and highlights the need for care that is designed around people's lives, with better information, personalised pathways and improved support during and beyond treatment. Delivery will be led through NHS England, Integrated Care Systems and Cancer Alliances, with further guidance on implementation expected over the coming months.

85. We are well placed to contribute to and benefit from the National Cancer Plan. We are one of the highest-recruiting organisations to cancer clinical trials nationally and are the first site in the UK to recruit patients to the Trans-EndoNET breast cancer study. We are also at the forefront of innovation, including participation in national cancer vaccine trials and continued investment in diagnostics, digital pathways and research-enabled care. As national priorities translate into system and local expectations, we will continue to align our cancer services, research activity and improvement programmes with the Plan and will keep the Board updated on local implications and progress.

Interim leadership arrangements at Devon Integrated Care Board

86. Libby Ryan-Davies has been appointed as NHS Devon's Acting Chief Executive Officer (CEO) and Accountable Officer (AO), effective from 01 February 2026.

87. Libby takes up the role until the appointment of a Cluster CEO (interim or substantive, depending on the outcomes of recruitment that is currently underway) for NHS Devon and NHS Cornwall and Isles of Scilly, which is expected to be from 01 April 2026 and is subject to NHS England approvals.

88. Having originally joined NHS Devon in August 2024 as a Transformation Director, Libby has held the Devon Deputy CEO role since April 2025. Libby will continue to lead NHS Devon and work closely with Susan Bracefield, NHS Cornwall and Isles of Scilly's Acting CEO/AO, on the Cluster plans for 2026/27 and ensuring they close out 2025/26 as expected. Both Susan and Libby will continue in these roles until the interim/substantive Cluster CEO starts (or the new Cluster Executive structure formally rolls out).

Leadership changes at Royal Cornwall Hospitals NHS Trust

89. Chief Executive Steve Williamson will be leaving the Royal Cornwall Hospitals NHS Trust (RCHT) in mid-April to take up the role of Chief Executive Officer at University Hospitals of Morecambe Bay NHS Foundation Trust.

90. Kim O'Keeffe BEM will be taking up the role of Acting Chief Executive Officer from 21 April when Steve leaves to take up his new role in Morecambe Bay. Kim has been part of the executive team for many years and Deputy CEO for the last five years.

91. I would like to take this opportunity to thank Steve for his years of service in Cornwall and the South West Peninsula and to wish him well in his new role.

Local media update

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

Key media releases and responses

Torbay Hospital Endoscopy Service awarded full national accreditation

Our teams play key role as South West hits one million operations milestone

Torbay scores a UK first for major clinical breast cancer research study

NHS partnership is helping people to get online

Voting now open for Torbay and South Devon NHS Foundation Trust's new award to celebrate their amazing volunteers

An open letter to the people of Torbay

National award recognises our role in supporting local careers

Torbay Hospital League of Friends funds new equipment to support hand therapy patients

Installation of new pharmacy robot marks next step in Torbay and South Devon NHS Foundation Trust's digital transformation

Designer Lucy Turner's work hits the marq at a new exhibition at Torbay Hospital

Textiles stories - new exhibition in the HeArts gallery

Coverage

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

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%	70.79%			
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	27 mins 5 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%	7.4%			
4	Elective - Virtual Elimination of 65ww in line with trajectory	IPQR report to FPC and to Board mapping performance against MTFP trajectories	99	84	76 (21st)			
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	654			
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%	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	32524			
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%	70.0%			

Point 1 – Improvement in December from October and November. Improved 23 places in national rankings to 62nd out of 118 providers. Improvement of ~6% from December 2024 performance.
Point 2 – December is best performance in financial year best since pre covid performance. Ambulance demand was second highest numbers of ambulances conveyed on record, following November which was largest. Performance on this standard has met the trajectory in 7 out of 9 months in 25/26 and December performance was a 72% improvement on December 2024.
Point 3 – Eleven consecutive months of meeting this standard. Currently ranked 34th in the country, improved from 88th at same point last year.

UEC General
Trust recognised as one of top 12 most improved Trusts in country across aggregated position for 4 hour performance, 12 hour performance, ambulance handover and category 2 response times.
UEC sprint plan in development and will be initiated from 5th February. Key focus areas across **ED** (minors, overnight performance, non admitted pathways), **Medicine Streaming** (maximising SDEC opportunities), **Surgical Streaming** (T&O and general surgery), **Ward Improvement** (4 focussed wards, brilliant basics), **ED Demand** (call before convey, re-direction), Frailty Phase 2 (SDEC).

Point 4 – 65% improvement from November. Trajectory of 40 would have been met without impact of unforeseen issues such as loss of ortho paedic 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 55th nationally compared to 117 at same time last year.
Point 7 - ~1000 patient improvement on same point last year. Currently ranked 15th nationally for RTT performance and in top 10 nationally most improved.
Point 8 – Have met this standard in every reporting month this financial year.

Elective General
Mobilisation plans in place to enact the outpatient sprint and day case sprint. Forecast impact of returning to overperforman ce in RTT position and improving 52 week wait % position to 0.8% of waiting list.
Continued validation and impacts on waiting list. Specific T&O improvement plan in place focussing on productivity, mutual ai d and IS opportunity in Q4.
Verbal confirmation received from region that Trust has exited Tier 2 for cancer performance following recovery across Q3.

Self-Assessment Against Exit Criteria

Torbay and South Devon NHS Foundation Trust

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Torbay and South Devon NHS Foundation Trust

Trust Board

Board Assurance Framework

Date of meeting	Date report produced
5 March 2026	24 February 2026

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	**Name and title:**	Emily Long Director of Corporate Governance and Trust Secretary
		Date:	

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 February 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 (in items for information pack)
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
N/a

Risks lodged on Datix:
N/a

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

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	Limited

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	Limited
	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.	COO	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	Limited
	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) – February 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 4137,4167, 1681,4255,3502, 4312, 4237, 4299, 4228, 4246, 4294, 3928, 1095, 4353, 4333, 4330,	12	Low	1	Up to 5	Quality, Safety and Patient Experience	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 22~~18~~ 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: MHRA assessment identified several areas of failure to comply, increase in perinatal incidents over the last 12 months, extended stays in ED, stroke performance, outlier for mortality for NELA, complaints and PALS backlog	**Moderate** Which is **above** the Trust's agreed risk appetite.
Patient Experience Risk:	2450 :Failure to Achieve the Standards Required for a 'Good' CQC Rating.	~~4293,~~ 3908,	**9**	Low-Moderate	5	Up to 12	Quality, Safety and Patient Experience	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 12 risks scoring above 13 currently recorded. The median scores are **within** the Trust's agreed risk tolerance score.	**Moderate** Which is **within** 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, 4315, 4320,	12	Low-Moderate	5	Up to 12	Performance	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 15, with 7~~6~~ 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	**High** Which is **above** the Trust's agreed risk appetite This has been adjusted upwards to reflect the operational performance and progress against RSP exit criteria.

	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**
								performance improvement through winter will be a key demonstrable of the reduction of this risk.	
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	Performance	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. 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.	**Moderate** Which is **within** the Trust's agreed risk appetite
Financial Risk:	2996: Financial Sustainability Risk Rating for 25/26 and 26/27	3274, 2996, 3867, 1083,	**12**	Low-Moderate	6	Up to 12	Finance	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 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 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, 2639, 4369, 4329, 4343,	**12**	Low	1	Up to 5	Finance	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 15, with 14~~12~~ 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	**High- Very 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**
								work, whilst it is acknowledged the risk cannot be mitigated in totality.	
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, Safety and Patient Experience	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. The factors increasing and decreasing risk this month were: E Coli bloodstream infections above target level, MSSA rates increased, limited assurance from ASW on IPC controls, sustained hand hygiene at 90%, improved data quality supporting targeted improvement work	**Moderate** Which is **above** the Trust's agreed risk appetite
Information & Technology Risk:	1159: Current IT Systems and Infrastructure Will Not Meet Future Demands.	3460,2838,2830, 3839, 2831, 1174, 1159, 2920,, 4175,	**9**	Moderate	6	Up to 12	Strategy and Business Intelligence	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 9 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	3804, 2542, 3519, ,2307, 1069, 3485, 2429, 4020 3521, 2718, ,	**12**	Low	1	Up to 5	Finance and Performance	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 17~~5~~ risks scoring above 13 currently recorded. The median scores are **above** the Trust's agreed risk tolerance score.	**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**
		,4201,4200, 4203, 4202, , 4197, 4236, 4222						- 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 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, 3956, 4163 4136 3607, 3183, 4270,	**12**	Moderate	6	Up to 12	People and Culture	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~~4~~ 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	People and Culture	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		3922	**9**	Low-Moderate	5	Up to 12	People and Culture	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 1 risk scoring above 13 currently recorded.	**Moderate** Which **is within** the Trust's agreed risk appetite
Strategy & Transformation Risk			**0**	Moderate	6	Up to 12	Strategy and Business Intelligence	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 0, with no risk scoring above 13 currently recorded.	**No risk associated with Risk Type**
Collaboration Risk)			**0**	Moderate	6	Up to 12	Strategy and Business Intelligence	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.	**No risk associated with Risk Type**

	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**
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	Leadership and Governance	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 12 ~~2~~ risks scoring above 13 currently recorded. The median scores are **within** the Trust's agreed risk tolerance score. There continues to be significant political, public and stakeholder interest in strategic change across the organisation and beyond. The forthcoming case for change for cardiology has generated substantial concern from the public, alongside critical media and social media commentary. There is also increasing scrutiny of the future of adult social care in Torbay and heightened attention on maternity services. Together, these issues are driving sustained engagement and challenge from partners, community groups and elected representatives, with a risk of further reputational impact and pressure on organisational capacity.	**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	Leadership and Governance	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 but also support from NHSE - High levels of legal and regulatory activity for the Trust to understand, review, roll out and/or respond to: i.e Board Self-Assessment - Increasing oversight and engagement with external reviews; such as PWC's Devon wide review Decreasing: - 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	**Moderate** Which is **above** the Trust's agreed risk appetite

*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 Mar 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 17th Feb 2026

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	109
Risk(s) increased to 15 and above for review	3
Reduced, closed or suspended risk(s) rated at 15 and above to note	6
Risks requiring validation	25

Risk Heat Map

Likelihood/ Probability of Risk Occurring	1 Minimal	2 Minor	3 Moderate	4 Major	5 Catastrophic	**Total**
5 Almost Certain	3	3	30	14	1	**51**
4 Likely	2	7	92	40	7	**148**
3 Possible	3	26	93	87	17	**226**
2 Unlikely	1	12	36	38	14	**101**
1 Rare	2	2	14	17	8	**43**
Total	**11**	**50**	**265**	**196**	**47**	**569**

Current Risk score by month – rolling year (at the point of report date – taken on 28th Jan)

Current Risk Score	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec- 25	Jan- 26
Very High (15-25)	29	33	31	32	32	34	32	29	23	26	24	25
High (13-19)	95	88	82	84	88	94	93	96	87	90	92	85
Moderate (6-12)	586	578	581	580	583	576	582	592	405	404	401	396
Low (1-5)	83	92	94	94	97	98	99	104	72	64	65	62
Total number of risks	793	791	788	790	799	802	804	821	587	584	583	568

The risk reduction in Oct 25 was due to medical device risks being removed from datix.

Escalation of Very High & High level risks (updated 28th Jan 26)

There are currently 32 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	⟺	01/04/2026	Financial Risk	[12/01/2026] ULP updated to exit 25/26 at £99.5m. Improved understanding of financial drivers and risks to ULP. Staff consultation underway to improve resources in finance team
4001	Pharmacy Aseptic Services - Risk to Provision of Systemic Anti-Cancer Treatments	20	⟺	30/04/2026	Clinical Safety Risk	[30/01/2026] An initial options appraisal for replacement/refurbishment of the aseptic preparation service was completed by Stride Treglown on Oct 25. In the NHSE external audit of Nov 25 the service was assessed as high risk to

						patient safety and service continuity due to: - A severely increased risk of microbial contamination of products due to further significant deterioration of the infrastructure and fabric of the facility since the previous audit. - An increased risk of unplanned facility closure impacting on service continuity. The aseptic preparation service has been placed in Stage 1 Compliance Management: Enhanced Oversight. This will be continued until there is an action plan in place around key risks that has support from Senior Management within the Trust. The capital scheme for the replacement of the Pharmacy Aseptic Suite was considered on 28/01/26 and has been prioritised to be taken forward in 26/27.
1083	Inability to maintain/operate the estate in accordance with customer needs, NHS HTMs & Stat/Mand reqts within allotted funding	25		30/01/2026	Financial Risk	[27/01/2026] Shortlisting for interview for six Estates Operations posts currently underway.
1159	Current IT Systems and Infrastructure Will Not Meet Future Demands.	20		24/04/2026	Information and Technology Risk	[05/01/2026] Open action around EPR investment in infrastructure updated with latest progress on DC migration and hardware investment to meet EPR warranted environment for EUDs etc.
2801	Excessive Storage of Flammable Items in Corridors for Prolonged Periods	20		27/02/2026	Health and Safety Risk	
3867	Clinical Coding Retention and Recruitment	20		01/12/2025	Financial Risk	
1697	Insufficient Permanent Workforce Capacity to Meet	20			Workforce Risk	[14/01/2026] SPPs are undertaking a range of activities to mitigate this risk. This includes, but is not limited to:

	Patient Need (Overarching Risk).		⇔	27/01/2026		•Monthly EOG workforce reporting, highlighting risks and issues and working with care group colleagues to mitigate these. •Working with other People and Education Directorate colleagues in ER, Recruitment and OD to support services experiencing workforce challenges e.g. development of a change management model •Liaising with Care Group Directors and senior leaders through business planning cycle and workshops.
1815	Non-Compliance With the National Cancer Waiting Time Targets.	20	⇔	28/02/2026	Performance Risk	
3249	Automated Dispensing System (Pharmacy)	16	⇔	24/04/2026	Performance Risk	[03/02/2026] New robot installed. Testing of new interface, which will work with Epic to begin. Can only really test and close risk fully once Epic is live.
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	
1947	Principal Overarching Risk (Medical Device Rolling Replacement Programme) (MDRRP)	16	⇔	24/04/2026	Clinical Safety Risk	[23/01/2026] The risk has been reviewed and remains significant due to ongoing capital and revenue constraints affecting the Medical Devices Rolling Replacement Programme (MDRRP). The Trust continues to operate with a substantial proportion of ageing and unsupported medical devices, many of which exceed their recommended service life and present increasing clinical, operational, financial, and regulatory challenges. Although existing governance processes, including MEPG oversight, provide a degree of mitigation, the underlying

						funding gap persists and continues to elevate the likelihood and impact of equipment failure. No material improvements in funding or device replacement capacity have been identified since the previous review. Continued monitoring is required to ensure that risks to patient safety, service continuity, and organisational performance are effectively managed.
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	
4136	Shortage of Therapeutic Radiographer and Support Workforce (Radiotherapy)	16	⟺	31/03/2026	Workforce Risk	[25/01/2026] Scoring reviewed in Planned Care CCSS Risk Meeting - risk score still current. 2 staff leaving in April which will continue to effect the service. Agency posts will need extending to maintain current CWTs. Clinical prioritisation process still in place but some improvement in CWTs due to agency. Therapeutic Radiographers only profession who can deliver Radiotherapy. Nationally working with HEE and NHSE to address problems with national shortage and also apprentice training. Working with Peninsula Cancer Alliance and reviewing demand and capacity work and effects of workforce.
2948	Delay in MH Patients Being Transferred to Appropriate Placement/Assessment Environment	16	⟺	30/01/2026	Clinical Safety Risk	[27/02/2024] risk remains. no change. MH patients often having long delays in ED awaiting bed
3287	Stroke Services (overarching risk)	16	⟺	28/11/2025	Clinical Safety Risk	

4315	Safeguarding Children Referral Form Upgrade (ICON)	16	New Risk	03/04/2026	Performance Risk	[04/02/2026)] Risk discussed at Risk Group- explained that there will need to be a change in process and training but this can't start until EPIC has been implemented. Agreed at current score until work around has been implemented
3456	Single Site Specialist for Breast Radiotherapy	16	⇔	01/11/2025	Workforce Risk	
3664	Lack of Security Cover at Community Sites	16	⇔	31/03/2026	Health and Safety Risk	
2965	Access to an Emergency Theatre for Obstetric Cases	15	⇩	31/03/2026	Clinical Safety Risk	[27/01/2026] Obstetric theatre 10 (on labour ward) is available for emergencies during the day. Between 6 and 9.30pm a second theatre (in main theatres) is available for obstetric emergencies. From 9.30pm to 8am theatre 1 is the obstetric theatre which is constantly staffed. A second theatre team at home is deployed for non obstetric emergencies. This is the mitigating plan until a second team can be employed to be resident. Theatres undertaking a consultation plan for permanent funding of a second resident team. Score reduced from 20 to 15
1070	Trust Patient Flow Pressures Resulting in Ambulance Handover Delays, Poor Levels of Care and Performance for 12hr & 4hr Standard	15	⇔	20/02/2026	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	

3839	BAU Support of Systems NOT Replaced By Epic	15	⇔	03/03/2026	Information and Technology Risk	
3460	Compromise or Failure of Cloud Hosted IT Services or Systems	15	⇔	03/04/2026	Information and Technology Risk	[03/02/2026] Updated DC migration action regarding further circuit delays and replanning of migration from May 2026.
3502	Increasing Acuity Within UTC Patients	15	⇔	01/04/2026	Clinical Safety Risk	
3944	Safe Care Requires a Hierarchy of Controls to Prevent and Control/ Manage the Spread of Infectious Diseases. (Overarching Risk)	15	⇔	21/05/2026	Infection Control and Prevention Risk	
4178	Sustainability of Dawlish MIU	15	⇔	31/03/2026	Communication and Reputational Risk	
2920	Activity Dataset Non-Compliance for Community Setting	15	⇔	30/04/2026	Information and Technology Risk	
3928	Clinical Governance Team - Demand Exceeding Capacity- UEC	15	⇔	01/03/2026	Clinical Safety Risk	
3783	Extension and Non Replacement of the Patient Transport Ambulance Fleet	8	⇩	11/12/2025	Communication and Reputational Risk	[12/02/2026] risk can close - vehicles replaced
3733	Failure to Ensure Effective Processes in Place to Support Safe Working with Ionising Radiation for Both Staff and Patients	6	⇩	04/05/2026	Health and Safety Risk	[09/02/2026] Quality management system has been procured and implementation planning is in progress

Torbay and South Devon NHS Foundation Trust

Board of Directors
Our Plan for Better Care

Date of meeting	Date report produced
5th March 2026	23rd February 2026

Author(s)		Report approved by	
Name and title:	Simon Tapley, Chief Strategy & Planning Officer	**Name and title:**	Joe Teape, Chief Executive Officer
		Date:	23.02.26

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. Due to extenuating circumstances, several of the programmes reviews were undertaken virtually this month.

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 February 2026 (Included in Items for Information Pack)

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

- **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)
An IIP risk register has been formally stood up in M7. Specific risk IDs are assigned and mitigation assessed to ensure appropriate action.

Risks lodged on Datix:
Risk deep dive to be undertaken in February.

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 February 2026. 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 extraordinary circumstances, the OPFBC Oversight Group meetings scheduled for Finance and People were stood down in February. Nevertheless, the workstream highlight reports have been reviewed by the Senior Responsible Officers (SRO's) to ensure continued oversight.

2.3 An Executive Assurance rating is applied per workstream aligned to the Board Assurance RAGs. Table 1 summarises the status position by month.

Table 1:

Programme / Workstream	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Leadership Programme					
1.1 Governance & Assurance					
1.2 Well-Led	Complete	Complete	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	On Hold	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	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	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					

2.4 The assurance rating for both the Community Services Redesign (Frailty) and the Culture, OD & Learning workstreams has improved to *satisfactory*. Frailty has shown clear operational traction—higher referrals, improved ED diversion and on-track mobilisation—all of which reduce delivery risk and demonstrate growing service readiness. The Culture, OD & Learning workstream has strengthened delivery through increased milestone completion, progress on key cultural programmes and improved staff-voice and wellbeing mechanisms.

2.5 Conversely, the assurance rating for the Governance & Assurance workstream and EPIC workstream, has reduced to *limited* in month. For Governance & Assurance, assurance has fallen because several critical governance deliverables—particularly those relating to the risk management framework, clarity of risk ownership and escalation processes, and the standardised reporting framework—are now off-track and have been escalated. A recent review highlighted insufficient organisational capacity to deliver these components as originally planned. A revised and formalised plan will be presented to ExCo in the coming weeks. Assurance for EPIC has reduced due to key elements of go-live readiness—particularly chemotherapy regimen validation, end-user training registration and Blood Transfusion LIMS integration—are now behind schedule. However, solid progress has been made on resolving key administrative and data-quality issues ahead of go-live. The backlog of clinic letters

has reduced, and external support has been secured to clear the remaining backlog within one month, enabling teams to refocus on outcome processing and wider readiness activities.

2.6 The PASP workstream, as originally defined within the Improvement Plan, remains on hold pending the outcome of Executive-level discussions with system partners. The Managed Services and Subsidiary Company workstream also remains on hold pending national direction. In addition, the Managing Our Estate workstream remains under review, subject to the outcome of the Executive consideration of the EFM Director's assessment report.

2.7 The programme's overall assurance rating remains 'Limited', primarily due to deliverable progress and the level of risk. Of the 111 open deliverables in the plan, 22.5% are categorised as off track, with some exceeding the January 2025 target completion date and others escalating as anticipated risks. Of the 100 deliverables scheduled for completion by the end of January 2026, 70% have been completed, representing an improvement from last months 66% completion rate (December 2025).

2.8 Given the time of year, the programme is prioritising completion of as many deliverables as possible before year-end. For deliverables that cannot reasonably be finalised, or those scheduled beyond March, discussions are being held with SROs to confirm the appropriate governance route, unless they form part of a proposed Year 2 workstream

2.9 Risk also remains a significant driver of the overall assurance rating. During the reporting period, 118 risks were recorded on the IIP risk register and shared with the Oversight Group. Six of these risks are currently scoring 20 or above and are listed in Annex 1. Following last months recommendation, PMO have worked closely with workstream leads to review risks reaching their target scores and as a result have closed 19 risks this month.

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–M10) delivery stands at £24.6m, with full year delivery of £28.8m and a forecast outturn of £32.8m. There remain additional CIP schemes, outside of the IIP remit, with a forecast outturn of £8.7m, 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-M10) and the full year effect, together with the forecast.

Table 2:

Our Plan for Better Care Workstream Dashboard								
Workstream	Original Plan	Transacted YTD (M1-M10)	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	£ 6,360,468	£ 7,838,011	£ 7,935,002	£ -	£ 96,991	£ 7,838,011	-£ 146,998
2.4b Continuing Health Care	£ 2,127,000	£ 2,480,759	£ 3,111,776	£ 3,150,234	£ -	£ -	£ 3,150,234	£ 1,023,234
3.1a Planned Care – Elective Care	£ 2,000,000	£ 1,600,000	£ 1,900,000	£ 1,900,000	£ -	£ -	£ 1,900,000	-£ 100,000
3.1b Planned Care – Diagnostics DM01	£ 580,000	£ 420,000	£ 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	£ 1,181,523	£ 1,302,595	£ 1,302,595	£ -	£ -	£ 1,302,595	-£ 319,405
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ -	£ -	£ -	£ -	£ -	£ -	-£ 1,500,000
4.4a One Devon Shared Services Finance	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
4.4b One Devon Shared Services Procurement	£ 338,000	£ 146,322	£ 167,058	£ 167,058	£ -	£ -	£ 167,058	-£ 170,942
5.1 Workforce Plan & Transformation**	£ 19,387,192	£ 12,447,715	£ 13,948,694	£ 17,868,892	£ 50,002	£ 2,995,130	£ 14,823,760	-£ 1,518,300
Total	**£ 36,886,192**	**£ 24,636,787**	**£ 28,772,134**	**£ 32,827,781**	**£ 50,002**	**£ 3,092,121**	**£ 29,685,658**	**-£ 4,058,411**
*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 Celebrating year one & looking ahead to year two

4.1 A close-down report for Year One of OPFBC is being prepared for Oversight review in March. This is being brought forward slightly earlier than usual in recognition of capacity constraints for EPIC go-live and the timetable for Year Two planning. The presentation will provide a clear summary of what has been achieved in Year One, alongside the key lessons learned that will shape and strengthen delivery in Year Two

4.2 As previously reported, Year Two of Our Plan for Better Care (OPFBC) will see core domains structured around the five signature moves and enabling priorities set out in the Trust's strategy. Thus, ensuring alignment between operational delivery and strategic ambition.

4.3 Workstreams are being shaped around the key milestones required in 26/27 to deliver the strategy, providing a clear foundation for progression into Year Two and maintaining focus on the outcomes needed to achieve our longer-term objectives.

4.4 Work continues to address the urgent need to address capacity and capability risks in the programme recast. Whilst resource requirements would remain similar, skill sets might need adjustment and investment.

5 Assurance recommendations and summary

5.1 The Board of Directors are invited to:

- **Note** the IIP delivery report and progress made during the reporting period with the Board of Directors invited to **Discuss.**
- **Acknowledge** the risks to delivery and ongoing work required to improve our risk position in the core domains.

- **Take assurance** that the improvement programme is executively owned and is evidencing impact to the organisation's key priorities.

5.2 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

NHS
Torbay and South Devon
NHS Foundation Trust

Board of Directors

Committee Chairs' Report

Date of meeting	Date report produced
5 March 2026	26 February 2026

Author(s)		Report approved by	
Name and title:	Sophie Byrne PA to Chairman	**Name and title:**	Sarah Fox Corporate Governance Manager
		Date:	27 February 2025

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' Reports

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 Trust strategy?

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 strategic 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

N/A	

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risks

Terms of authorisation, NHS England licence and regulations
National policy, guidance

Committee Chairs' Report – 21 January 2026

Audit and Risk 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:

- Board Assurance Framework – Satisfactory – receive
- External Audit Progress Report - note
- Information Governance Update – Satisfactory – note work undertaken/risks
- EPRR Quarterly Update and Assurance Action Plan – Satisfactory – note progress made
- PSIRF Maturity Audit – Satisfactory – note progress made
- External Recommendations (including VFM) Update – Satisfactory - note
- Internal Audit Recommendations (Core Financial Systems) Update – Satisfactory - note
- Modern Slavery, Human Trafficking and Ethical Trading Statement – Satisfactory - approve
- Committee Terms of Reference – Satisfactory - receive
- Review of Committee Themes – Satisfactory - note
- ASW Assurance Progress Report – review/note
- Counter Fraud Progress Report – receive
- Cyber Security Assurance Update – Satisfactory/Limited - receive
- Tender Waivers – Limited - note
- Losses and Special Payments – Satisfactory - note

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

Diligent Boards: South Devon Health Information Services: Current Books

ASSURANCE RECOMMENDATION:

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

ALERT:	Risk management system continues to develop but needs a focus of effort to advance significantly over the next quarter. Must ensure it provides comfort/guidance to board over major issues and operates an efficient and effective system of managing non major risks.
ADVISE:	Controls over ASC direct payments need to be reviewed, subject to the constraints of the ongoing fraud investigation.

	IG provided limited assurance on FoI Compliance due to capacity issues. Current compliance at 20%, although similar pressures are being encountered by other trusts. Need to be able to focus on bringing our PSIRF work, a Patient Safety Culture and the (depleted) Quality Improvement Team closer together under a single Executive portfolio, so we are better joined up. QI is essential to drive and support change from those directly involved, rather than a top-down approach. Limited assurance was provided on a couple of cyber areas (Backup Provision/Recovery and Workforce Awareness/ Training), esp in light of higher click through rate on simulated phishing emails. Competition Waiver system remains at limited assurance due to issues with centralised procurement service. Future ARC meetings' timing will be reviewed to achieve approval of annual plans before the start of the year, ad will the system of creating of annual IA/CF plans.
ASSURE:	Satisfactory assurance was provided on EPRR system, External Audit recommendations, overall internal audit system and progress, most cyber areas and other areas. ARC committee terms of reference were approved subject to minor admin changes.
RISK:	The recent data breach that involved incorrect disclosure of staff (including members of committee)'s details is being investigated and has been reported to ICO.
CELEBRATE OUTSTANDING:	Significant progress has been made in general system improvements and closing down audit recommendation to allow the possibility of moving from Limited to Satisfactory Internal Audit Opiton, but only if the pace of progress ia maintained for the next three months. PSIFR review by ASW revealed areas of good practice that are being shared to other trusts.

Committee Chairs' Report – 28 January 2026

Finance and Performance Committee

REPORTS RECEIVED BY COMMITTEE:
The Board are asked to note that the following reports were received by the Committee and are escalated for their attention: • NHS Devon ICS Governance Review Update – Satisfactory – To receive • Month 9 Finance Report – Satisfactory/Limited – To receive • Planning 2026/27 – January Update – Satisfactory/Limited – To receive • National Cost Collection Index 2024/25 – To Note • Operational Performance Report – Limited/Satisfactory – To receive • Tower Risk Summit Report – Limited – To receive • Capital Spend and Planning – 25/26 to 27/28 – Satisfactory – To receive • Digital Update – Satisfactory/Limited – To receive • Electronic Patient Record Progress Report – Satisfactory – To receive • Cyber Assurance 12 month look forward – Satisfactory/Limited - To receive • Trauma and Orthopaedics (T&O): Income, Profitability and Activity Plan Performance – Received but not discussed (delayed to February FOC) **The full Committee pack reviewed can be found on Diligent here:** **Diligent Boards: South Devon Health Information Services: Current Books**
ASSURANCE RECOMENDATION:
The Board are asked to AGREE the recommended assurance rating and TAKE [LIMITED- SATISFACTORY – SIGNIFICANT] ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	
ADVISE:	• Continues on track to deliver 2025/26 financial plan although challenges remain: o Loss of Deficit Support Funding impacting final outturn and cash flow (additional cash requested); informed Region will not consider final outturn a breach of performance due to loss of DSF o Clarifying/accounting for £6m in plan to be finalised with potential impact on final ULP o Uncertainty & lack of clarity remains on workforce controls; action agreed to set up cross Executive

	working group to determine consistent & improved control for next FY • Positive progress with next year and mid-term planning process including constructive challenge with ICB on identified activity/funding assumptions. Risk remains that final planning figures present a significant gap/shortfall with NHSE expectations: o Action agreed to clearly identify ASC impact in plan • Capital spend £13m behind plan for year; number of works underway make it challenging to meet plan • Comprehensive capital investment plan for next financial year with £14m in plan for maintenance/remedial works but noting the efforts made to secure this funding, it is still significantly short of the £40m investment funding identified to meet the needs of a failing infrastructure estate • Clear detailed forward look at cyber security approach & investment needs; delivery requires capital, operational & resourcing funding to be prioritised & built into next year's plan; failure to address recommendations increase Trust exposure& risk • Update on CFHD highlights issue with neurodiversity pathway; a quality performance issue being escalated through QPC
ASSURE:	• Actions set out in response to ICB/PwC system-wide review of 'grip & control'; agreed to continue to monitor & conduct period (3 monthly) check to ensure actions delivering intended outcomes: • Operational performance maintained in most key metrics despite winter pressures (in particular January) e.g. ambulance handover performance in December best ever even with 14% increase in comparison to previous year; e.g. exiting Tier 2 monitoring for Cancer for confirmed by Region • Overall satisfactory assurance with Digital initiatives/programmes: o Confirmed appointment of interim TSD CIO o System-wide TOM remains slow progress due to issues beyond TSD control o Challenges remain with completing data centre relocation although on track for June completion with no negative wider impact identified o EPR focus on programme go-live preparation & business readiness (inc detailed activity planning); business benefits realisation planning is maturing

	in approach & detail, inc aligning with next year CIP programme
RISK:	• Prioritisation, and focus of works on the Tower (structure & fire risk mitigations) continue with engagement with extended parters (inc fire authorities); plans being formulated to undertake extended works requiring decanting of floors; co-ordination of this with delivery of services & other major delivery events (EPR) requires detailed planning; Tower still remains high risk • Overall fragility of estate continues to be a risk to service delivery & impacts productivity
CELEBRATE OUTSTANDING:	• Encouraging to note growing alignment between planning, strategy and operational delivery

Committee Chairs' Report – 25 February 2026

Finance and Performance Committee

REPORTS RECEIVED BY COMMITTEE:
The Board are asked to note that the following reports were received by the Committee and are escalated for their attention: • Finance and Operations Committee Themes – Satisfactory – To receive • Month 10 Finance Report – Satisfactory/Limited – To receive • Planning 2026/27 – February Update – Limited – To receive • Service Line Report 2025-26 Progress Update – Satisfactory/Limited – To receive • Operational Performance Report – Limited/Satisfactory – To receive • Child Family Health Devon Integrated Governance Board Report – (not discussed) – To receive • Capital Spend and Planning – 25/26 to 30/31 – Satisfactory/Limited – To receive • Disposal of Surplus Property – Satisfactory/Limited – To receive • Model Health System 2024-25 – Estates and Facilities metrics (ERIC) – Satisfactory/Limited – To receive • Digital Update – Satisfactory/Limited – To receive **The full Committee pack reviewed can be found on Diligent here:** **Diligent Boards: South Devon Health Information Services: Current Books**
ASSURANCE RECOMENDATION:
The Board are asked to AGREE the recommended assurance rating and TAKE [LIMITED- SATISFACTORY – SIGNIFICANT] ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	Decision on future of Teignmouth Hospital still pending with no clear timetable: - Ongoing work & costs to mitigate fire & safety risks whilst still in use - Data being collected & options assessed on relocating services & staff; options appraisal being developed which will include options to retain - Significant staff & stakeholder concerns to be considered Ongoing fragility of estates infrastructure, Tower risks, medical equipment replacement & maintenance backlog (>£60m) (despite efforts of teams)
ADVISE:	Received presentation from March on insurance renewal process (for submission by 31.3.26); key points to note:

	- Significant cover (>£1.6B) & significant fees; requires multiple providers - Tender process managed through Devon Procurement shared services (not Peninsula); not clear if economies of scale across Devon (& possibly Peninsula) being leveraged FY26/27 planning is continuing with next submission due 19th March: - Robust check & challenge & discussions internally & with ICB - ULP at£99.5M – a concern but as predicted; deficit makes TSD a national outlier (nb advised all Devon acutes are underfunded in comparison nationally) Performance reporting (NOF4 targets) consistent with previous month & overall improving trajectory (although not meeting target in number of areas): - Deeper dive into Trauma & Orthopaedics highlights significant loss-making largely due increase in non-elective trauma (high cost/loss making) with corresponding reduction in elective (profitable) - Action plan in development to address but not expected to deliver positive impact until at least Q2 26/27 & dependent on wider strategy agreement at system-level. Received Estates Returns Information Collection (ERIC) report (NHS mandatory annual data return on physical estate & associated facilities management): - Despite fragility of estate infrastructure, TSD compares adequately at national level on efficiency & costs measures (note 2024 data) - Opportunities identified for further efficiency improvements & cost savings - Risks obscuring fragility of estate & maintenance back log (est £60m +) Digital ongoing delays with data centre relocation (with risks of current site still not fully resolved/mitigated) Delays with ASC upgrade to Liquid Logic system potential to impact this year savings target/CIP
ASSURE:	Month 10 financial report on plan excl. removed DSF ; forecast to meet end year plan (exc DSF) with £1m favourable full year forecast. Service Line activity reporting is maturing as a process; quality of information improving. Next step is to better align outputs/data from SLR with performance data to determine underlying factors/causes & drive targeted corrective actions Continuing to attract capital funding although challenge to spend £44m funding by end of current financial year; focus & actions in place to ensure funding used effectively Within 5 yr capital plan funding allocated (based on risk assessment) for next financial year for EPIC (£8m), theatres £2m) & 3 critical infrastructure projects (Linac replacement £5m, Cardiac Cath Lab £5.7m, Aseptic Pharmacy 2.5m)

	Progress on disposal of surplus buildings
RISK:	Underlying position £99.5m deficit impacted by more non-recurring CIP & removal of deficit support funding. New potential unfunded cost pressure (est up to £5m) from band 5 nursing re-banding. Given scale of Devon system deficit, risk that achievements in meeting plan & reasons for ULP at start of FY26/27 is lost/not recognised. Importance of ensuring narrative on FY26/27 planning is clear & consistent, Lack of clarity & progress with One Devon TOM impacting decisions & cost: - Leadership risk mitigated for TSD with interim appointment - no clarity or leadership on One Devon approach & funding of cyber security risks with TSD upgrade proposal requiring additional approvals & funding (revenue costs)
CELEBRATE OUTSTANDING:	Improving quality of reporting; next step is to more effectively align & integrate reporting to enable a read-across eg financial, performance, productivity, & drill down through deep dives

Committee Chairs' Report – 27th January 2026

Quality and 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: • M09 Integrated Workforce Performance Report & Workforce Plan progress 2025/26 – Limited/Satisfactory – To receive • Combined Gender, Ethnicity, Disability Pay Gap Report – Satisfactory – To receive • Adult Social Care Report – Limited/Satisfactory – To receive • Quality Report for Healthcare – Limited/Satisfactory – To receive • External Regulatory Oversight Group Report – Limited/Satisfactory – To receive • Perinatal Quality and Safety Report – Limited/Satisfactory/Significant – To receive • NHS Resolution Maternity Incentive Scheme – Year 7 – Satisfactory/Significant – To receive • Safer Staffing Report – Satisfactory – To receive • Working Lives of Resident Doctors – Limited/Satisfactory/Significant – To receive • Infection Prevention Control Update – Limited/Satisfactory – To receive • CFHD Integrated Governance Report – Limited/Satisfactory – To receive • Quality Improvement Annual Report – Satisfactory – To receive • IPQR Dashboard – To note • Infection Prevention Control Dashboard – To 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 ratings above and TAKE ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	Increase in Neonatal mortality for a unit of our size and complexity. 4 cases in last 12 months. This triggered a MOSS alert and was escalated nationally and to CQC. A local review also underway with CNO oversight. Fragility in maternity workforce with QIS neonatal nurses coverage sitting at 61% against national benchmark of 70%.

	Birthrate+ analysis indicates a shortage of 3.81 WTE midwives. Homebirth benchmarking has identified areas of operational fragility in sometimes meeting demand. Obstetric workforce pressures continue to affect leadership capabilities.
ADVISE:	The committee noted the use of the agreed themes headers, but recognised ongoing work was needed to promote and ensure effective progress in meeting our objectives regarding Public Health and Health promotion initiatives. Useful discussion on Workforce plan and difference between HR and Finance reporting numbers relating to 'contracted' (drawn down from ESR) and 'worked' (ledger paid) WTE's. Worked WTE are 123 over and £1.5m overspent in M09. Appraisal remains <80% for both Medical and AFC staff against a target of >90%. We saw early signs of value in this combined assurance committee within the area of PSIRF and J&LC coming together. ASC while receiving a CQC outcome of 'GOOD' and standard DOLs backlog is improving the community DOLs backlog remains, workforce fragility and statutory backlogs continue and limit overall assurance.
ASSURE:	*Mandatory training is 89.35% against a target of 85%.* *Good discussion on Gender, Ethnicity and Disability Pay Gap report, showing broadly equitable pay across the majority of staff. Networks established.* *We were given assurance that all 10 safety actions would be in place by submission for CNST MIS. Internal Audit identified assurance for 7/10 as Green and Amber for 3/10 . Plans described to convert these to green were described for compliance.*
RISK:	We discussed Neurodiversity W/L and apparent need for a Paediatric assessment which was capped in volume and

	limiting progress. Models elsewhere are going to be investigated by the COO and the committee updated.
CELEBRATE OUTSTANDING:	Improvement in QI activity across the Trust from a much-reduced team with widespread examples of increased efficiency and transformation. Important for the Board to consider whether we can go further and faster as transformation becomes part of our future. The CQC Maternity survey on patient and family experience evidenced an uplift with feedback better in 38% of questions and aligned in 60% compared to other Trusts.

Committee Chairs' Report – 24th February 2026

Quality and 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: • M10 Integrated Workforce Performance Report & Workforce Plan progress 2025/26 – Limited/Satisfactory – To receive • People Services Strategy and Future Model Update – Satisfactory – To receive • Update on 2025 National Staff Survey Quarter 4 PULSE Survey Results CONFIDENTIAL – Limited/Satisfactory – To receive • Culture Plan Progress Report – Satisfactory – To receive • Restorative Just and Learning Culture Plan – Satisfactory – To receive • Cultural Insights Review Group (CIRG) Report – Satisfactory – To receive • Appraisal Update – Limited – To receive • Quality Report for Healthcare – Limited/Satisfactory – To receive • The improvement plans developed in response to the results of the Care Quality Committee NHS Patient Experience Survey programme for 2025 – Satisfactory/Significant – To receive • February 2026 Mortality Score Care – Satisfactory – To receive • Stroke Deep Dive – Limited/Satisfactory – To receive • AFC Job Evaluation Band 5-6 Job Evaluation Review for Registered Nurses – Satisfactory – To receive • Adult Social Care Report – Limited/Satisfactory – To note • IPQR Dashboard – To note • Infection Prevention Control Dashboard – To 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 ratings above and TAKE ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:	Increase in use of corridor care spaces as more timely ambulance handovers have been enabled. This has been associated with a rise in moderate harm incidents.

	As previously reported there has been a rise in perinatal incidents and 3 investigations are nearing completion. We were informed of a backlog in outstanding inquests that needs to be addressed. The Trust has been notified the coroner will be issuing a Regulation 28 relating to a case dating back to 2022 where no 'incident' was reported at the time. No further details available at this stage, but raises concerns about historical incident reporting within our governance system. There remain backlogs and delay in responding to complaints, however the backlog has reduced by 50% since December down to 300. AFC job evaluation of band 5 registered nurses is a national exercise that will require extensive collaborative work between CNO & CPO teams, but this review I believe is good for that band of nurses. Capacity to undertake the work and the potential financial risk is unknown, although early indication suggests this is fully funded centrally.
ADVISE:	Integrated workforce report M10 confirms 237.78 wte above the budgeted establishment with a YTD expenditure of £5.78m. National Staff Survey response rate for TSDFT was down 4% to 35.55%. We discussed ways to improve this to get better representation. Benchmark data is currently under embargo until national release end March/early April.
ASSURE:	Culture plan progress continues. CIRG established to bring together staff survey, FTSU, ER hotspots, sickness trends, patient feedback etc Plan is to develop a live cultural dashboard this year. RJLC implementation plan has commenced, and we discussed the important joint portfolio working with PSIRF. Mortality score card data continues to slowly improve with HSMR in the expected range. 2 areas where SHMI flagged as higher mortality were GI Bleeding and CCF. These are being monitored but we were informed the former was within expected limits.

RISK:	Stroke was triggered as an outlier nationally for mortality by the SSNAP. A deep dive has been undertaken with the aim of ensuring a full understanding of where the stroke pathway was not meeting expected targets. 9 key recommendations for improvement were outlined.
CELEBRATE OUTSTANDING:	Generally very positive responses from patients experience data collected by CQC survey in Maternity for 2025. High levels of confidence in staff. Reported areas for improvement include partner support overnight, discharge delays and pain management post-partum.

Torbay and South Devon NHS Foundation Trust

Board of Directors

Operational Performance Report

Date of meeting	Date report produced
5th March 2026	24th February 2026

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:	16th February 2026

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 Recovery Support Programme (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	No Change
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	No Change
Diagnostic Performance	Limited	No Change

Appendices
N/A

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance and Operations Committee – 25 February 2026

Key recommendations and actions requested
The Board are asked to AGREE the recommended assurance ratings and identify any areas requiring additional assurance.

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

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 January 2026 in UEC, and December 2025 in all elective metrics. The paper will also include detail on the forecasted positions in each of these performance domains for December and January where available.

3. National Benchmarking

3. The table below reflects latest published data (as at 15/01/26) 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.

Provider	Elective proportion waiting within 18 weeks Rank out of 118 Dec 2025	Elective proportion waiting over 52 weeks Rank out of 118 Dec 2025	Cancer faster diagnosis Rank out of 119 Dec 2025	Cancer 62-day combined Rank out of 119 Dec 2025	Diagnostics proportion waiting over 6 weeks Rank out of 117 Dec 2025	A&E 4-hour performance Rank out of 118 Jan 2026	A&E 12-hour performance Rank out of 118 Jan 2026
Torbay And South Devon NHS Foundation Trust	67.5% 19	2% 72	78.3% 67	79.8% 25	30.4% 82	67.9% 69	13.6% 54

Metric	Previous reported rank (out of 118)*	Latest available rank (out of 118)*	Improved/ Worsened
RTT 18-week wait	17 (Nov 2025)	19 (Dec 2025)	Worsened
RTT 52-week wait	61 (Nov 2025)	72 (Dec 2025)	Worsened
Cancer FDS	72 (Nov 2025)	67 (Dec 2025)	Improved
Cancer 62-day wait	62 (Nov 2025)	25 (Dec 2025)	Improved
Diagnostic wait over 6wks	85 (Nov 2025)	82 (Dec 2025)	Improved
UEC – 4-hour wait	62 (Dec 2025)	69 (Jan 2026)	Worsened
UEC 12-hour wait	34 (Dec 2025)	54 (Jan 2026)	Worsened

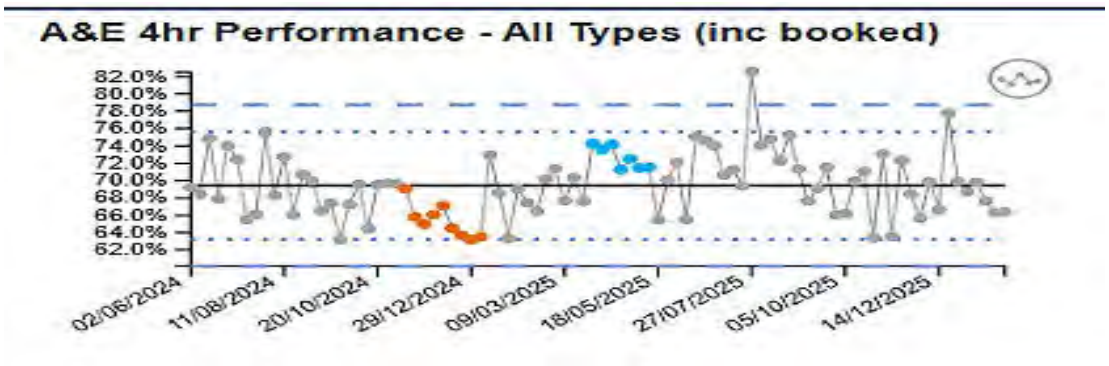
*National published data

4. Urgent and Emergency Care

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS																
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Operational Plan trajectory Jan 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1981		2532	1625	1268	839	1530	1159	725	943	1823	810	624	559	1283	2034
Average handover time (mins)	45 mins		84	62	47	36	52	45	32	38	60	33	29	27	45	42
Total average time in ED (hours/minutes)			06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		818	677	615	415	688	498	457	426	655	585	549	520	918	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.7%	7.4%	13.3%	7.0%
UEC 4-hour target (RAG against local trajectory to national target)	78%		66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	72.3%
% patient discharges pre-noon	33%		19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	5%

4-hour and 12-Hour Performance

4. The Trust did not achieve the revised January trajectory of 73.6% or national target of 78.0% for 4-hour performance in January. 4-hour performance for January 2026 worsened to 67.9% but remained a ~2% improvement in January 2025. 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. The Trust is currently undertaking a review of the UEC plans in place for Q4 to support an improvement to 74% by end of March 26. 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.



5. The current UEC sprint plan for the remainder of Q4 focusses on tangible actions linked to the original 6 key areas of focus within the 25/26 UEC recovery plan. These areas are
   - ED Performance
   - Medicine Streaming
   - Surgical Streaming
   - Paediatric Performance
   - Ward Improvements
   - UEC Demand Management

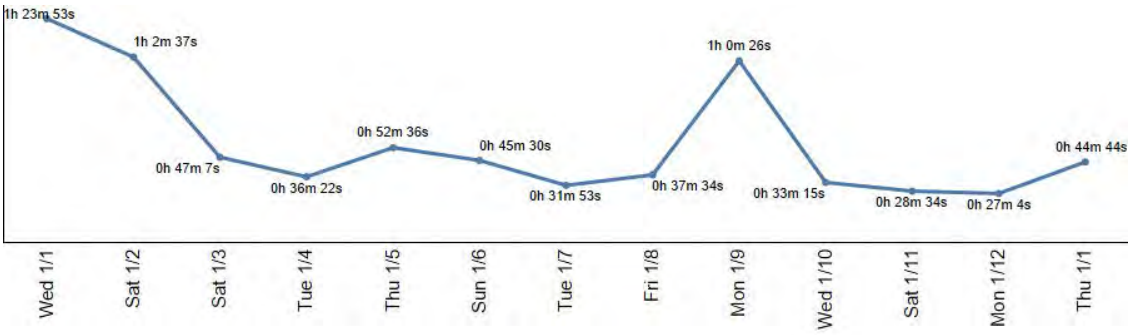
6. In January 2026, the ICO managed 10,319 all type UEC attendances. The Emergency Department recorded 6,916 type 1 attendances which is a 5.8% increase on the previous year. The current all type UEC demand growth in FY25/26 is 4.78% against a planned increase of 2%.

7. The number of patients waiting longer than 12 hours for admission or discharge in the emergency department increased to 13.3% of total attendances and was the first month in this financial year that the national standard of 10% was not met. Current projections for February show this performance returning to national standards.

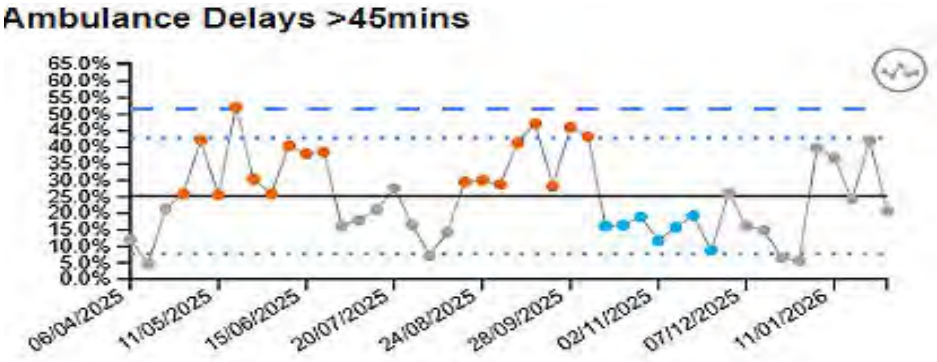
Ambulance Handover Delays

8. The total number of ambulance conveyances to the Trust in January 2026 was 2543 which was a slight reduction on the number of conveyances in December 2025. This is a 13.84% increase on January 2025.

   Ambulance handover dashboard: average handover time:



9. The Trust ambulance handover position worsened through January to a position of 44 minutes and 44 seconds per handover. During this period there was an increase in the total delays over 45 minutes as the chart below shows. It would be expected that the worsening in performance will have suppressed an element of the demand growth and if performance had remained at Q3 levels, the level of ambulance growth would have been in excess of the 13.84% experienced. The increase in 45-minute breaches can be seen below.



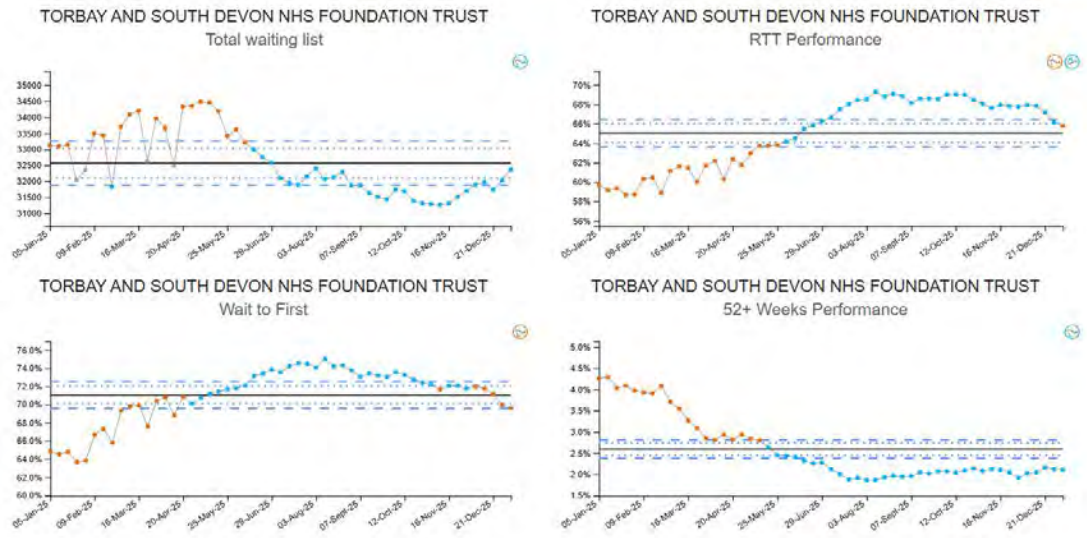
10. It is important to note that while improvements in ambulance handover performance have been clear, there has been an associated impact in the requirement to open additional escalation spaces and the costs associated with these. Work is ongoing to quantify the numbers of patients that have been accommodated in the ED corridor, the cohort area and other escalation areas across the Trust. Current forecasting shows improvements in the February ambulance handover performance and returning to the levels seen in Q3.

11. The board is asked to note that assurance is **limited** against delivery of the 4-hour performance targets. **Satisfactory** assurance can be provided on average ambulance handover times and 12-hour performance.

5. Elective Care – RTT

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRI	Target March 2026	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Operational Plan trajectory
RAG rated against monthly Operational Plan trajectory																
Oversight Framework																
Elective recovery																
RTT 78 week wait incomplete pathway	0		12	14	7	4	8	8	9	16	13	16	9	9	13	0
RTT 65 week wait incomplete pathway	0		204	215	141	145	126	95	97	105	110	109	84	94	83	0
RTT 52 week wait incomplete pathway	268		1238	1209	931	914	805	740	615	618	615	647	607	663	604	383
RTT % Incomplete pathways <18 wks	66.8%		61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	66.2%	65.9%
RTT Wait for first appointment <18 weeks	70.3%		63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	69.9%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	78.7%	57.1%	75.8%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	77.7%	78.1%
Cancer: No of patients waiting >62 days to start treatment	138		95	94	111	133	225	223	220	257	176	132	91	119	159	138
Cancer: % of patients > 62 days to start treatment	tbc		6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	5.9%	7.6%	tbc

12. The table above represents the most recent month's Trust level data and is not the final nationally reported position due to the delayed publication of national data in January 2026. The position for January 2026 remains a forecast and is subject to change. The charts below demonstrate the current progress against the key RSP exit criteria measures as reported regionally.



13. The charts detail the finalised December position and also the forecasted January position which has been submitted nationally as part of the required weekly submissions. It should be noted that while the Trust had achieved each of these standards in all months up to September, there was a clear plateau of the progress against each of these metrics heading into the autumn. An elective sprint is currently underway which is aimed at all patients waiting a first outpatient appointment over 40 weeks, patients awaiting an elective day case and ensuring clear validation standards are met.

14. Additional focus is being provided across a number of key areas for elective delivery through Q4. A daily review of issues such as theatre utilisation, cancellations on the day, outpatient utilisation, validation rates, fallow theatre

sessions is being undertaken to identify areas for rapid improvement. In addition to this, the Trust has obtained additional funding to support an increase in outpatient activity in excess of the original operating plan. This activity will support a return to compliance on RTT 18-week performance and the % of patients receiving first OPA with 18 weeks standard. Since commencing this sprint, the Trust has already seen an improvement in the first outpatient and validation standards, and these will be reported next month.

15. The Trust continues to experience 65-week breaches despite ongoing improvement against this metric. The December positioned worsened slightly from November due to the impacts of industrial action and the Christmas period. The main contributor to this issue remains long waiters in orthopaedics, although issues have arisen in ophthalmology due to short notice absence. At the time of writing, several additional actions are being undertaken which expect to improve the February and March positions.

16. Activity to the end of January 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 2% behind last year and 6% below plan although we have reported more outpatient attendances with procedure recorded (17% increase).
    - Elective inpatients are showing a greater variance to plan below planned levels of activity. For day cases, activity is above both plan and last year.

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

Setting	Attendance Type	24/25	25/26 Plan	25/26	Variance against Plan	Variance to last year 24/25
Day Case	Spell	33,648	33,925	34,540	2%	3%
Elective	Spell	2,890	3,303	2,743	-17%	-5%
Non-Elective	Spell	33,319	34,113	34,737	2%	4%
		69,857	71,340	72,020	1%	3%
First	Attendance	76,056	79,800	74,888	-6%	-2%
	Procedure	22,292	22,052	22,869	4%	3%
Follow-up	Attendance	204,095	213,987	200,948	-6%	-2%
	Procedure	72,845	61,213	71,822	17%	-1%
		375,288	377,052	370,527	-2%	-1%
A&E Dept Type 1	Attendance	67,174	72,101	70,906	-2%	6%
A&E Dept Type 3	Attendance	35,293	35,775	36,262	1%	3%
		102,467	107,876	107,168	-1%	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% activity

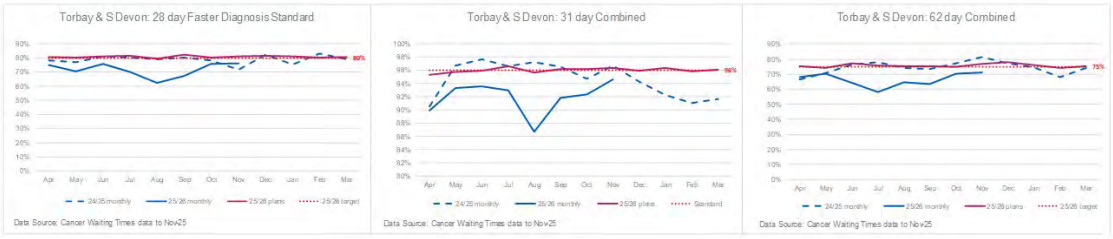
v levels undertaken in 2019/2020 with a current delivery of 115%. This has been supported through improvements in counting and coding, particularly in day case activity and outpatients' activity with a procedure.

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

6. Cancer and Diagnostics

20. The core 28-day faster diagnostic cancer standard was met in December. The Trusts 62-day cancer position also achieved in December and is forecast to continue to meet the standards in January. Due to the improvement in cancer performance, the Trust has received confirmation of exit from Tier 2 monitoring in January.

21. A risk to the January 2026 28-day FDS performance position has been identified. Short notice absence in dermatology during the December has caused a backlog in January. The backlog will be cleared during the month of January, and performance is forecast to return to compliance in February 2026.



22. Diagnostic performance (DM01) has remained a challenge throughout FY25/26 with a worsening of performance in December 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 non-obstetric ultrasound, DEXA and flexi cystoscopy.

23. 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. The new CDC contract is now in place, and the Trust is awaiting confirmation on a plan to deliver the levels of activity to clear the backlog in non-obstetric ultrasound. If this plan is confirmed, the activity provided would enable the Trust to clear the backlog and deliver a ~12% improvement to overall DM01 performance by May 2026.

24. 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 further details will be provided in the next paper.

7. Assurance recommendations and summary

It is recommended that, noting the above, the Board 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	No Change
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	No Change
Diagnostic Performance	Limited	No Change

Torbay and South Devon NHS Foundation Trust

Board of Directors

Month 10 Finance Report

Date of meeting	Date report produced
5th March 2026	16th February 2026

Author(s)		Report approved by	
Name and title:	Nichola Rees Finance Partner	**Name and title:**	Andrea Wright Director of Operational Finance
		Date:	16th February 2026

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

Executive summary

The Trust finance report seeks to provide assurance to the Board on the financial position year to date (YTD) as at 31st January 2026 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 10 the Trust is reporting a net YTD deficit of **£21.0m** against a planned deficit of **£10.7m.** The **£10.3m** variance relates to deficit support funding (DSF) not received for months 7 to 10. The net forecast deficit for the year end (based on a forecast by care group – slide 8) is **£22.4m** against a planned deficit of **£8.0m**. The forecast variance of **£14.5m** is due to Q3 and Q4 deficit support funding **£15.4m** shortfall offset with £**1.0m** improvement additional dental income variance to plan.

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 £8.0m planned deficit. The gross risk has reduced from £18.9m at month 6 to £6.0m in month 10 due to recovery actions. The main risks relate to cost pressures and slippage in recurrent CIP schemes. The Trust is forecasting achievement of the revised control total (£1m favourable to plan, excluding DSF).

This relies of delivery of £6.0m of further savings, of which £0.6m is identified as high risk.

The Trust is reporting £28.8m YTD CIP achievement, £2.4m behind plan (slide 6) although recurrent delivery is lower than plan (£23.9m v £17.0m). The annual forecast is to achieve the £41.5m plan, albeit split recurring £21.4m (vs £32.8m plan) and non-recurring £20.2m (vs £8.7m plan).

The planned exit underlying position for 25/26 (before national/system support) has increased from £81.8m planned recurrent deficit to £99.5m forecast recurrent underlying deficit, mainly due to the under delivery of recurrent CIP. Additional analysis is being undertaken to assess latest run rates and worked WTEs to identify any additional risks and mitigations to this assessed position.

Cash forecast shows risk around short-term performance due to the withdrawal of deficit support funding (DSF). Additional Revenue PDC of £3.3m has been confirmed in Q4 with a further application for £12.2m submitted for drawdown in M12, to mitigate the withdrawal of DSF (slide 14).

As at month 9 the Devon ICS is reporting a year to date £57.3m deficit, £50.6m higher than plan, £13.5m is related to unreceived deficit support funding (DSF). The forecast for the year end is £64.4m higher than plan at system level; £26.9m of this is unreceived deficit support funding (slide 16).

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
Finance and Operations Committee

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 £10.3m YTD due to withholding of deficit support funding (DSF).
- FOT to 31st January 2026 is £14.4m adverse to plan, reflecting withholding of Q3 and Q4 deficit support funding £15.4m, partially offset with £1.0m of additional dental income. The Trust expects applications of PDC Revenue Support to mitigate the cash impact of the loss of DSF.

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

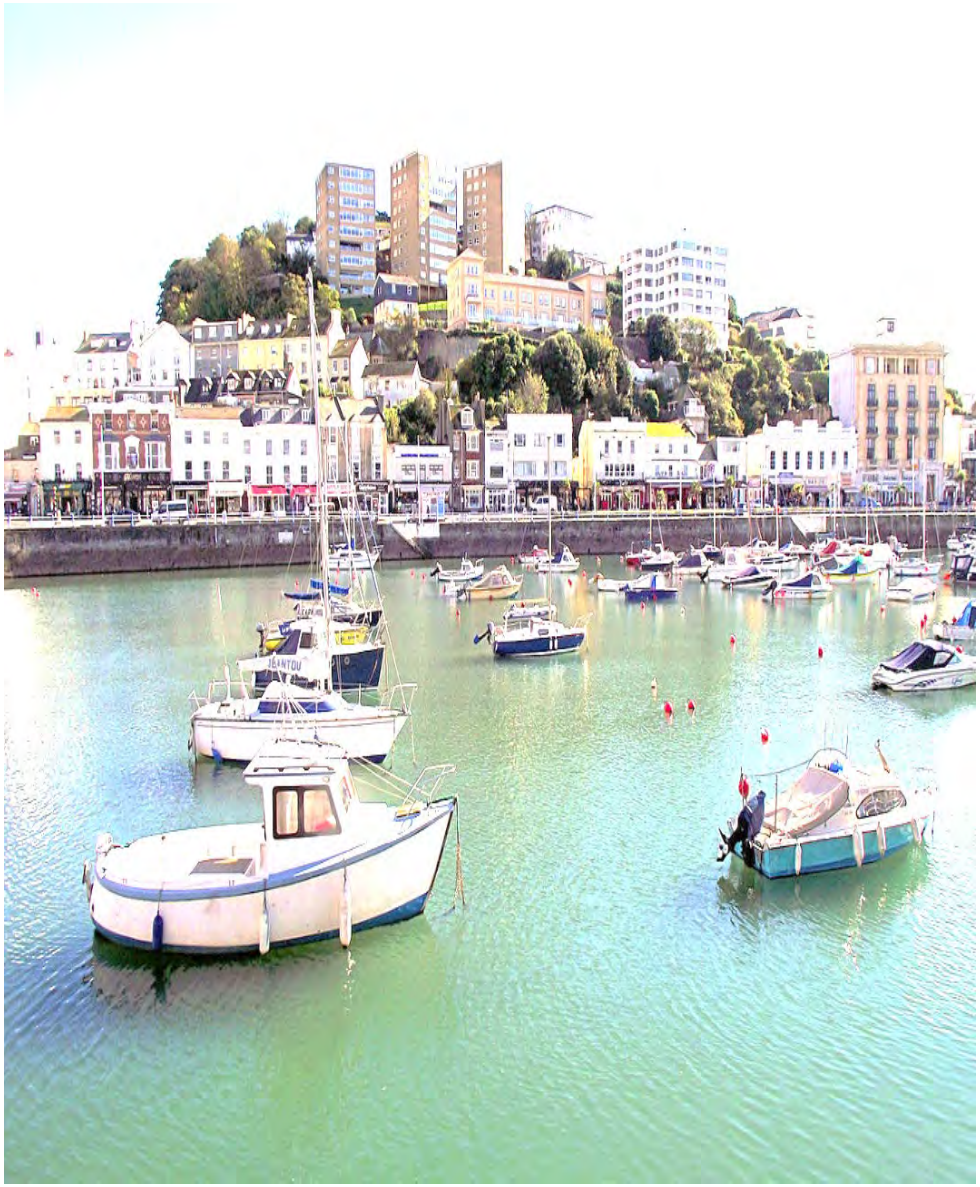
Aim	Impact
Population Health and Wellbeing	
Quality of services provided	
Sustainable and efficient use of resources	Robust financial information and forecasting is key to ensure the financial sustainability and ensuring efficient use of the Trust resources

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



NHS
Torbay and South Devon
NHS Foundation Trust

Monthly Financial Performance Report

Month 10

Executive Summary

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the financial position year to date (YTD) as at January 2026 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 10 the Trust is reporting a net YTD deficit of **£21.0m** against a planned deficit of **£10.7m.** The **£10.3m** variance relates to deficit funding not received months 7 to 10. The net forecast deficit for the year end (based on a forecast by care group – slide 8) is **£22.4m** against a planned deficit of **£8.0m.** The forecast variance of **£14.5m** is due to Q3 and Q4 deficit support funding **£15.4m** shortfall, offset with **£1.0m** improvement additional dental income variance to plan.

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 £8.0m planned deficit. The gross risk has reduced from £18.9m at month 6 to £6.0m in month 10 due to recovery actions. The main risks relate to cost pressures and slippage in recurrent CIP schemes. The Trust is forecasting achievement of the revised control total (£1m favourable to plan, excluding DSF). This relies of delivery of £6.0m of further savings, of which £0.6m is identified as high risk.

The Trust is reporting £28.8m YTD CIP achievement, £2.4m behind plan (slide 6) although recurrent delivery is lower than plan (£23.9m v £17.0m). The annual forecast is to achieve the £41.5m plan, albeit split recurring £21.4m (vs £32.8m plan) and non-recurring £20.2m (vs £8.7m plan).

The planned exit underlying position for 25/26 (before national/system support) has increased from £81.8m planned recurrent deficit to £99.5m forecast recurrent underlying deficit, mainly due to the under delivery of recurrent CIP. Additional analysis is being undertaken to assess latest run rates and worked WTEs to identify any additional risks and mitigations to this assessed position.

Cash forecast shows risk around short-term performance due to the withdrawal of deficit support funding (DSF). Additional Revenue PDC of £3.3m has been confirmed in Q4 with a further application for £12.2m submitted for drawdown in M12, to mitigate the withdrawal of DSF (slide 14).

As at month 9 the Devon ICS is reporting a year to date £57.3m deficit, £50.6m higher than plan, £13.5m is related to unreceived deficit support funding (DSF). The forecast for the year end is £64.4m higher than plan at system level; £26.9m of this is unreceived deficit support funding. (slide 16).

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 10

Torbay and South Devon NHS Foundation Trust

	M10				YTD M10				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	59.6	60.0	60.9	0.9	590.2	598.8	606.8	8.0	729.3	718.6	730.4	11.8
Operating Expenditure - Pay	(30.5)	(30.6)	(31.7)	(1.2)	(304.6)	(314.5)	(320.3)	(5.8)	(389.0)	(375.6)	(381.9)	(6.3)
Operating Expenditure Non-Pay and Financing Cost	(33.0)	(31.5)	(31.2)	0.2	(308.7)	(320.7)	(322.9)	(2.2)	(373.5)	(381.9)	(386.4)	(4.5)
Surplus / (Deficit) excluding DSF	**(3.9)**	**(2.0)**	**(2.0)**	**0.0**	**(23.2)**	**(36.4)**	**(36.4)**	**0.0**	**(33.2)**	**(38.8)**	**(37.9)**	**1.0**
Deficit Support Funding (DSF)		2.6	0.0	(2.6)		25.7	15.4	(10.3)		30.8	15.4	(15.4)
Surplus / (Deficit) including DSF	**(3.9)**	**0.5**	**(2.0)**	**(2.6)**	**(23.2)**	**(10.7)**	**(21.0)**	**(10.3)**	**(33.2)**	**(8.0)**	**(22.4)**	**(14.5)**

The Trust's financial position at the end of January shows a year-to-date deficit of **£21.0m**, against a planned deficit of **£10.7m.** The **£10.3m** variance relates to four months Deficit Support Funding (DSF) not received (months 7 to 10). The position excluding DSF is **£36.4m** deficit year-to-date, £0.0m variance to plan.

Year to date - Operating Income **£8.0m** favourable to plan (favourable variances include - Pass Through Drugs & Devices £2.4m, Council grant income £0.7m, other income incl. R&D & Education £5.9m, partially off set with an adverse variance on CIP delivery of £1m, removal of deficit support funding M7-10 £10.3m). Pay costs are higher than plan **£5.8m**, Non pay costs **£2.2m** higher than plan (slide 11). DSF is **£10.3m** adverse to plan where M7-10 funding is being withheld.

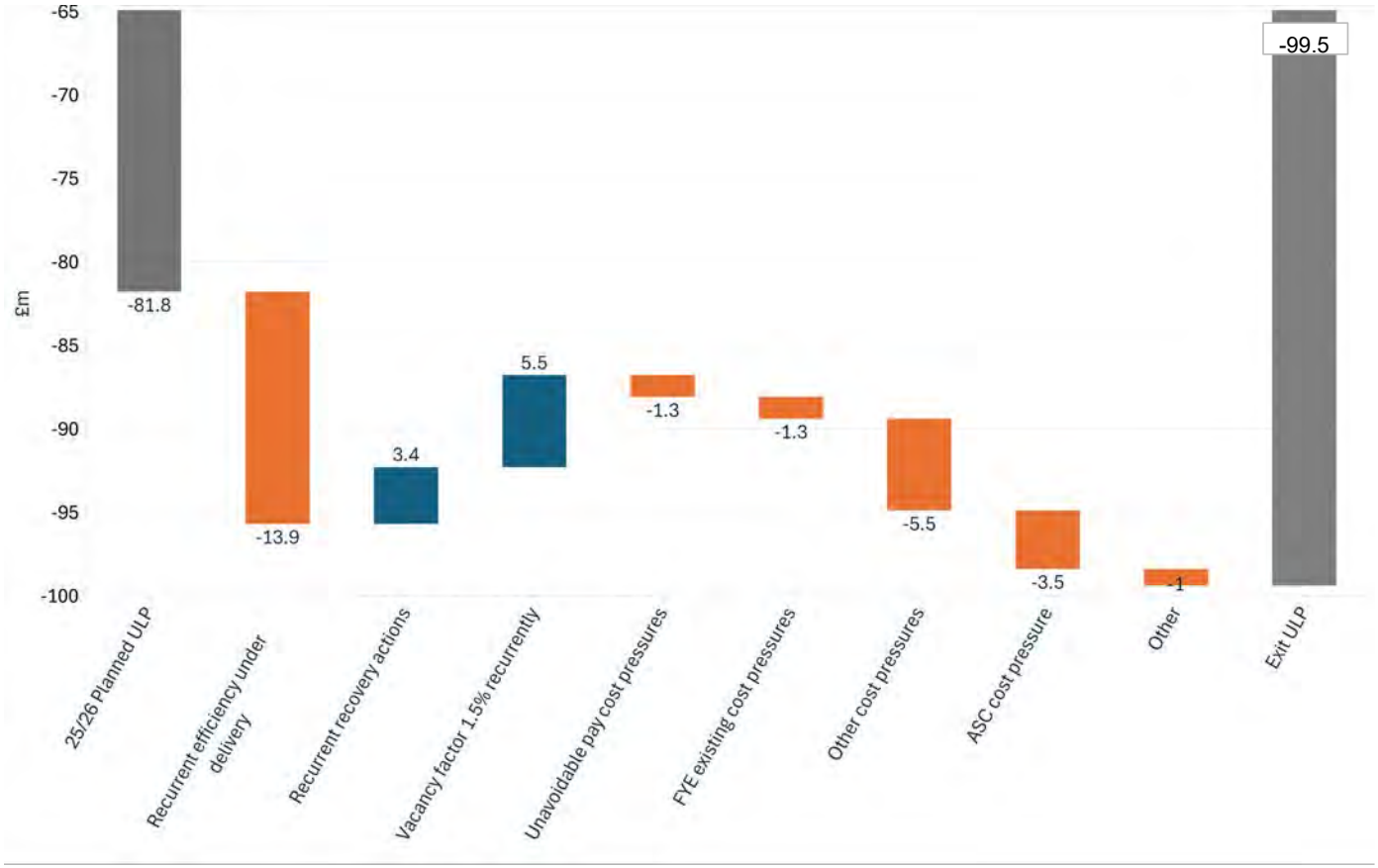
The Trust is reporting a year end forecast of **£22.4m** deficit with a shortfall on Q3 and Q4 deficit support funding of **£15.4m.** Work has now been concluded on revising the forecast outturn including risks and mitigations and is set out on slide 5. The position excluding DSF of **£15.4m** received is **£37.9m** deficit, **£1.0m** favourable to plan due to additional allocation of **£1.0m** dental income.

Forecast - Income **£11.8m** favourable to plan (favourable variances include - Pass Through Drugs & Devices £2.9m, Council grant £0.7m, R&D, Education & other income £1.9m, EPR £3.9m (offset with costs) and other income £4.1m, partially offset with an adverse variance on CIP delivery £1.6m. Pay costs higher than plan **£6.3m** mainly temporary staffing costs and industrial action, Non pay costs **£4.5m** higher than plan (slide 11). DSF is **£15.4m** adverse to plan where Q3-4 funding is being withheld.

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

Bridge from Planned Exit 25/26 ULP to Updated Recurrent ULP (based on M6)

Torbay and South Devon NHS Foundation Trust



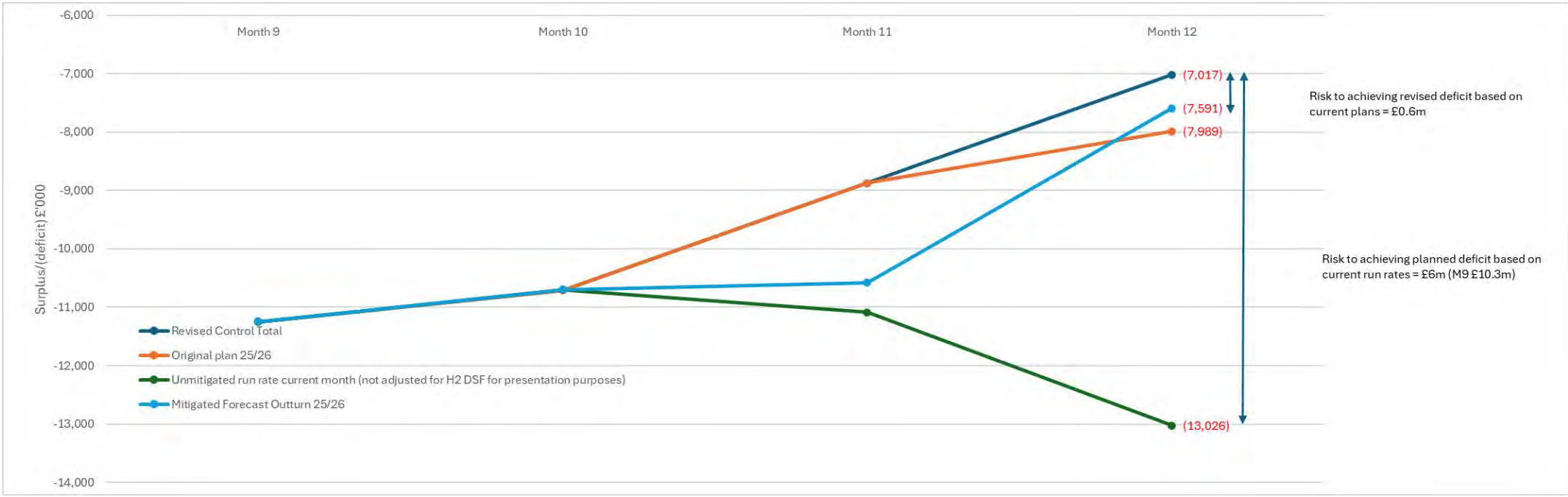
	£'m
25/26 Planned ULP	**-81.8**
Recurrent efficiency under delivery	-13.9
Recurrent recovery actions	3.4
Vacancy factor 1.5% recurrently	5.5
Unavoidable pay cost pressures	-1.3
FYE existing cost pressures	-1.3
Other cost pressures	-5.5
ASC cost pressure	-3.5
Other	-1
Exit ULP	**-99.5**

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



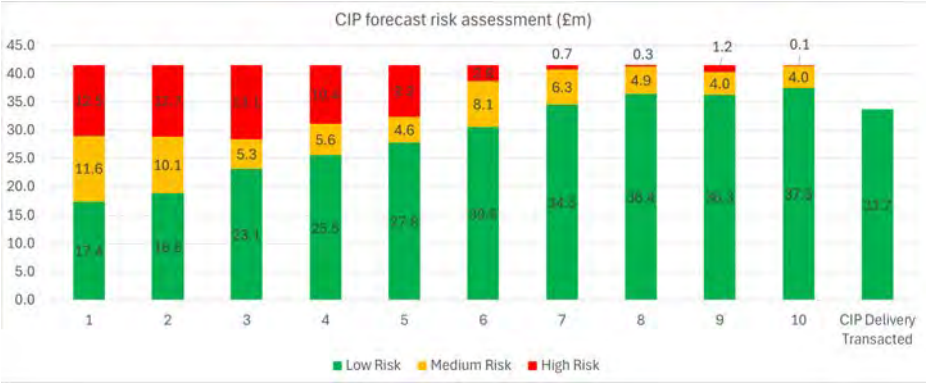
- The Trust has a planned deficit of £8.0m. Following allocation of additional dental income the expectation is that the Trust will deliver an outturn position that is £1.0m favourable to this of £7.0m deficit (this excludes the impact of withdrawn DSF).
- At the end of Q2 the gross risk to forecast was assessed at £18.9m to delivering the £8m planned deficit, with CIP delivery improvement and other recovery actions needed to bring the Trust back to the planned deficit.
- The risk to forecast has reduced as the year has progressed and recovery plans and CIP delivery have crystalised
- The latest forecast from the Month 10 position reflects a base forecast, at recurrent runrate with no mitigating actions (excluding the impact of no DSF for Q3-4) of £13m deficit (M9 £18.3m), against the revised control total of £7m deficit; presenting a £6m gap to plan delivery (M9 £10.3m).
- The Trust is forecasting achievement of the control total (excluding loss of Q3-4 DSF), this relies on delivery of further CIP and recovery plans of £6.0m, of which £0.6m are high risk. The forecast excluding high risk recovery actions reflects a gap to delivery of £0.6m.

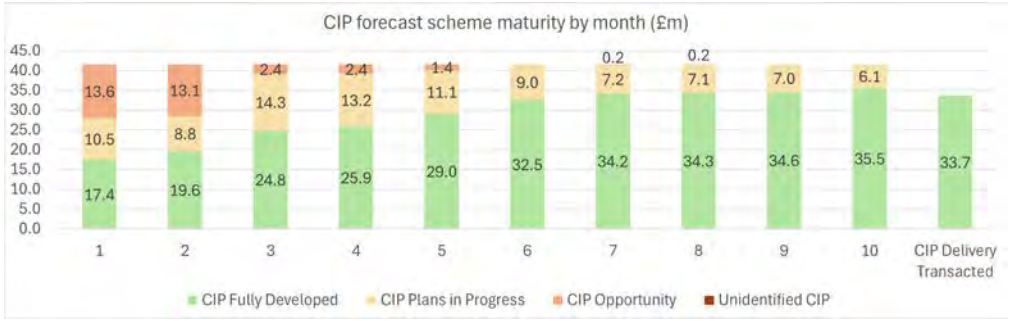
Torbay and South Devon NHS Foundation Trust

Efficiencies/CIP – maturity & risk

	Year to Date			Forecast Outturn		
	Plan CIP delivery £m	Actual CIP Delivery £m	Var +/(-) £m	Plan for the year £m	Forecast £m	Var +/(-) £m
Recurrent efficiencies	23.9	17.0	(6.9)	32.8	21.4	(11.4)
Non-recurrent efficiencies	7.3	11.8	4.5	8.7	20.2	11.4
Total	**31.2**	**28.8**	**(2.4)**	**41.5**	**41.5**	**0.0**
Recurrent %	77%	59%		79%	51%	
Non-recurrent %	23%	41%		21%	49%	

Care Group	High Risk Forecast CIP Delivery £m
Medicine and Urgent Care	0.04
Planned Care and Surgery	0.05
Shared Corporate Services	0.03
Grand Total	**0.11**





The Trust is reporting £28.8m YTD CIP achievement, £2.4m behind plan. The annual forecast is to still achieve the £41.5m plan although at M10 forecast the recurring figure is £21.4m (£11.4m less than plan) and non-recurring £20.2m (£1m ahead of plan). The recurrent savings will continue to be assessed and expected to increase in Q4

There is **limited assurance** around delivering the full efficiency requirement particularly in relation to levels of recurrent delivery.

Efficiencies/CIP - by Care Group

Total CIP Delivery	Delivered YTD			Forecast Outturn		
Care Group	Plan £m	Delivery £m	Var +/(-)	Plan £m	Delivery £m	Var +/(-)
Families & Communities	5.0	5.6	0.6	6.4	6.9	0.5
Medicine and Urgent Care	3.7	3.8	0.1	4.6	4.6	(0.0)
Planned Care and Surgery	6.5	6.9	0.4	8.4	9.0	0.6
Shared Corporate Services	8.6	4.8	(3.8)	13.0	11.6	(1.3)
Children and Family Health Devon	0.7	0.9	0.3	0.7	1.1	0.4
Adult Social Care – Torbay	6.7	6.7	0.0	8.4	8.3	(0.1)
Total	**31.2**	**28.8**	**(2.4)**	**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	2.8	3.9	1.2	3.8	4.9	1.2
Medicine and Urgent Care	3.2	1.8	(1.4)	4.0	2.3	(1.7)
Planned Care and Surgery	4.3	3.1	(1.2)	5.6	3.5	(2.1)
Shared Corporate Services	7.2	1.8	(5.4)	11.3	2.7	(8.6)
Children and Family Health Devon	0.1	0.0	(0.1)	0.1	0.0	(0.1)
Adult Social Care – Torbay	6.4	6.4	(0.0)	8.1	8.0	(0.1)
Total	**23.9**	**17.0**	**(6.9)**	**32.8**	**21.4**	**(11.4)**
Recurrent as a % of Total	**77%**	**59%**		**79%**	**51%**	

CIP forecast currently reflects achievement in line with plan total (£41.5m) although with a lower than planned level of recurrent efficiency, as reductions in forecast delivery on recurrent workforce savings have been made with further non-recurrent transactions. This represents a risk to the recurrent exist cost position in the 2026-27 plan. Additional analysis is being undertaken on M10 pay costs and WTEs to assess the risk (and identify any further opportunities).

There are £0.1m of high risk rated schemes within this as noted on slide 6.

Care Group Summary

Care Groups	M10				YTD M10 25/26				Financial Year			
	PY 24/25	CY 25/26			PY 24/25	CY 25/26			PY 24/25	Forecast Outturn 25/26		
	Actual £m	Plan £m	Actual £m	Var +/(-) £m	Actual £m	Plan £m	Actual £m	Var +/(-) £m	Forecast Outturn £m	Annual Plan £m	Forecast Outturn £m	Var +/(-) £m
Children and Family Health Devon (CFHD)	0.1	(0.0)	(0.1)	(0.1)	1.6	0.1	1.1	1.0	1.9	0.0	1.2	1.1
Families & Communities	(10.7)	(11.5)	(11.3)	0.2	(106.2)	(116.1)	(115.3)	0.9	(127.2)	(138.6)	(138.4)	0.2
Medicine and Urgent Care	(7.6)	(7.9)	(7.4)	0.4	(78.0)	(79.6)	(80.0)	(0.3)	(93.2)	(95.3)	(96.2)	(0.9)
Planned Care and Surgery	(12.2)	(13.0)	(12.5)	0.6	(127.2)	(132.7)	(133.4)	(0.7)	(153.0)	(158.7)	(159.9)	(1.2)
Corporate	(4.4)	(4.0)	(3.7)	0.3	(41.7)	(44.1)	(42.8)	1.3	(50.1)	(51.8)	(51.4)	0.4
Workplace (Estates)	(2.5)	(2.5)	(2.8)	(0.3)	(26.0)	(25.9)	(25.7)	0.2	(30.8)	(30.9)	(30.9)	(0.0)
Reserves & Other Income (Inc Fin Costs)	41.4	47.6	44.1	(3.5)	432.9	470.0	459.4	(10.6)	513.5	565.2	554.0	(11.2)
Adult Social Care – Torbay	(8.2)	(8.1)	(8.3)	(0.1)	(78.6)	(82.4)	(84.4)	(2.0)	(94.3)	(97.9)	(100.8)	(2.9)
Surplus / (Deficit) Total	**(3.9)**	**0.5**	**(2.0)**	**(2.6)**	**(23.2)**	**(10.7)**	**(21.0)**	**(10.3)**	**(33.2)**	**(8.0)**	**(22.4)**	**(14.5)**

CFHD: YTD £1.0m lower than plan due to vacancies and non pay underspend. Underspend position to continue although reducing as vacancies are filled and reinvestment in pressured services; forecast underspend £1.1m.

Families and Communities: Both YTD (£0.9m) and full year outturn (£0.2m) are now in a under spend position, as a result of over delivery of CIP, partially offset by growth pressures.

Adult Social Care (Torbay): YTD £2m adverse to budget increasing to £2.9m for the full year. The FOT position is principally driven by in year non pay cost pressures across Domcare (£1.3m) and Long stay services (£0.9m) from growth in client numbers and Supported Living due to increases in package of care costs driven by complexity (£0.6m).

Medicine & Urgent Care: YTD £0.3m higher than plan due to ED Medical staffing £0.3m, Cardiology consumables £0.4m and escalation capacity £0.4m partially offset with underspends in Medicine wards. Forecast higher than plan £0.9m due to escalation costs £0.6m, ED medical staffing costs £0.4m and Cardiology consumables £0.5m partially offset by underspend in Medicine wards.

Planned Care: YTD £0.7m higher than plan due to medical pay £0.9m, theatre and lab consumables £0.6m and drugs £0.2m, offset by release of deferred income accrual £1.0m. Forecast £1.2m higher than plan due to consumables £0.9m, medical pay £0.9m and CDC contract funding shortfall £0.3m, partially offset by deferred income release £1.0m.

Workplace: YTD £0.2m lower than plan driven by £0.7m estates vacancies, estates maintenance and utilities costs (budget phasing) and £0.1m income for 24/25 for retail sales. Forecast to break even, due to a £0.6m under-delivery of CIP offset with estates vacancies and lower utilities costs.

Corporate: YTD £1.3m lower than plan driven by £0.5m R&D surplus income held in reserves, £1.6m CIP over-delivery, and underspends from vacancies and overachieved income, offset by £0.8m of cost pressures (insurance, procurement transformation, people digital, operational support). Forecast £0.4m lower than plan reflecting £0.3m CIP under-delivery and £0.8m continued cost pressures, partially mitigated by £0.6m R&D reserves income and £0.9m vacancies and overachieved income.

Reserves & Other Income (inc Finance costs) : YTD £10.6m adverse to plan, mainly due to Deficit Support Funding (DSF) not received for M7-10 of £10.3m, as well as other contract income adverse variances amounting to £0.3m adverse to plan. Forecast £11.2m adverse to plan due to DSF not received for Q3-4 £15.4m, offset with £4.8m of other net favourable variances, including delivery of further mitigating run rate improvements from recovery plan.

Workforce

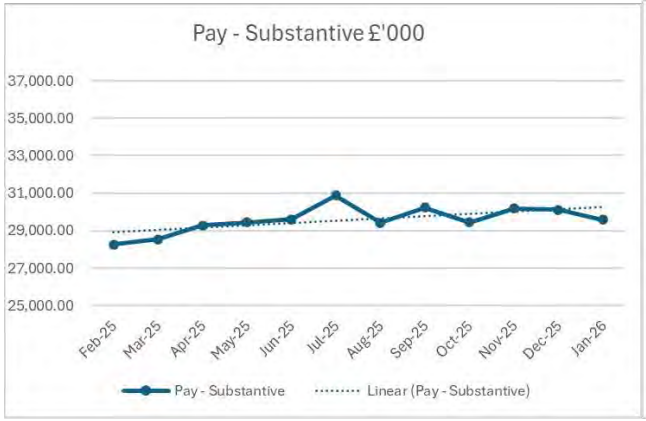
Torbay and South Devon NHS Foundation Trust

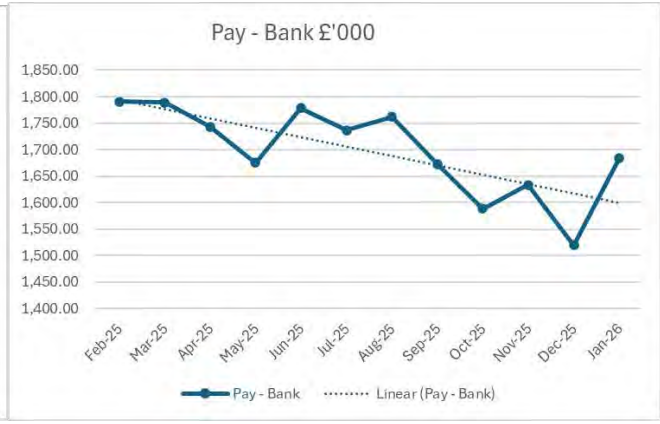
	Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Class	Plan £m	Actual £m	Var +/(-) £m	Full Year Plan £m	Forecast £m	Var +/(-) £m	WTE Plan	WTE Worked	Var +/(-)
Non-executive directors	(0.2)	(0.1)	0.0	(0.2)	(0.2)	0.0	7	5	1
Pay - substantive	(292.4)	(298.2)	(5.8)	(349.2)	(355.6)	(6.4)	6,033	6,247	(214)
Pay - bank	(16.1)	(16.8)	(0.7)	(19.3)	(20.0)	(0.7)	309	317	(8)
Pay - agency	(5.9)	(5.3)	0.7	(7.1)	(6.3)	0.8	63	75	(12)
Grand Total	**(314.6)**	**(320.4)**	**(5.8)**	**(375.8)**	**(382.0)**	**(6.3)**	**6,411**	**6,644**	**(233)**

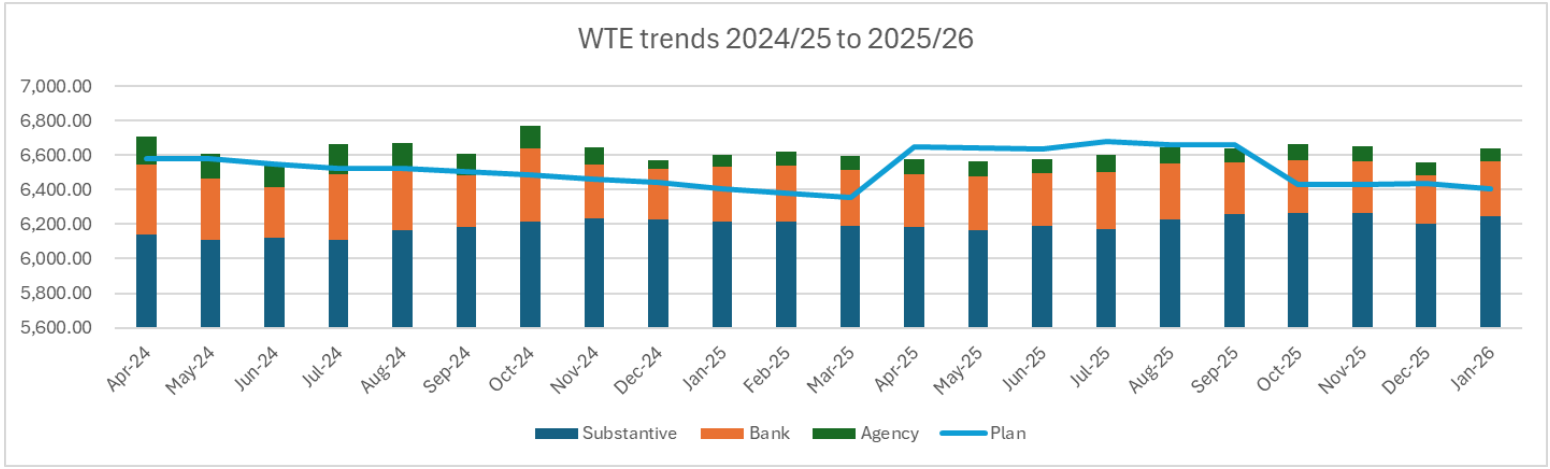
- As at end of January there are 233WTE higher than plan due to the phasing of an additional 230 WTE reduction in the CIP programme from M7. The CIP delivery expectation has been revised following a full review of workforce additional pay controls to reduce costs. There are additional efficiencies expected above plan in other areas of non pay and income as part of the revised recovery actions to ensure the overall delivery CIP plan.
- The YTD financial position £5.8m higher than plan for overall pay costs, mainly with substantive posts higher than plan due to efficiency programme phasing, industrial action and medical staffing pressures.
- Forecast year end over expenditure of £6.3m is due mainly to efficiency programme phasing and continuing medical staffing pressures and industrial action.
- There is an ongoing WTE review being carried out to reconcile WTE figures to costs and ensure consistency

Month 10 – Rolling Worked WTE and Pay Run Rate Trends

Torbay and South Devon NHS Foundation Trust







10

Non-Pay Summary

Description	M10				YTD M10 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	(0.6)	(0.8)	(0.8)	0.0	(7.6)	(8.3)	(8.1)	0.1	(9.1)	(9.9)	(9.7)	0.2
Drugs costs	(4.2)	(3.9)	(4.2)	(0.3)	(41.5)	(40.3)	(43.8)	(3.5)	(50.0)	(48.0)	(52.6)	(4.6)
Non-executive directors	(0.0)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	(0.1)	0.0	(0.2)	(0.2)	(0.2)	0.0
Other non-pay operating costs	(7.4)	(5.8)	(5.4)	0.5	(57.6)	(62.0)	(58.9)	3.1	(70.6)	(73.4)	(70.7)	2.7
Procurement	(11.2)	(11.2)	(11.2)	(0.0)	(109.0)	(112.9)	(113.8)	(0.9)	(132.8)	(134.7)	(135.9)	(1.1)
Purchase of social care	(9.5)	(9.5)	(9.5)	(0.0)	(92.6)	(95.4)	(97.2)	(1.7)	(110.6)	(113.4)	(116.0)	(2.5)
Financing Costs	(0.0)	(0.2)	(0.1)	0.1	(0.3)	(1.7)	(1.1)	0.7	(0.1)	(2.1)	(1.3)	0.8
Operating Expenditure Non-Pay and Financing Costs	**(33.0)**	**(31.5)**	**(31.2)**	**0.2**	**(308.7)**	**(320.7)**	**(322.9)**	**(2.2)**	**(373.5)**	**(381.9)**	**(386.4)**	**(4.5)**

Non-pay YTD **£2.2m** adverse to plan:

- Pass through drug costs **£2.3m** adverse (offset with income), other drugs **£1.2m** adverse (rheumatology, general surgery, outpatients, labs)
- Procurement and Other Non-Pay Operating costs **£2.2m net** favourable to plan comprising of:
  - Recovery plan actions **£3.2m,** planned care over delivery of CIP **£1.2m** (offset under delivery income), ERF **£0.8m** (costs are in pay), CFHD **£0.5m**,
  - Higher than plan EPR costs **£1.6m** and pass through devices **£0.7m** (both offset with income), Corporate costs **£1.4m** (insurance, procurement transformation, people digital and NHP)
- Purchase of social care **£1.7m** adverse to plan due to: growth in client numbers and complexity (**£2.6m** adverse) offset by an accrual benefit (**£0.9m** favourable).
- Finance costs lower than plan **£0.7m,** CNST **£0.1m**

Non pay forecast is **£4.5m** adverse to plan due to:-

- Pass through drug costs **£2.6m** adverse to plan (offset with income), other drugs **£1.9m** adverse to plan (rheumatology, general surgery, outpatients, labs)
- Procurement and Other Non-Pay Operating costs **£1.6m** net favourable to plan including £4.2m recovery plan run rate improvements:-
  - Corporate adverse to plan **£2.9m** due to: under delivery CIP **£1.8m,** non pay costs **£1.1m** higher than plan (insurance, procurement transformation, people digital and NHP).
  - Planned Care favourable to plan **£2.6m** due to: over delivery non pay CIP (**£1.6m** favourable - offset with under delivery CIP income), ERF (**£1.0m** favourable - offset with ERF pay costs)
  - CFHD & risk share favourable to plan **£0.7m**
  - Other Costs favourable to plan **£1.3m** due to: increased costs in funded costs for EPR (**£2.0m** adverse) and pass through devices (**£0.8m** adverse), offset with recovery plan runrate improvements.
- Purchase of Social Care adverse to plan **£2.5m** due to growth in client numbers and complexity.
- Finance costs favourable to plan **£0.8m,** CNST **£0.2m**

Torbay and South Devon NHS Foundation Trust

ERF Income Position against 19/20 Baseline

Care Group	M10 Income 19/20 £m	M10 Income 25/26 £m	M10 Income Variance £m	M10 Income Variance %
Planned Care and Surgery	46.7	50.3	3.6	108%
Medicine and Urgent Care	9.1	13.0	3.9	143%
Families and Communities	5.5	7.1	1.5	128%
Grand Total	**61.3**	**70.4**	**9.1**	**115%**

- The table shows the M10 position against the 24/25 version of the 19/20 ERF baseline adjusted for number of working days and the 25/26 tariff uplift.
- If income per working day remains at current levels through out the last quarter the year end position will be 113.3% 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. There is currently a provision of £760K in the year-to-date position relating to the ICB marginal rate thresholds.

Productivity Metrics (national data) – M7 25/26 vs M7 24/25

M7	M7 2526 vs M7 2425
Inflation adj. expenditure growth	2.2%
Cost weighted activity growth	4.1%
Implied productivity growth	1.8%

- National productivity data is produced every month, 3 months in arrears. Implied productivity is tracked against prior year figures to demonstrate improvements in productivity once accounting for increases in funding.
- There was a back dated change to activity data recorded actioned in month 6 that has improved the position.
- As at month 7, implied productivity is improved from same period in 24/25 by 1.8%
- Further adjustment is likely needed in relation to ASC and CHC spend which is included in this calculation but activity is not. Correcting for this should improve the metric by approx. 0.2%.

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.

Work has begun to develop a productivity opportunity matrix and a productivity dashboard to drive better local understanding of the metrics. Work has also been completed on an initial review of the Productivity Opportunities pack provided by NHSE and linked to the planning process for 2026/27 and beyond.

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.
Productivity work will be linked to SLR, planned Clinical Service Reviews and other transformation and CIP work.

Cash Position – Month 10

	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	(4.9)	(15.7)	(10.8)	(16.1)
Capital Non-Cash movements (depr&amort)	19.4	19.4	0.0	23.6
Working Capital Movement	13.7	(22.6)	(36.3)	(19.7)
Net cash generated from / (used in) operations	**31.5**	**7.8**	**(23.7)**	**14.5**
Net Capital Expenditure (Purchase/Disposals)	(45.6)	(22.0)	23.5	(68.8)
Interest Received	0.9	1.3	0.4	1.5
Net cash generated from/(used in) investing activities	**(44.7)**	**(20.7)**	**23.9**	**(67.2)**
PDC paid/received	24.3	28.0	3.7	72.8
Loans paid/received	(1.7)	(1.7)	0.0	(2.0)
Capital on finance leases and PFI	(4.2)	(3.6)	0.6	(4.2)
Interest element on loans, finance lease and PFI	(2.0)	(1.8)	0.2	(2.2)
Net cash generated from/(used in) financing activities	**16.4**	**20.9**	**4.5**	**64.5**
Closing cash balance	**3.2**	**7.9**	**4.7**	**11.7**

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	**(15.7)**
Finance income	1.3
Finance expense	(2.7)
PDC dividend expense	(4.8)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	**(21.9)**
Capital donations/grants/peppercorn lease I&E impact	0.7
PFI revenue costs on an IFRS 16 basis	2.9
PFI revenue costs on a UK GAAP basis	(2.7)
TOTAL Provider Surplus/(Deficit) - System performance mea	**(21.0)**

Torbay and South Devon NHS Foundation Trust

The closing cash balance for M10 is £4.7m higher than plan, explained by;

- The Opening cash balance at the start of the year of **£23.4m** was utilised to settle prior year closing creditors in M1-2.
- Net cash generated from operations is **£23.7m** below plan, due to £10.3m withheld Q3-4 DSF with the remaining difference primarily related to the timing of creditor payments.
- Investing activities show a **£23.9m** variance, reflecting re-phasing of the capital plan and some delay in National Schemes programmes.
- Financing activities show **£4.5m** variance primarily due to higher than planned capital PDC drawn to this date due to additional funding received.

Cash Risk: Non-recurrent deficit support funding for Q3/Q4 has been withdrawn (£15.4m), however revenue PDC cash support has been applied for to mitigate this amount in full, but £12.1m is yet to be approved. Non-cash backed balance sheet releases at year-end and failures to meet CIP targets remain as additional risks.

Torbay and South Devon NHS Foundation Trust

Cashflow Forecast – Month 10

	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Start Date 01.02.2026	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Cash Balance B/F	8.3	12.7	11.7	2.5	3.1	4.3
Total Receipts	86.2	86.5	60.5	65.5	68.2	60.4
Total Payments	(81.7)	(87.5)	(69.7)	(65.0)	(66.9)	(61.9)
Net Movement	4.5	(1.0)	(9.2)	0.6	1.2	(1.5)
Cash Balance C/F	**12.8**	**11.7**	**2.5**	**3.1**	**4.3**	**2.8**

The Month 10 cashflow forecast has been prepared based on the following basis:

- The forecast for M01 - M04 2026/27 is based on the most recent 2026/27 plan but could be subject to change if further iterations of the plan are issued.
- £2.2m Revenue PDC Cash Support has been received in M10, however an application for £2.3m for drawdown in M11 has been reduced to £1.1m by NHSE to reflect the £1.2m funding confirmed to mitigate industrial action costs.
- A further application for £12.2m Revenue PDC Cash Support has been submitted for drawdown in M12 to fully mitigate Q3/Q4 DSF withdrawal.
- The capital plan and associated funding sources remain as per the M10 capital plan.
- Latest forecasts suggest capital creditors of £7.2m as at 31 March 2026, thereby increasing the year-end closing cash position from the plan closing cashflow of £2.2m.

Balance Sheet – Month 10

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	295.8	274.5	(21.3)
Other Non-Current Assets (Receivables)	4.0	4.3	0.2
Cash & Cash Equivalents	3.2	7.9	4.7
Working Capital (excl cash)	(23.9)	(38.5)	(14.6)
Non-Current Liabilities (Loans/Leases/Other)	(52.9)	(51.1)	1.8
Total Assets Employed (Assets + Liabilities)	**226.2**	**197.1**	**(29.1)**
Public Dividend Capital	306.4	308.3	1.9
Revaluation	61.0	60.7	(0.3)
Surplus / (Deficit) Sub Total	(11.6)	(21.9)	(10.3)
I&E reserves	(129.6)	(150.0)	(20.4)
Reserves Total	**226.2**	**197.1**	**(29.1)**

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	**(15.7)**
Finance income	1.3
Finance expense	(2.7)
PDC dividend expense	(4.8)
Other gains/(losses) including disposal of assets	0.0
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	**(21.9)**
Capital donations/grants/peppercorn lease I&E impact	0.7
PFI revenue costs on an IFRS 16 basis	2.9
PFI revenue costs on a UK GAAP basis	(2.7)
TOTAL Provider Surplus/(Deficit) - System performance mea	**(21.0)**

- Fixed Assets are lower than plan **£21.3m** due to re-phasing of the Capital Plan. However, it is expected that the year-end position is expected to exceed plan due to additional capital allocations 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 **£4.7m** higher than plan, explained in detail in cashflow position report (slide 13)
- Working Capital (excl cash) variance of **£14.6m.** £2.9m is related to re-phasing of ICB income to account for CIP risk profile. The remainder is due to lower receivables than planned.
- Loans and Leases liabilities are **£1.8m** lower than plan, due to a reduction of leasing in favour of outright purchase. The total position for the year is expected to align with plan by year end.
- PDC capital drawdown to the end of M10 is **£19.8m**, £0.5m above the plan due to additional schemes approved. Total PDC Capital for the year is looking to be at **£51.0m**, £31.7m higher than plan. PDC revenue drawdown is **£10.2m**, £3.6m higher than plan.
- Year-to-date capital expenditure stands at **£27.8m**, (plan £31.7m, delays against Estates backlog maintenance and National Schemes spend).

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

Torbay and South Devon NHS Foundation Trust

As at month 9 the Devon ICS is reporting a year to date £57.3m deficit, £50.6m higher than plan, £13.5m is related to unreceived deficit support funding (DSF). The forecast for the year end is £64.4m higher than plan at system level, £26.9m of this is unreceived deficit support funding.

Description	Month 10			DSF Impact		Forecast Outturn			DSF Impact	
	Plan £m	Actual £m	Var +/(-) £m	Lost DSF £m	Variance excluding lost DSF £m	Plan £m	Forecast £m	Var +/(-) £m	Lost DSF £m	Variance excluding lost DSF £m
Devon ICB	6.0	7.5	1.5	0.0	1.5	8.0	8.0	0.0	0.0	0.0
Devon Partnership NHS Trust	0.0	0.0	0.0	0.0	0.0	0.0	2.7	2.7	0.0	2.7
Royal Devon University NHS FT	(0.2)	(36.5)	(36.3)	0.0	(36.3)	0.0	(44.0)	(44.0)	0.0	(44.0)
Torbay and South Devon NHS FT	(11.3)	(19.0)	(7.7)	7.7	0.0	(8.0)	(22.4)	(14.4)	15.4	1.0
University Hospitals Plymouth NHS FT	(1.3)	(9.3)	(8.0)	5.7	(2.3)	0.0	(8.6)	(8.6)	11.5	2.9
Total	**(6.8)**	**(57.3)**	**(50.6)**	**13.5**	**(37.1)**	**0.0**	**(64.4)**	**(64.4)**	**26.9**	**(37.4)**

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 9 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	No change

Devon Financial Escalation Framework – TSDFT Assessment

Dimension	Measure	RAG thresholds	Month 8	Month 9	Month 10
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			
	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%
	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%		
	Forecast revenue variance to plan, excluding the impact of loss of DSF	Red rating where more than 0.5% adverse of plan operating expenditure Green rating where on or favourable to plan	0.0%	0.1%	0.1%
	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		0.3%	0.1%
	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			
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	1%	3%	0%
	Percentage efficiency delivery against plan year to date	Red rating where less than 95% Green rating where plan value achieved or exceeded	99%	96%	
	Percentage forecast recurrent efficiency delivery against plan	Red rating where less than 95% Green rating where plan value achieved or exceeded			
Cash Management	Forecast cash support required from the System	Green rating where none Red rating where required	None	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			
	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		76%	82%
	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	100%	100%	100%

Torbay and South Devon NHS Foundation Trust

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 months 7 to 10 inclusive
- Forecast outturn ULP was reassessed in month 6 to indicate net underlying expenditure adverse to plan by £17.7m (move to £99.5m)
- DSF £15.4m assumed not to be received in full in forecast position

Efficiency programme

- Year-to-date achievement of efficiencies is marginally below the planned phasing at month 10.
- The forecast achievement of recurrent savings at 65% of plan.

Capital plan

- Funding approval status of schemes has improved to 82% with funding approval, but there is no significant increase to the forecast value of the programme.
- Capital expenditure profile YTD remains low at 47% of plan. However, spend is being closely tracked and governance in place to ensure achievement.

Torbay and South Devon NHS Foundation Trust

Board of Directors

Perinatal Quality and Safety Report

Date of meeting	Date report produced
5 March 2026	19 January 2026

Author(s)		Report approved by	
Name and title:	Joanna Bassett - Director of Midwifery	**Name and title:**	Nicola McMinn Chief Nurse and DIPC
		Date:	19 January 2026

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

Executive summary

The purpose of the report is to provide the Board with a summary of the information and metrics contained within the supplementary perinatal safety and governance report (November and December 2025). It is to alert, advise and assure with key risks highlighted along with celebration of successes. The purpose of the perinatal governance report (**Appendix 1)** is a required component of the maternity reporting framework for NHS England (NHSE) and aims to assure the Board on critical elements of the maternity safety agenda by:

- Outlining the Trust position on perinatal mortality and morbidity
- Reporting progress and compliance with priority areas of focus.
- Provide system level assurance on maternity quality and safety.

This executive summary paper was requested by the Executive Committee alongside the Board Level Non-Executive Safety champion so that visibility and oversight of key risks was clear with mitigations apparent.

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
2.1Alert- neonatal mortality	Limited	Reduction due to increased perinatal mortality and oversight
2.2 Alert- workforce fragility	Limited	Reduction due to impending resignation
2.3 Alert- Triage model	Satisfactory	Measures in place to mitigate in the absence of formal BSOTS model
3.0 Assure	Satisfactory	Improvement in compliance with MIS. Oversight measures in place
4.0 Advise	Satisfactory	Mitigations and oversight in place
5.1 Celebrating success. - Maternity CQC survey 5.2 Culture and Leadership	Significant Satisfactory	Improvement from 2024 with evidence that actions implemented have been effective. Progress being made with psychological support and leadership capacity

Appendices

Appendix 1 - Torbay and South Devon NHS FT MATERNITY BOARD REPORT (available in Board information pack)

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

Metrics contained within this report have been presented at the monthly maternity Governance and Service meeting as well as at the monthly Maternity and Gynaecology Quality Meeting. The data is also shared as a slide set for the monthly Families and Communities Care Group governance meeting. Escalation of concerns will be via this quality group and/ or via the executive quality group. The CQC action plan is presented monthly at the Trust External Regulatory Oversight Group. Quality and People Committee

Key recommendations and actions requested

The Board is asked to note and agree the assurance recommendations and to confirm that this executive oversight report is sufficient to enable assurance of key issues that are described in full in the supplementary report. (Appendix 1)

The Board is also asked to:

- Note actions to strengthen midwifery workforce sustainability, including progressing the Birthrate Plus-identified uplift of 1.11–3.81 WTE through the business planning process.
- Acknowledge neonatal workforce risks and support recruitment, QIS training expansion, and structural review to meet BAPM medical and nursing standards.
- Support ongoing culture and wellbeing initiatives, including listening events, psychological support, and embedding SCORE survey actions into the perinatal improvement plan.

How does this report further our Trust strategy?

This report describes the quality of maternity care that is accessible and available to the pregnant population and their families in Torbay and South Devon. It also describes the mechanisms that are in place that monitor this care.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	This report supports the aims described by demonstrating best practice guidance in the delivery of care to promote the health and wellbeing of pregnant people and babies
Quality of services provided	
Sustainable and efficient use of resources	

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience:	The perinatal safety report sets clear safety standards for Trusts in relation to maternity services. This enables oversight and assurance around best practice.

Risk

n/a

Risks lodged on Datix:

n/a

External Standards affected by this report and associated risks
NHS England licence and regulations National policy, guidance– Maternity Incentive Scheme (MIS) NHS Resolution CQC

Perinatal Quality and Safety Report – Executive Summary

1.0 Introduction and background

The purpose of the report is to provide the Board with a summary of the information and metrics contained within the supplementary perinatal safety and governance report (appendix 1). It is to alert, advise and assure with key risks highlighted along with celebration of successes.

This executive summary paper was requested by the Executive Committee alongside the Board Level Non-Executive Safety champion so that visibility and oversight of key risks was clear with mitigations apparent.

2.0 Alert/Risks

2.1 Neonatal mortality and the MOSS signal.

In November 2025 we recorded a term neonatal death following Hypoxic Ischemic Encephalopathy (HIE) with cooling in a Level-3 Neonatal Intensive Care Unit and withdrawal of care at day 5; This death followed 2 neonatal deaths in May 2025 (previously reported to the Board) and triggered a MOSS alert—a national AI-enabled safety surveillance signal indicating rates above expected parameters for our unit's size and complexity. The alert was immediately escalated via the national SOP to the Executive Committee and the CQC, with a critical safety review launched. This sequence has increased external interest and necessitates sustained, visible executive grip until the risk normalises.

2.2 Workforce fragility impacting resilience.

There are several workforce challenges that could impact the resilience of the service. Neonatal nursing qualified in speciality nursing (QIS) coverage sits at 61% against a British Association of Perinatal Medicine (BAPM) 70% benchmark. Despite initiative-taking actions, retirements in the next quarter are likely to worsen the percentage temporarily. The associated action plan has been in place for several years and the team continue to address ways to mitigate gaps in the rota. There are also changes to the BAPM requirement for medical staffing which may have implications for future workforce modelling. The service is continuing to work to address these risks and will seek support is required via the Care Group escalation processes.

Obstetric workforce pressures continue to impact on leadership capability as consultants are required to cover clinical activity. A replacement consultant begins in post in February 2026, and further recruitment is being explored through realignment of job planning and external funding.

The homebirth benchmarking has identified some areas of operational fragility that relates to the ability to consistently offer homebirth to women that may request this. A

strengthening of the governance and oversight of the service is being undertaken to address this.

2.3 Triage model not yet at steady-state

The full BSOTS model will not be fully live until end-April 2026 due to estates works and the EPIC go-live schedule. Interim processes and audits are in place; however, this remains a short-term operational risk (e.g., waits, potential self-discharge, and incident linkage), warranting continued Board-to-ward oversight.

3.0 Assure

3.1 To address the concerns described in 2.1 the service has initiated actions as well as strengthening oversight.

Thematic Review and External Scrutiny
Given the clustering and nature of the incidents, a thematic review has been commissioned, supported by the Chief Nurse and NHSE regional teams, to assess cross-cutting issues and ensure learning is independently validated. This escalated review aligns with national scrutiny of maternity services and early feedback around culture and leadership raised by the national team.

Operational Safety Measures Implemented
A range of targeted mitigating actions have been enacted, including:

- Re-audit and re-communication of emergency call bell protocols and fetal monitoring processes
- Strengthening multidisciplinary escalation pathways.

Governance, Oversight and Executive Escalation
Repeated concerns regarding neonatal and maternity safety have been formally escalated to:

- Exec Huddle,
- Trust Board,
- ICB/ regional team
- NHSE Maternity Safety Support Programme (MSSP).

Culture, Leadership and Learning
National colleagues have highlighted cultural and leadership challenges that may be constraining improvement pace. In response, the Trust has:

- Intensified Executive visibility on the unit,
- Strengthened governance participation.

Initiated leadership development and psychological safety intervention. Regular updates on progress will be shared through the Quality and People Committee.

3.2 Compliance

The service remains on track for full compliance for Maternity Incentive Scheme (MIS) Year 7 with assessment by Audit Southwest confirming that evidence appears sufficient. Compliance with Saving Babies' Lives v3 stands at 91.3% (Q2), with credible plans addressing remaining gaps, including timely CO monitoring at booking, GAP/GROW coverage, and ongoing PERI Prem implementation.

4.0 Advise

4.1 Neonatal workforce stabilisation.

To address the QIS gap and protect resilience, the Board is asked to note that authorise targeted incentives have been requested and that support may needed to progress the organisational change proposal to align establishment with demand. As part of the Maternity Incentive scheme update (separate paper), the Board has been asked to consider an appropriate timescale for completion of the QIS action. The Care Group will also be considering how to support resilience as part of planning the strategic direction for perinatal services.

4.2 Midwifery establishment planning (Birthrate+).

The Birthrate+ analysis indicates a deficit of 3.81 WTE. Approval has been sought to incorporate this into 2026/27 planning, with a progress update via the Our Plan for Better Care oversight group.

4.3 Safety Improvement Plan -Maternity Safety Support Programme (MSSP)

The MSSP has now transitioned to Maternity and Neonatal Improvement Support Team (MatNeoIST). The Trust entered a six-month period of Targeted Maternity and Neonatal Improvement Support starting 8th January 2026.The ask is for the Trust to:

- **Accept and participate in a six-month targeted support programme focused on:**
  - Obstetric leadership and capacity
  - Culture and leadership
  - Governance and board effectiveness
- **Work with the allocated Midwifery and Obstetric Improvement Advisors.**

5.0 Celebrating Success

5.1 Service-user experience.

The CQC Maternity Survey 2025 evidences a pronounced uplift in the experiences of woman and families; the service performed better than other trusts on 38% of questions and aligned on 60%. The team—working with Maternity and Neonatal Voices Partnership (MNVP) —has produced a focused action plan reflecting free-text analysis. This is a tangible outcome of staff effort to improve communication, consistency, and compassion in care. A full summary of the findings will be presented to the Quality and People Committee in March 2026.

There has also been a positive change around how the service user voice is embedded within safety and quality processes.

The Devon MNVP has recruited a neonatal lead and increased capacity; from January 2026. MNVP is now quorate across key meetings (QUAD, PMRT, safety walkarounds). This strengthens co-production and supports equitable, personalised care.

5.2 Culture and leadership.

Progress has been made in the effectiveness of the perinatal leadership team. There has

been a change in obstetric leadership with a very small uplift in professional activity (PA) to increase capacity with a further increase to be explored following discussion at the executive operations group meeting. QUAD leadership and listening events have supported psychological safety workstreams and clearer escalation behaviours. The clinical psychology team are offering their first session at the end of January 2026 which will focus on frontline midwifery leaders and doctors.

6.0 Assurance recommendations and summary

The Board is asked to note and agree the assurance recommendations and to confirm that this executive oversight report is sufficient to enable assurance of key issues that are described in full in the supplementary report. (Appendix 1)
The Board is also asked to:

- Note actions to strengthen midwifery workforce sustainability, including progressing the Birthrate Plus-identified uplift of 1.11–3.81 WTE through the business planning process.
- Acknowledge neonatal workforce risks and support recruitment, QIS training expansion, and structural review to meet BAPM medical and nursing standards.
- Support ongoing culture and wellbeing initiatives, including listening events, psychological support, and embedding SCORE survey actions into the perinatal improvement plan.

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
2.1Alert- neonatal mortality	Limited	Reduction due to increased perinatal mortality and oversight
2.2 Alert- workforce fragility	Limited	Reduction due to impending resignation
2.3 Alert- Triage model	Satisfactory	Measures in place to mitigate in the absence of formal BSOTS model
3.0 Assure	Satisfactory	Improvement in compliance with MIS. Oversight measures in place
4.0 Advise	Satisfactory	Mitigations and oversight in place
5.1 Celebrating success. - Maternity CQC survey 5.2 Culture and Leadership	Significant Satisfactory	Improvement from 2024 with evidence that actions implemented have been effective. Progress being made with psychological support and leadership capacity

Torbay and South Devon NHS Foundation Trust

Board of Directors

Safer Staffing Review

Date of meeting	Date report produced
5 March 2026	11 December 2025

Author(s)		Report approved by	
Name and title:	Natalie Herring Deputy Chief Nurse Corrine Jackson Safer Staffing lead	**Name and title:**	Nicola McMinn. Chief Nursing Officer
		Date:	19 January 2026

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
Not applicable.

Executive summary: Introduction and background

This paper provides assurance to the Board regarding the safety, effectiveness and sustainability of the nursing establishment within the Trust's inpatient areas. It sets out the approach taken to assess workforce requirements, aligned with the NHS England (NHSE) (2018), Developing Workforce Safeguards guidance and the National Quality Board (NQB) (2016) framework.

The Trust has been reviewed by the Regional Safer Staffing team on behalf of the Chief Nursing Officer for England and is assessed as aligned with the National Quality Board guidance.

This paper provides assurance to the Board that a triangulated approach, combining evidenced based tools, professional judgment and patient outcomes have been used to review and assess nursing workforce establishments, ensuring we have the right staff, with the right skills, in the right place at the right time.

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
Executive summary	Satisfactory	On target
Assurance of Safer staffing review process	Satisfactory	On target

Appendices

Nil

Appendices

N/A

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

Executive Committee
Nursing, Midwifery and AHP Workforce Council
Outcomes from the Safer Staffing Paper shared with: Chief Nursing Officer, Associate Directors of Nursing and Professional Practice
Quality and People Committee

Key recommendations and actions requested

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

It is recommended the Board take satisfactory assurance that 2024/25 SNCT outcomes have been reviewed in conjunction with professional judgement to ensure the nursing bed base workforce is fit for purpose and actions are being taken to continue to drive down costs that fall outside of the set establishments. This is based on satisfactory assurance given noting the risks identified and the work being undertaken to mitigate these.

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

The report provides assurance that inpatient staffing establishments can meet the needs of the population it cares for in providing safe and effective care.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	Ensures right care to the right patient at the right time.
Quality of services provided	Provides a safer staffing establishment.
Sustainable and efficient use of resources	Provides a safer staffing establishment.

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality, Safety and Patient Experience	By reviewing and adopting a recommended safer staffing establishment care will meet the needs of the population it serves. Ward environments undoubtably have an impact on visibility of patients and the model required to provide safe and effective care. Current review relates to inpatient areas only.
Leadership and Governance	
Performance	Appropriate staffing levels will aid performance and low.
People and Culture	Patients will receive care from right staff, with the right skills, in the right place at the right time improving outcomes and experience. Safer staffing review will ensure a safe and sustainable workforce. SNCT provides a range of flexible working policies and inclusive work practices, ensuring a welcoming and respectful environment for all staff.
Strategy and Business Intelligence	Digital literacy training will be required to support the nursing workforce in the transition to EPR. EPR will reduce duplication and increase time to care. The safer staffing care tool (SNCT) provides an opportunity to review roles and service delivery to ensure it is providing the most efficient outcomes for the population it serves.
Finance	The safer staffing model will eliminate waste and ensure productivity.

Risk

Risks lodged on Datix:

Risk ID 3925 Acuity of Ward v Staffing Levels (Workforce Risk)
Risk ID 3778 Discharge Lounge: Out of Hours Clinical Risk with Non-Substantive Staffing

External Standards affected by this report and associated risks

External Factors:
Breach of NMC regulatory standards
Breach of Care Quality Commission regulated standards
Failure to meet ICB service specifications
Impact on NHS England targets compliance
Failure to comply with NHSE guidance around safer staffing requirements

Internal Factors:
Staff burnout, increased sickness and poor retention with high turnover if fail to get the staffing requirement correct
Impact on quality and safety for patients cared for affecting patient outcomes
Negative patient experience with an increase in complaints, concerns if unable to meet patient need
Impact on Trust reputation

Assurance of Safer Staffing Review Process

The Trust is required to undertake a transparent bi-annual review of clinical nurse staffing to ensure the *right staff*, with the *right skills* are in the *right place* at the *right time* to deliver high quality care to patients and service users. The nurse staffing review must be presented to a **public meeting of the Trust Board**.

The NQB (2016) guidance sets out three requirements of providers.

Providers:

- **Must** deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively.
- **Should** have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and always keep them safe.
- **Must** use an approach that reflects current legislation and guidance where it is available.

To ensure transparency and visibility, the table below shows the TSDFT position against each of the DWS requirements, together with actions to address any shortfalls**.**

External Assurance

The Trust's safer staffing arrangements have been reviewed through engagement meetings with NHS England and the Regional Safer Staffing Team acting on behalf of the Chief Nursing Officer for England.

This external review confirmed that the Trust's approach is aligned with the National Quality Board (2016) guidance and NHS England's Developing Workforce Safeguards, with the Trust assessed as meeting **8 of the 9 national safer staffing** standards**.** Comparative feedback from NHS England indicates that the Trust is performing strongly relative to peer organisations across the Southwest, particularly in relation to the maturity of its safer staffing governance, the consistent application of nationally endorsed Safer Nursing Care Tools, and the quality of its triangulated clinical workforce dashboards.

The Trust's approach to integrating professional judgement with acuity, quality and operational data was identified as more developed than that seen in many comparable providers**,** providing robust assurance of safe, effective and sustainable staffing.

The Regional Safer Staffing Team highlighted opportunities to further strengthen alignment between safer staffing reviews and workforce planning, including headroom modelling and Board development on safer staffing accountability. These actions are incorporated within the Trust's Quarter 4 forward plan, ensuring continued external validation and strengthening assurance to the Board.

DWS Requirement	TSDFT position	Narrative / Action
1. Trusts must formally ensure NQB's (2016) guidance is embedded in the safe staffing governance.	Compliant	Guidance integrated into bi-annual reviews/reporting
2. Trusts must ensure the three key safe staffing components are used in local processes (evidence-based tools [where they exist], professional judgement & patient/staff outcomes)	Compliant	This paper will evidence the use of evidence-based tools, professional judgment and review of outcomes as part of the process.
3. The Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Compliant	Governance statement contained within the 2023/24 Annual Report
4. Providers must have an effective workforce plan that is updated annually and signed off by the Chief Executive Officer (CEO) and Executive Directors. The Board should discuss the workforce plan in a public meeting.	Partial compliance	Annual planning process is led by the CPO, further work is required to link nursing workforce supply, pipelines and bi-annual reviews.
5. Providers must ensure they have an agreed local quality dashboard to cross-check comparative data on staffing and skill mix with other efficiency and quality metrics. This should be reported to the Board on a monthly basis.	Compliant	A new triangulation dashboard has been created and is being used as part of the IPRQ monthly report. Areas included are Safer Staffing adult in patient areas, Paediatrics, Emergency Department, EAU4, Community Hospitals.
6. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS England resources. This must also be linked to professional judgement and outcomes.	Compliant	Bi-annual reviews are reported to the Trust board. Annual establishment review will incorporate 3 census checks a year with a rolling

		programme for seasonal variation.
7. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Compliant	Licences are held for the relevant evidence-based tools. These are not locally manipulated.
8. As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full equality and quality impact assessment (EQIA) review.	Compliant	Skill mix changes recommended through the bi-annual review process will have accompanying EQIA as appropriate. EQIA Panel in place chaired by either CNO/DCAHP.
9. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full EQIA.	Compliant	Service changes recommended will have accompanying EQIA as appropriate. EQIA policy is under review to include this process. Completion due Jan 2025.

Safer Staffing Review: Bi-Annual Assessment of Nurse Staffing Levels

The Trust continues to undertake a bi-annual review of nurse staffing levels to ensure compliance with national safer staffing requirements. As part of this process, the Trust has embedded the use of nationally endorsed, evidence-based Safer Nursing Care Tools (SNCT) to support objective measurement of nursing workload and inform establishment setting. These tools enable the calculation of recommended staffing levels aligned to the *average* acuity and dependency of patients within each clinical area.

The SNCT methodology was introduced in September 2024 and is now fully embedded across the organisation. The Board can be assured that these tools, used alongside triangulated *professional judgement*, support a robust assessment of patient and staff outcomes.

The Trust currently holds licences for the following evidence-based establishment-setting tools:

- **Adult Inpatient Safer Nursing Care Tool (SNCT)**
- **Community Nursing Safer Staffing Tool (CNSST)** – relaunched nationally in January 2025 following a planned pause

- **Emergency Department Safer Nursing Care Tool (ED SNCT) ***
- **Children and Young People's Safer Nursing Care Tool (CYP SNCT)**

Each tool provides a validated method for workload measurement and, when applied accurately, recommends staffing levels aligned to patient need. In line with national guidance, calculation of average acuity and dependency requires the completion of *at least two* separate 30-day censuses each year, with daily allocation of the correct acuity and dependency category for every inpatient. While these averages do not capture episodic spikes in complexity, they provide a consistent and transparent basis for nursing workforce planning.

Scope of the September 2025 Census

The September 2025 (third cycle) review included the following areas:

- Adult inpatient wards (acute and community hospitals)
- Paediatric inpatient ward
- Emergency Department*
- Discharge Lounge
- Acute Medical Unit (AMU)

The District Nursing teams have completed their first full census using the Community Nursing Safer Staffing Tool (CNSST). As this is the inaugural use of the tool within the Trust, the dataset is currently being validated to ensure accuracy and reliability. Completion of this data cleansing is expected by the end of January 2026.

Outcomes from the September 2025 Safer Staffing Census

Workforce utilisation in September 2025 reflected the increased acuity and dependency recorded during the census period.

Total nursing FTE usage was **1,082.9 FTE**, exceeding both:

- the **budgeted establishment of 1,013.4 FTE**, and
- the **SNCT-modelled requirement of 937.55 FTE** (September 2025 census), as well as the **combined annual mean of 931.6 FTE** (February and September 2025).

This variance demonstrates that *actual staffing needs* (based on professional judgement) continue to exceed both funded levels and SNCT recommendations, driven by sustained high-acuity case mix and complex dependency profiles across clinical areas.

Acuity and Dependency Findings

The table overleaf summarises acuity and dependency levels recorded across the three most recent census periods.

Census Period	Empty Beds	Level 0	Level 1a	Level 1b	Level 1c	Level 1d	Level 2	Level 3
September 2024	3%	49%	6%	39%	3%	0%	1%	0%
February 2025	3.7%	44.4%	6.8%	38.1%	3.7%	0.2%	2.8%	0.4%
September 2025	2.59%	39%	7.5%	38.9%	2.88%	0.2%	1.43%	0.22%

The September 2025 results indicate:

- A continued reduction in Level 0 patients
- A sustained proportion of Level 1b and 1a patients, indicating higher baseline demand
- Persistent, albeit small, cohorts of Level 2 and Level 3 patients
- Decreased empty bed numbers, contributing to higher operational pressure

These data collectively reflect increasing complexity and care intensity across inpatient areas.

Acuity and Dependency Summary

During the reporting period, the Trust observed several notable trends in patient acuity and dependency.

- Empty bed numbers decreased by 1.11%, indicating a marginal increase in bed occupancy.
- The proportion of Level 0 patients reduced by 5.4%, highlighting a shift towards patients with more complex clinical needs.
- Overall acuity increased by 0.7%, and the dependent patient workload rose by 0.8%, demonstrating higher care intensity across inpatient areas.

For patients requiring Enhanced Therapeutic Observations, acuity and dependency levels for those scored at Level 1c decreased by 0.82%, with Level 1d patients remaining stable. Demand for specialist beds and enhanced nursing care remained consistent throughout the census period. Collectively, these indicators reflect a modest yet sustained rise in patient complexity and dependency.

It is important to note that Safe Nursing Care Tool (SNCT) outcomes cannot be reviewed in isolation. Professional judgement remains *essential*, taking account of quality, safety, patient experience, clinical outcomes and wider operational factors not fully captured through acuity-based assessments.

Combining SNCT censuses provides a more comprehensive view of activity and supports informed workforce planning for the forthcoming financial year. The combined data identifies a variance between SNCT recommendations of 931.6 WTE and the current funded establishment of 1,013.4 WTE, resulting in an apparent variance of 81.8 WTE.

Professional judgement is applied to understand the drivers behind this variance.

Through safer staffing review meetings, several contributing factors have been identified.

- The design and configuration of the Trust's estate—particularly within the Emergency Department—require higher workforce numbers to maintain safe oversight across multiple clinical zones, contributing to 49.22 FTE.
- A similar issue impacts Louisa Carey Ward, where the team supports SSPAU, Outpatients and Paediatrics ED, although the budget sits solely within Louisa Carey's inpatient establishment. This, combined with reduced bed occupancy, accounts for a further 13.65 FTE that does not reflect actual operational requirements.
- The Trust has participated in NHS England's beta testing of the revised CYP SNCT, which is expected to offer a more accurate representation of paediatric workforce needs. Publication of the revised tool is anticipated for Spring 2026.

Additional factors influencing establishment requirements, and not fully reflected in acuity-only calculations, include:

- Use of escalated spaces, such as the cohort/discharge lounge, which are staffed from bed-based budgets.
- Workforce allocation across two floors or multiple clinical areas, reducing the efficiency of standard nurse-to-patient ratios (e.g., AMU Level 2/3, Louisa Carey and SSPAU).
- Reduced occupancy during SNCT data collection periods, leading to lower staffing recommendations than required at full capacity.
- Increased numbers of patients requiring enhanced care (ETOC), including those requiring ratios greater than 2:1.
- Junior skill mix requiring enhanced supervision, training and preceptorship.
- Inadequate suitability of current tools for specific clinical areas (e.g., Cromie Ward functioning as a high-turnover assessment model).
- Atypical reductions in eating disorder activity during the September census on Allerton Ward and Paediatrics, not reflective of usual workforce need.
- *Extended Emergency Department stays (>12 hours), which the current tool only captures once, underestimating actual nursing time required. Work is under way with regional teams to improve tool accuracy.
- Additional escalation areas operating without aligned budgets (e.g., cohort areas and expanded discharge lounge capacity).
- Increased unavailability through vacancies, sickness, parental leave, study leave and other factors exceeding headroom assumptions. This will be a focus for improvement in 2026, alongside further reductions in bank and agency use.

Summary

Of the 23 inpatient areas included in the 2024/25 safer staffing review, 11 demonstrated SNCT recommendations *aligned* with their current funded establishments. Two areas were identified as significant outliers due to their service configuration across multiple clinical spaces. The remaining 10 areas showed an over-establishment of 18.93 FTE for 2024/25. Work commenced in November to redeploy this resource to support the delivery of ETOC, with the aim of reducing agency usage and strengthening consistency in temporary staffing deployment.

*Since the launch of the Emergency Department Safer Nursing Care Tool (ED SNCT) in 2021, license holders have reported an increase in the number of patients requiring care for 12 hours or more in the ED daily. This has led to concerns being raised by NHS and international license holders that the tool may be recommending sub optimal staffing establishments as the previous version of the tool was not designed to capture the workload of this patient group.

Responding to these concerns, the Shelford Group has now developed an addendum to the tool which will enable organisations to calculate the workload for patients requiring care for 12 hours or more.

The addendum for patients requiring care for 12 hours or more in the emergency department is for use at establishment setting stage only, supporting organisations to identify the staffing resource required for the next financial year but allowing local decision making on how this is deployed, throughout the week or yearly in response to known periods of pressure.

As we move forward with streamlining urgent care pathways and can reduce the number of patients requiring care for 12 hours or more in emergency departments, organisations will be able to decrease the need to use this part of the resource

Next Steps

The Board is asked to note the following actions arising from the 2024/25 SNCT review, designed to strengthen assurance and support reduction in nursing workforce expenditure within bed-based care:

- The Head of Nursing Workforce and Safer Staffing Lead will continue to work with NHSE to ensure national tools accurately reflect clinical activity and care requirements.
- The Safer Staffing Lead will review options to more clearly represent Louisa Carey Ward's data pending publication of the revised CYP tool.
- Phase 2 of the Emergency Department redevelopment will include a comprehensive workforce review.
- Redesign of the ETOC model will continue, with the objective of reducing reliance on bank and agency staffing.
- A deep-dive review into workforce unavailability will be undertaken to identify key drivers and reduce the requirement for temporary staffing.
- A commitment to a fully integrated nursing workforce plan by end of Q4
- Board development session on safer staffing accountability, NQB requirements and the boards statutory responsibility will be delivered in Q4

Assurance and Recommendations

The Trust is required to undertake a transparent bi-annual review of clinical nurse staffing to ensure the *right staff*, with the *right skills* are in the *right place* at the *right time* to deliver high quality care to patients and service users. The nurse staffing review must be presented to a public meeting of the Trust Board.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Executive summary	Satisfactory	On target
Assurance of Safer staffing review process	Satisfactory	On target

Torbay and South Devon NHS Foundation Trust

Board of Directors

Information: Legal and Regulatory Updates

Date of meeting	Date report produced
5 March 2026	24 February 2026

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	**Name and title:**	Emily Long Director of Corporate Governance
		Date:	

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: **Published in 2026 (or due early 2026)** 1. **Interim report – National Maternity & Neonatal Investigation** (Baroness Valerie Amos) – interim findings on maternity and neonatal care across NHS England (final recommendations due Spring 2026). Independent maternity and neonatal investigation: Terms of Reference & interim impressions (UK … 2. **ADHD Taskforce Final Report (2025)** – independent taskforce on ADHD services (report published late 2025; implementation updates ongoing). NHS England responds to ADHD Taskforce final report (Nov 2025) 3. **NHS England – Review of NHS Performance & Delivery** – broad NHS performance review across sectors (official NHS England publication; March 2025). Review of NHS performance and delivery (NHS England) **Published in 2025** 4. **Dash Review of the Care Quality Commission (CQC)** – independent review of CQC's operational effectiveness (May–Oct 2024 review published 2025). Dash review of the CQC (NHS Confederation summary)

5. **Maternity & Neonatal Infrastructure Review Findings** – NHS England infrastructure survey & analysis of maternity/neonatal services (report published Sept 2025). Maternity and neonatal infrastructure review findings (NHS England)
6. **Care Quality Commission – State of Care (2024/25)** – CQC's annual national review including maternity care focus (CQC *State of Care 2024/25* report). CQC State of Care 2024/25 (CQC)
7. **CQC Maternity Survey 2025** – national patient experience survey results for maternity care in NHS settings. Maternity survey 2025 (CQC)

Published 2023–2024 (still relevant to ongoing NHS reviews)

8. **Cass Review (Gender Identity Services & Policy)** – interim and final actions arising from the Cass Review into children's gender identity services. Cass Review (Wikipedia overview)

Other Relevant Ongoing Reviews / Formal Reports

9. **National Maternity & Neonatal Investigation – Trust-specific focus** – list of 12–14 NHS trusts examined as part of the national investigation. 14 NHS trusts the focus of national maternity investigation (UK Gov)
10. **ADHD Services Independent Review** – national review launched in January 2026 into ADHD diagnostic and treatment pathways (reported in press).

Direct Links to Full Reports/Official Publications

- **Review of NHS performance and delivery (NHS England)** – full NHS performance review (Mar 2025). Review of NHS performance and delivery report (NHS England)
- **Dash Review of the CQC** – summary of operational effectiveness review (NHS Confederation). Dash review of the CQC (NHS Confederation)
- **Maternity & Neonatal Infrastructure Review** – NHS England's infrastructure review findings (Sept 2025). Maternity and neonatal infrastructure review findings (NHS England)
- **National Maternity & Neonatal Investigation (Terms & Interim)** – UK Gov Terms of Reference and interim impressions (Dec 2025). Independent maternity and neonatal investigation: Terms & interim insights (UK Gov)
- **CQC Maternity Survey 2025** – CQC survey data report. Maternity survey 2025 (CQC)
- **CQC State of Care Report 2024/25** – CQC's broader annual review (2025). CQC State of Care 2024/25 report (PDF)
- **ADHD Taskforce Final Report Response (NHS England)** – response to ADHD Taskforce report and actions. NHS England responds to ADHD Taskforce report (Nov 2025)

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
n/a

Risks lodged on Datix:
N/a

External Standards affected by this report and associated risks
Best Practice

Workplan - Public Board of Directors 2025/26

	May	July	September	November	January	March
Preliminary matters	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan	Welcome, Apologies and Quoracy Declarations Workplan
Standing Items	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map (full DRR)	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map	Minutes and matters arising BAF/ Risk Map (full DRR)
Approval Items	Review of Directors' Interests Operational Plan	Committee Annual Reports	~~Annual Adult Care Strategic Agreement~~ Winter Plan		Maternity CNST	SFIs/SoD/Sos (2026) Review of Board Workplan Risk Management Strategy/Policy Trust Strategy
Cyclical items	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR Mortality Safety Scorecard Maternity: • Perinatal Governance Report ~~CQC Registration Annual Report~~ ~~Safer Staffing~~ ~~Quarterly Guardian of Safe Working Hours~~ Annual Staff Survey Report ~~Board Self-Assessment~~	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR Mortality Safety Scorecard Maternity: • Perinatal Governance Report ~~Patient Experience Annual Report~~ Infection Control Annual Report Annual Revalidation Report ~~People and Education Annual Report~~ Our Plan for Better Care	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees IPQR ~~Operational Plan (review of performance)~~ EPR Status Report Maternity: • Perinatal Governance Report • Maternity Bi-Annual Staffing Safeguarding Children Annual Report ~~Safeguarding Adults Annual Report~~ Adult Social Care Local Account Mortuary Report ~~Guardian of Safe Working Hours (amalgamated report)~~ Our Plan for Better Care	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees Operational Performance Report EPR Status Report Finance Report Mortality Safety Scorecard Maternity: • Perinatal Governance Report Patient Safety Incidents Annual Report CQC National Inpatient Survey Quarterly Guardian of Safe Working Hours Freedom to Speak Up Bi-annual Report ~~F2SU/Whistleblowing annual report~~ Our Plan for Better Care Information: Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees Operational Performance Report EPR Status Report Finance Report Mortality Safety Scorecard Maternity: • Perinatal Governance Report • Maternity Bi-Annual Staffing • Maternity CNST EPRR – NHSE Assessment Our Plan for Better Care Information: Legal and Regulatory Updates	Patient Story Chairman's Report Chief Executive's Report Reports from Board Committees Operational Performance Report Summary of Planning Guidance and Trust Approach EPR Status Report Finance Report Digital Strategy Update Maternity: • Perinatal Governance Report • Maternity CQC Patient Survey • Maternity Bi-Annual Staffing 7 Day Week Assurance End of Life Annual Report Safer Staffing (main pack) Quarterly Guardian of Safe Working Hours Freedom to Speak Up Bi-annual Report Gender Pay Gap Report Green Plan Our Plan for Better Care Information: Legal and Regulatory Updates
Information Items						
Closing matters	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting	Review of meeting Matters for escalation/AOB Date of next meeting
Deferred from previous meeting		Mortality Safety Scorecard (May) Inpatient Nursing Safer Staffing Review (May) GOSW (May)	CQC Registration Annual Report (May) ~~Patient Experience Annual Report~~ ~~Delivery of the Workforce Plan~~	Safeguarding Adults Annual Report Patient Experience Annual Report Annual Adult Care Strategic Agreement Delivery of the Workforce Plan Research and Development Annual Report Advanced Clinical Practice Actions from Developmental Well Led – Strengthening Governance Arrangements	Charity Committee Annual Report (and montage video)	

				Resetting Recovery Support Exit Criteria SHD Developments Annual Report and Accounts and Operational Update Audit and Risk Committee Annual Report		
Requested Reports	NHS WRES/WDES Report		Month 5 Finance Report Our Plan for Better Care People Programme 5.3 Culture Plan Information: Legal and Regulatory Updates Responding to the invited Developmental Well Led Review			
Future Items			Green Plan			

Tba – bi-annual research and development report

Key:
Strategy
Quality and Safety
Performance
Workplace and Culture
Governance/Regulatory
Finance

Torbay and South Devon
NHS Foundation Trust

Public
Board of Directors -
Items for Information

Date: Thursday 5 March 2026

Time: 11.15 pm - 1.15 pm

The Boardroom, Hengrave House,
Torbay Hospital

Find us:

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Facebook LinkedIn Instagram X (Twitter)

Working with you, for you

Board of Directors – Items for Information

REPORTS PRESENTED TO THE BOARD FOR INFORMATION

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

Appendices to Board Reports

- Board Assurance Framework
- Our Plan for Better Care Report Appendix
- Perinatal Quality and Safety Report Appendix

Finance and Operations Committee

- Electronic Patient Record Progress Report
- Integrated Performance and Quality Report

Quality and People Committee

- Combined Gender, Ethnicity, Disability Pay Gap Report
- Maternity Care Quality Commission Survey Report
- Mortality Score Card
- NHS Resolution Maternity Incentive Scheme – Year 7
- Working Lives of Resident Doctors

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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**	
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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**	
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 (February 2026)	**Previous assessment: Limited (January 2026)**	
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 (February 2026)	**Previous assessment: Limited (January 2026)**
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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**	
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 (February 2026)	**Previous assessment: Limited (January 2026)**
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: Limited (February 2026)	**Previous assessment: Satisfactory (January 2026)**
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. • Maternity and neonatal services are not consistently aligned to the level of clinical acuity and complexity being managed, particularly in a level 1 setting , leading to potential delays in escalation, increased staff anxiety, deterioration in workforce confidence and trainee experience, and an increased risk of adverse outcomes for women and babies.	• 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. • Limited longitudinal evidence that escalation behaviours and senior support are consistently available • Incomplete assurance that staff wellbeing support is consistently accessed following traumatic 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:**
• 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. • Staff intelligence including trainee feedback	• 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. • Perinatal Improvement Board chaired by CNO	• 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	**Board oversight Committee: Quality and People Committee**	
Current assessment: Limited (February 2026)	**Previous assessment: Limited (January 2026)**	
Overarching comment & rationale for assessment: Board approval of revised Governance infrastructure (November 2025); implementation ongoing. We have a single plan and will take action once and well, though it will be some months to fully embed and achieve satisfactory assurance, though the project is on track, as reported to OPFBC. Programmes for Board and Executive Development were finalised and at Board development (October 2025) and presented at November Board; these must now be actioned. 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	• Assessment of gaps in resource and consideration of RSP support • Oversight and priorities reviews at Executive Committee • Board approval of governance proposals and implementation commenced	• 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:**
• Governance delivery group (operational oversight) • Monthly flash report and progress made against KPIs	• Integrated improvement plan and oversight of delivery with regular check and challenge in place • Insightful Board self-assessment	• RSP oversight • Internal audit oversight • External audit oversight • Well led review (2025) • Independent review (2024)

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 (February 2026)	**Previous assessment: Limited (January 2026)**	
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 including Devon ICB and wider system financial pressures • RSP resource and support is withdrawn • Potential for organisational changes / changes to group model	• Executive Development days – Team development using established and recognised methodologies- Meeting dates arranged for this financial year • Executive huddles allowing team deep dives into planned and emerging strategic and operational topics. Meetings planned for the next quarter • Alignment and mapping of individual personal objectives to the CEO objectives completed. • Planning underway for 6 month achievement reviews and initiation of 360 reviews for the Executive team • Interim CFO and Acting CPO in post until Mach 2026 to allow organisational and departmental stability	• Recruitment to substantive posts planned to commence Oct / 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:**
• Chief Executive oversight	• Integrated improvement plan and oversight of delivery with regular check and challenge in place • Insightful Board self-assessment	• RSP oversight • Internal audit oversight • External audit oversight • Well led review (2025) • Independent review (2024)

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 (February 2026)	**Previous assessment: Limited (January 2026)**
Overarching comment & rationale for assessment: Board approval of revised Governance infrastructure (November 2025); implementation ongoing. We have a single plan and will take action once and well, though it will be some months to fully embed and achieve satisfactory assurance, though the project is on track, as reported to OPFBC. Programmes for Board and Executive Development were finalised and at Board development (October 2025) and presented at November Board; these must now be actioned. 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:**
• 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	• 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.

	groundwork for revised governance infrastructure (changes to policy and meetings), noting the aforementioned. • The BAF has been reshaped to increase granularity of reporting with SMART objectives. This was socialised as a mechanism for internal control with the Audit Chair and then presented and agreed at the Audit Committee in July and subsequently reviewed at Board development in August 2025. • The first IQPR Improvement Task & Finish Group was held in July to socialise the need for change with key stakeholders, with weekly meetings now planned to give pace to needed improvements. Balanced scorecards have been well developed with testing took place at Executive Operational Groups on 12th August.	
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 (operational oversight) • Monthly flash report and progress made against KPIs	• 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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**
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	Gaps in control & associated actions: • Framework designed and Cultural Insight Group now established – proposal to develop a dashboard for the triangulation of data under development. Referral and feedback process requires

	People Committee and Trust Board.	refinement. Update due at QPC in February. • Framework to be developed and shared with Cultural Insights Group - Networks all established but process and framework requires agreement – CPO to develop recommendation and people team to map engagement framework. Update via Culture Plan progress report to be received by QPC in February. • No Employee Relations caseload reporting to support understanding the themes and hot spot areas. New dashboard now developed with fortnightly reviews with CPO and team underway. Development required for managers and leaders – proposal developed which requires approval for implementation aligned to leadership framework. ER casework metrics to be included in future integrated workforce reports – from March 2026. • No evidence to demonstrate impact of compassionate leadership framework. Review has been undertaken and Restorative Just and Learn proposal has been developed and is being presented to the QPC in February.
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 (February 2026)	**Previous assessment: Limited (January 2026)**
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 (February 2026)	**Previous assessment: Limited (January 2026)**
Overarching comment & rationale for assessment: The trust is responsible for effective fire safety which combines active and passive fire engineering 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, design 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 & Functional Suitability: • 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 of lithium batteries	• Management of fire and evacuation policy in place • Secondary Fire Risk Assessments completed for Level 5,6,7,8 between 5th December 2025 to 31st December 2026 • New Ward Checks have been introduced in Wards in Tower. • Staff Training targeted at high-risk clinical areas in upper levels of the Tower (50 fire and evacuation wardens) • Organisation wide training in place (Mandatory training compliance is at 91% completed online every 2 years) • Established Improvement Programme for Fire Management System.	• Devon and Somerset Fire & Rescue Service DSFRS reviewing action by trust to ensure all reasonable action is being undertaken for the Tower (following meeting on 17/12/25). • Fire Strategy to be Commissioned to start February 2026. • Quality Design Review Meetings took place16th/17th December to progress fire design for the Tower. • NHS E, DSFRS and Authorising Engineer attended site 17th December to complete fire safety review of the Tower. • Fire & emergency evacuation action plans and action cards being developed by 31st January 2026. • Associated fire drills and exercises to be undertaken by 28th February 2026.
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 (February 2026)	**Previous assessment: Limited (January 2026)**

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 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. Capital prioritisation meeting 12/01/26 to sign off capital programme prior to board submission. • Capital Plan to be ratified at Trust Board by 31st January 2026. • Lack of a modern CAFM system limits the ability to proactively manage critical estates risk. Investment decision in new CAFM system included in operating plan for Estates and Facilities Management Division 19th January 2026. • 6 facet survey to provide up-to-date estate condition report. Complete 31st January 2026.

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 operational estates and facilities management.	• Internal Audit reviews of capital governance, procurement, and risk management. • External Audit assurance on capital accounting and asset management. • NHSE scrutiny and approval of major capital schemes and business cases. • Health & Safety Executive, CQC, and Fire Authority inspections. • PLACE assessments and national ERIC and PAM data benchmarking.

• 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.	• 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.	• 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 (February 2026)	**Previous assessment: Limited (January 2026)**
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 KPIs 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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**
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 (February 2026)	**Previous assessment: Limited (January 2026)**
Overarching comment & rationale for assessment: The Torbay and South Devon NHS Foundation Trust Board approved the Trust Green Plan in September 2025. The Green Plan positions the Trust to make 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.	

Risk to delivery:		
Aggravating factors:	**Mitigating factors:**	**Gaps in control & associated actions:**
• Insufficient capital to improve estate decarbonisation. • Limited SME resource to deliver sustainability workplan • No energy and decarbonisation specialist • Condition of estate means significant amount of assets are environmentally inefficient. • Inadequate technology to monitor and manage the	• Capital programmes to improve the environmental efficiency of the estate. • 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.	• Management Plan for EFM will identify a role for environment and sustainability lead, 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. (April 2026) • 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)

environmental performance of the estate.	• Green plan has been refreshed by the Board in September 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:**
- 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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**
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 & status (January) -** people directorate workshops have taken place and a draft strategy developed. This is feeding into the Trust wide strategy development and is due to QPC in February. • People strategy to align and be co-designed alongside the refreshed Trust strategy. **Actions & status (January) -** as above. • The Our plan for better care programmes need to be reset with appropriate leadership and resource. **Actions & status (January)** – Chief People Officer and Programme Leads to review following approval of strategy. This is still in progress. • Clarity is required for oversight and assurance for delivery of the strategy. **Actions & status (January)** - To be socialised via QPC in February and then approved at Executive Committee date TBC but aligned to Trust strategy. • Workforce planning numbers hav escalated a WTE gap and WTE CIP schemes have not delivered the reductions in 25/26. Actions & status (January) - Deep Dive to be undertaken by Finance and Workforce Teams and improved reporting required. Revised workforce report due to EOG in

		January and Board in February. Improvement required in governance and reporting of CIP schemes related to WTE.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	**Second Line of Defence - Oversight Functions and Internal Assurance**	**Third Line of Defence - External Assurance:**
• Chief People Officer weekly review with workstream lead • People Dashboard, IPR, staff survey, WRES and WDES, student surveys, NETs, GMC NTS, exception reporting, ER caseload data, workforce information and NHSP reports, directorate risk register. • Individual team and service reviews as part of management and team meetings. • 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. • 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 (February 2026)	**Previous assessment: Limited (January 2026)**
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 & status (January)** – Review will be undertaken aligned to 5.3 programme review. Update on progress against actions to be reviewed at QPC in February. Restorative Just and Learn proposal has been developed and will be socialised in January. • An improved collective and inclusive wellbeing approach is required. **Actions & status (January)** – stakeholder workshops have taken place. Draft proposal was discussed at Exec Co in December, and a proposal has been developed and will be presented to Exec Co in January for approval to move to business case stage.
Three lines of defence:		

First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
• Chief People Officer weekly review with workstream lead • People Dashboard, IPR, staff survey, WRES and WDES, student surveys, NETs, GMC NTS, exception reporting, ER caseload data, workforce information and NHSP reports, directorate risk register. • Individual team and service reviews as part of management and team meetings. • 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.

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 (February 2026)	**Previous assessment: Limited (January 2026)**
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.	• Clarity on strategy needed to support defining what structure is needed for future. **Actions & status (January)** - In progress please see above objectives. • Independent advice and support needed. **Actions & status (January)** - CPO has identified support and first meeting has taken place. • Structure review – setting up agile teams to facilitate effective and efficient completion of work, information and communications flow, including governance, reporting and assurance. **Actions & status (January)** - CPO is drafting proposal with independent support and following strategy development outputs. Draft organisational change proposal to be developed early February.

		• 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. - **Actions & status (January)** - Business case for medical e-rostering approved Autumn 2025 – delay due to concerns with capacity to deliver alongside EPR – decision needed on timescales to progress. Viridian dashboard now available for other staff groups and has been presented to the initial stakeholder group. Safer staffing report being reviewed and need to triangulate with Viridian dashboard. • 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. **Actions & status (January)** - evidence provided to support the outstanding action. Aligns to culture plan and regular updates to be provided to the CQC Group
Three lines of defence*:*		
First Line of Defence - Operational and Management Controls	**Second Line of Defence - Oversight Functions and Internal Assurance**	**Third Line of Defence - External Assurance:**
• SRO (CPO) weekly review with workstream lead • People Dashboard, IPR, staff survey, WRES and WDES, student surveys, NETs, GMC NTS, exception reporting, ER caseload data, workforce information and NHSP reports, directorate risk register. • Individual team and service reviews as part of management and team meetings. • NHSE and HEI reporting.	• Monthly flash report submitted to the Oversight Group • Monthly review by the People & Education Leadership Team (PELT). • Monthly review of Care Group and EOG	• ICB/NHS • NHSE Senior Leader Visit (annual). • NHSE and CQC visits and or reports. • Regular review at the ICB Workforce Delivery Management Group (Tactical and Strategic Cells)

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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**
Overarching comment & rationale for assessment: NHS England launched its national 10-Point Plan on 29 August 2025, requiring all trusts to deliver urgent improvements to junior doctors' working conditions within 12 weeks. Incorporated into the NHS Oversight Framework, the plan mandates Board-level oversight and corrective action if milestones are missed. In response, the Trust has rapidly initiated delivery across all ten areas, led by Chief Medical Officer Dr Kate Lissett in collaboration with the Resident Doctors' Representative Committee (RDRC). A progress update is scheduled for Executive Committee review on 23 October 2025.	

Existing resources—such as the Flexible Working Champion and the 2025/26 Doctors in Residence Support Booklet—are being aligned with the national plan to ensure a joined-up local response. With early actions underway and governance structures in place, the current assurance level is rated Satisfactory, indicating reasonable confidence in timely delivery, while recognising that full compliance and measurable outcomes are still in progress.		
Risk to delivery:		
Aggravating factors:	**Mitigating factors:**	**Gaps in control & associated actions:**
• Compressed timescale for delivery – a wide range of improvements must be implemented or initiated within 12 weeks, creating pressure on capacity and coordination.	• Board-level leadership -in progress (October 2025): A senior lead for resident doctor wellbeing (Chief Medical Officer) has been confirmed, and a resident doctor representative to the Board will be identified. • Clear leadership & accountability: CMO supported by DME, education leadership and medical HR are leading the programme and reporting progress to the Board, ensuring governance oversight. • Structured implementation: A self-assessment audit is underway, with an action plan co-developed with the Resident Doctors' Committee. Progress will be reviewed at the Executive Committee in October 2025. • Existing support: The Trust's Flexible Working Champion, Support Booklet, and wellbeing resources provide a strong foundation and are being aligned with the national plan.	• Workplace wellbeing audit & facilities improvement plan –Due November 2025: • Rota management compliance (8-week/6-week rule) – Ongoing from Sept 2025: • Payroll accuracy improvement programme • Mandatory training portability – In place (October 2025) • Study leave expense reimbursement – Due November 2025:
Three lines of defence*:*		
First Line of Defence - Operational and Management Controls	**Second Line of Defence - Oversight Functions and Internal Assurance**	**Third Line of Defence - External Assurance:**
• Through PGMEC, regular implementation meetings with project leads are held to track progress on each of the 10 actions and resolve operational issues as they arise. • Exception reporting by junior doctors is actively monitored. • Resident Doctors' Representative Committee (RDRC).	• Quality and People Committee receive a monthly update on this objective, including a review of progress and outstanding risks. • Executive oversight is maintained via the Executive Committee and internal performance reviews. A dedicated progress report on resident doctors working lives is scheduled at the Executive Committee in October 2025 for assurance	• NHSE Oversight Framework monitoring: Starting Autumn 2025, NHS England will publish trust-level metrics on key aspects (availability of basic facilities, compliance with advance rota notice, incidence of payroll errors, etc. Regulatory reviews: Periodic NHSE Senior Leadership visits (annual) and CQC well-led inspections include evaluation of workforce wellbeing and organisational culture • Educational oversight: External bodies like the General Medical Council (GMC) and Health Education England (Deanery) conduct annual surveys (e.g. GMC National Training Survey) and quality assurance visits that gauge junior doctor satisfaction and training conditions..

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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**

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
- Currently refreshing the Our Plan for Better Care for 2026/27

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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**

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.
- Formal sign off of strategy by Board of Directors in February. Stakeholder engagement plan will then be activated.

Risk to delivery:

Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
• Complexity of the partnership landscape • Challenging financial/performance position	• Strong emphasis of process on engagement and listening • Support of communications team	• Challenges

and competing pressures for staff and leaders		
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: Limited (February 2026)	**Previous assessment: Satisfactory (January 2026)**
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 (February 2026)	**Previous assessment: Satisfactory (January 2026)**
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.
Formal sign off of strategy by Board of Directors in February. Stakeholder engagement plan will then be activated.

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 (February 2026)	**Previous assessment: Limited (January 2026)**

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 (February 2026)	**Previous assessment: Limited (January 2026)**

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.	• 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	• Lack of certainty on medium/long-term national funding allocations post-NHP delay. • Limited internal capital headroom to address urgent risks without external funding. • No guarantee of success in national competitive bidding rounds despite strong cases. • Revenue affordability constraints may limit ability to accept or progress capital funding even if secured. • Influence on national prioritisation decisions ultimately limited to advocacy, not control.

• External approval processes (NHSE, DHSC, Treasury) are lengthy and subject to political priorities. • Dependence on wider system prioritisation may dilute Trust-specific bids.	completed before the end of the year.	
Three lines of defence:		
First Line of Defence - Operational and Management Controls	**Second Line of Defence - Oversight Functions and Internal Assurance**	**Third Line of Defence - External Assurance:**
• Executive Directors and Capital Development Director leading capital strategy, lobbying, and business case development. • Clear risk-based prioritisation of schemes through Estates Strategy and Capital Planning processes. • Engagement with ICS partners and NHSE regional teams to influence allocations. • Routine monitoring of pipeline schemes, risk registers, and backlog maintenance data.	• Board-level oversight via Executive Committee and Building a Brighter Future Committee. • Regular review of capital risk and assurance within the Board Assurance Framework (BAF). • Independent assurance from ICS capital planning groups on alignment and prioritisation. • Compliance checks against national planning guidance, NHSE business case requirements, and governance frameworks.	• Internal Audit reviews of capital planning, prioritisation, and governance processes. • External Audit opinions on financial statements and capital accounting treatment. • Independent reviews by NHSE/DHSC (e.g. Gateway Reviews, HMT business case scrutiny). • Parliamentary and regulatory oversight (NAO, CQC, Public Accounts Committee inquiries) into capital allocations and NHP delivery

SUPPORTING OBJECTIVE: To provide a resilient digital infrastructure, that underpins the delivery of clinical and corporate services. To implement the electronic patient record (EPR), improving operational, clinical and resourcing productivity and quality.		
Executive lead: Chief Strategy and Planning Officer	**Board oversight Committee: Finance and Operations Committee**	
Current assessment: Limited (February 2026)	**Previous assessment: Limited (January 2026)**	
Overarching comment & rationale for assessment: Current IT systems do not sufficiently meet business requirements and are exposed to substantial risks due to legacy system vulnerabilities and increasing global cyber threats. Although efforts have been made to enhance the infrastructure, comprehensive risk mitigation remains contingent upon the successful deployment of Epic in April 2026 and the planned transfer of Trust datacentres to a fully managed environment by mid-2026. The EPR Programme, in collaboration with EPRR teams, is actively evaluating datacentre cyber-attack risks and enacting robust safeguards to support rapid recovery. Additionally, these teams are coordinating business continuity planning to address 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 and infrastructure 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 (NHS auditing consortium). • A cyber assurance framework protects Epic's digital infrastructure. • Rolling IT hardware upgrade programme. • IT investments are prioritised by risk and backed by capital funding for 2025/26. Additional funding has enabled pull forward of 26/27 FY plans.	• Risk remains of sophisticated cyber-attacks despite existing security measures. o Cyber Security Manager conducts best practice reviews, self-assessed and reported to the Audit & Risk Committee. • Ongoing capital and revenue investment needed to maintain and improve digital infrastructure. o IM&T and CIDG operate a rolling 5-year capital investment plan for key infrastructure upgrades. This

	• The shift to managed infrastructure services and Microsoft 365 InTune (to securely manage devices, access, and apps) is in progress. The procurement of a new system driven by Torbay Council for ASC, with the Health component transitioning into the EPR.	remains at risk due to budget restrictions. Datacentre relocation has been delayed due to Openreach circuit installation problems. Risk to the EPR programme has been mitigated by scheduling data moves to post 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. • Budget focussed on critical infrastructure upgrades.	• 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: Satisfactory (February 2026)	**Previous assessment: Satisfactory (January 2026)**

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: Limited (February 2026)	**Previous assessment: Satisfactory (January 2026)**	
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 £81.8m 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 given that delivery of the financial plan in 2025/26 will be achieved through a higher level of non-recurrent savings than planned, The recurrent underlying position has deteriorated to £99.5m Planning for 2026/27 continues and a full assessment of the exit underlying position has been undertaken (£99.5m). 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. Development of the 2026/27 continues with an initial plan submission completed on 17 December 2025. The next 3 year plan submission was made on 12 February 2026.		
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 given to ICB relating to CHC to either transfer responsibility of agree risk share by end of February. • Review underway to assess the financial and non-financial risks of exiting the s75 arrangements with a view to a Board decision in March 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 February • Care Groups to either identify recurrent pay savings or agree to a recurrent vacancy factor being applied to their budgets by end of February • 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 February
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 (February 2026)	**Previous assessment: Limited (January 2026)**

Overarching comment & rationale for assessment:

The Trust Board agreed a financial plan for 2025/26 to deliver a deficit of £8m. As at month 10 the Trust is reporting a deficit to plan of £10.3m, solely due to the exclusion of deficit support funding. The year-to-date position, including deficit support funding, remains on plan.

The Trust is £2.4m behind meeting its CIP target to date, however following a review of the forecast outturn based on current run rate, there is a gross risk of £6.0m 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 are plans to deliver £6.0m of the further savings including £0.6m of high-risk actions identified. The current risk to delivering the forecast outturn is therefore £0.6m.

Rationale for assessment: limited assurance based on losing DSF and therefore not delivering initial forecast outturn. With DSF the Trust would deliver a forecast outturn deficit of £7m which is £1m favourable to plan due to receipt of an additional £1m dental income from the ICB.

Risk to delivery:

Aggravating factors:	**Mitigating factors:**	**Gaps in control & associated action**
• 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	• Further work required to analyse productivity and benchmarking information and develop plans for improvement to be included in the 2026/27 planning round • Business cases submitted for national PDC to support critical infrastructure and constitutional standards awaiting national approval by end of February 2026.

	• Multiyear 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 i.e. Finance, Performance, Workforce, Quality and Safety through Executive Operations Group	
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 (February 2026)	**Previous assessment: Limited (January 2026)**
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.

BUILDING A Brighter Future

NHS
Torbay and South Devon
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Our Plan for Better Care

Torbay and South Devon NHS Foundation Trust

February 2026

Our Estate
Our People
Our Digital

Executive Summary

Torbay and South Devon NHS Foundation Trust

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) our workstream monthly assurance position, b) CIP delivery against applicable workstream and c) 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 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

Workstream Progress Summary February

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Programme / Workstream	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Leadership Programme					
1.1 Governance & Assurance					
1.2 Well-Led	Complete	Complete	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	On Hold	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	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	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					

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:

- Assurance has reduced across Governance & Assurance and EPIC due to slippage in key deliverables, resource constraints and competing priorities; targeted recovery actions are now in progress.
- Managing Our Estates remains under review, pending the outcome of the Executive review of the EFM' Director's assessment report expected in February
- PASP and Managed Services & Subsidiary company arrangements remains on hold pending national direction.
- Assurance has improved in Community Services re-design (Frailty) and Culture, Organisational development & learning

The Improvement Programmes Impact to CIP (M10)

Torbay and South Devon NHS Foundation Trust

Our Plan for Better Care Programme Dashboard

Programme	Original Plan	Transacted YTD (M1-M10)	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	£ 8,841,227	£10,949,787	£ 11,085,236	£ -	£ 96,991	£ 10,988,245	£ 876,236
Performance	£ 5,452,000	£ 3,201,523	£ 3,706,595	£ 3,706,595	£ -	£ -	£ 3,706,595	-£ 1,745,405
Finance	£ 1,838,000	£ 146,322	£ 167,058	£ 167,058	£ -	£ -	£ 167,058	-£ 1,670,942
People	£ 19,387,192	£ 12,447,715	£13,948,694	£ 17,868,892	£ 50,002	£ 2,995,130	£ 14,823,760	-£ 1,518,300
Total	**£ 36,886,192**	**£ 24,636,787**	**£ 28,772,134**	**£ 32,827,781**	**£ 50,002**	**£ 3,092,121**	**£ 29,685,658**	**-£ 4,058,411**

Our Plan for Better Care Workstream Dashboard

Workstream	Original Plan	Transacted YTD (M1-M10)	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	£ 6,360,468	£ 7,838,011	£ 7,935,002	£ -	£ 96,991	£ 7,838,011	-£ 146,998
2.4b Continuing Health Care	£ 2,127,000	£ 2,480,759	£ 3,111,776	£ 3,150,234	£ -	£ -	£ 3,150,234	£ 1,023,234
3.1a Planned Care – Elective Care	£ 2,000,000	£ 1,600,000	£ 1,900,000	£ 1,900,000	£ -	£ -	£ 1,900,000	-£ 100,000
3.1b Planned Care – Diagnostics DM01	£ 580,000	£ 420,000	£ 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	£ 1,181,523	£ 1,302,595	£ 1,302,595	£ -	£ -	£ 1,302,595	-£ 319,405
4.3 Managed Services & Subsidiary Company Arrangements	£ 1,500,000	£ -	£ -	£ -	£ -	£ -	£ -	-£ 1,500,000
4.4a One Devon Shared Services Finance	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
4.4b One Devon Shared Services Procurement	£ 338,000	£ 146,322	£ 167,058	£ 167,058	£ -	£ -	£ 167,058	-£ 170,942
5.1 Workforce Plan & Transformation**	£ 19,387,192	£ 12,447,715	£13,948,694	£ 17,868,892	£ 50,002	£ 2,995,130	£ 14,823,760	-£ 1,518,300
Total	**£ 36,886,192**	**£ 24,636,787**	**£ 28,772,134**	**£ 32,827,781**	**£ 50,002**	**£ 3,092,121**	**£ 29,685,658**	**-£ 4,058,411**

*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.

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–M10) delivery stands at **£24.6m,** with full year delivery of **£28.8m** and a forecast outturn of **£32.8m.** Highlighting a variance of **£4.1m**.

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 **£8.7m**, 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

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- During this reporting period **118 risks were recorded** on the IIP risk register & shared with OPFBC.
- **6 of these risks are currently scoring 20** or above and are listed below– 2 are new high risks compared with last month.
- **5 new risks are presented for approval:** 1x ASC, x1 Outpatients, x1 Cancer Services, 1x Frailty & x1 People and education capability. These new risks will be formalised for February reporting.
- **9 risks has reduced residual scores in month**; Adult Social Care Risk 2.4a-18, Maternity & Neonatal safety 3.4-04, Finance risks 4.1a-02, 4.1b-01, 4.1b-02, 4.1b-03, 4.1b-04, People workstream risks 5.1-06 & 5.2-02 Continuing Health Care; risk 2.4b-05. **6 risks have increased this month**, including Board & Exec Development 1.3-06 (from 3→6) and several One Devon shared finance risks: 4.4a-01 (12→16), 4.4a-03 (4→6), 4.4a-05 (4→6), 4.4a-06 (9→16), and 4.4a-07 (12→20).
- Following last periods recommendation, the PMO worked closely with workstream leads to review risks reaching target scores and as a result have requested **closure of 19 risks** (3x 3-5yr strategy, 2x EPIC, 4x ASC, 2x CHC, 1x Elective Care, 3x Cancer, 3x Frailty, 1x People & Education capability)

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 work flow 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	↔
5.1-02 Workforce Plan & Transformation	**Risk:** Workstream will be unable to achieve required WTE workforce reductions in corporate services and infrastructure through transformation change required. **Cause:** Pace of change from this large scale corporate reform is taking longer than expected and workstream is reliant on external factors for reductions to be scoped and progressed. **Consequence:** Unlikely to achieve WTE reductions and associated CIP in 25/26 as planned which will further impact in 26/27. Reliance on other areas means a detailed delivery plan to reach targets still remains unknown at M7 with limited assurance the target can be met in year.	16	1) Workstream Lead continues to obtain status position from other leaders or through CIP reporting to understand any plans in progress. Mitigation is limited as control at this stage. 2) Inviting Corporate Services leads to meet to provide an update to current progress. This will take place at the Workstream Leads meeting.	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

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

Workstream & Risk Reference	Risk Description	Initial Risk Score	Mitigations	Current Risk Score	Risk Trend
4.4a-07 One Devon Shared Services: Finance	**Risk:** Proposed go-live date of 1 April 2026 unachievable. **Cause:** The planned transfer of the finance team to One Devon on 1 July 2026 will also be delayed. There is likely to be a knock-on impact on the new Epic system and other finance systems, as Epic has been configured to interface with SBS rather than the existing Unit 4 system **Consequence:** From 1 April 2026, the Unit 4 finance system will be unsupported, introducing operational and technical risks. The Epic system may experience integration issues, as it was not designed to interface with Unit 4. Additionally, ongoing uncertainty around revised TUPE timelines may negatively affect staff morale and increase the risk of staff turnover.	16	1) A formal letter has been sent to SBS to outline Devon wide concerns.. 2) SBS has responded to letter, and this is being reviewed by Devon wide CFOs 3) A review is taking place to establish a detailed project plan of remaining work, and also confirmation from SBS that their systems testing is at least 95% successful 4) Discussions are on-going with Epic to understand the impact of the SBS delay.	20	↑
5.1-03 Workforce Plan & Transformation	**Risk:** Inability to achieve workforce CIP in 25/26. **Cause:** Largely due to not running a compulsory redundancy scheme as originally planned. **Consequence:** Remains a £6m CIP gap with no robust associated plans to close and potential for double counting if not correctly calculated.	16	1) CFO has shared paper with private board to recalculate gap with £1.7m secured against £6m target. 2) Robust workforce controls remain in place including; vacancy freeze, break glass only, overtime controls & bank & agency reductions. 3) Executive CIP deep dives continue with care groups with an aim to review and close the gap where possible. 4) Deep Dive of current workforce WTE is underway with CEO to meet with Exec Directors to review	20	↔
2.4a-19 Adult Social Care	**Risk:** One Devon Finance transition to SBS and change of finance system may create misalignment with programme requirements **Cause**: Timelines and details are not known Consequence: Impact technical ability to integrate with ASC CMS where needed – this will impact capacity of team, cost and duration of ASC CMS programme to include any potential rework	15	1) Undertake a comprehensive assessment of the implications of not achieving an April 1st go-live and begin developing contingency plans 2) Assess whether the generic system output can be adapted or transformed into a usable format for programme needs	20	↑

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Appendices

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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

- ✓ Work is ongoing to review and refresh the Trust's Risk Management Framework. Following review of the initial draft, the Director of Corporate Governance (DCG) has reassessed delivery capacity and identified the need to adjust supporting resource to strengthen completion of the work.
- ✓ The Audit and Risk Committee (ARC) has been briefed about current position of risk management framework , and oversight continues through the Governance Delivery Group and Risk Group. A formal project plan will be presented to the Executive Committee in the coming weeks.
- ✓ The refresh of all Committee Terms of Reference has been completed and will be published on the Trust website imminently.
- ✓ A draft 'Onward Delegation Framework' has been prepared, together with a communications plan. Further amendments are required to reflect organisational changes, and a request to extend the associated deliverable will be submitted through programme governance to ensure alignment and robustness.
- ✓ Work continues to review the recommendations and actions arising from the Well Led report to confirm delivery and closure.
- ✓ There remains one Internal Audit recommendation relating to the Board Assurance Framework, which is being progressed with Internal Audit.

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	The Board signed off the Governance plan in their November meeting and it is being implemented.	⬆
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	Complete and process in place	★
Deadlines are met for executive and sub-committee meeting papers	Deadlines are clear and communicated	>90% over 6 months review period	On track – Ongoing with measurement over period of time.	⬆
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 and continues to be embedded	⬌
% 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	⬆

Next Steps

- ➢ Executive Committee to be sighted on the formal Risk project plan.
- ➢ Ongoing development of the 'Onward Delegation Framework'.
- ➢ Ratification of the draft Articles of Association for SDH Developments and Charity.
- ➢ Review of Well Led recommendations and actions to ensure they have been delivered.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Limited

Board & Executive Development

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The workstream is progressing well, with only two outstanding deliverables.
- ✓ CPO recruitment remains on track, pending guidance from the ICB on potential impacts arising from their structural changes.
- ✓ Progress on the Leadership Behavioural Framework had been paused due to other organisational priorities but with the potential for scheduling at a Board Development session in March. The Trust is largely aligned with the national Leadership Compact, except for 360-degree feedback, which will be introduced into Non-Executive Director (NED) appraisals from April. Non-Executive Nominations and Remuneration Committee (NED NomRem) were briefed at the time of publication, and an initial assessment was completed

Key Performance Indicator	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%	Completed -Executive Development Sessions scheduled.	★
Delivery of board development sessions as scheduled	12	100%	Completed - Board Development Sessions approved at Board in November and scheduled.	★
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

- ➢ Progress with CPO recruitment.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

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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

- ✓ Following Executive Team developments in December, an updated draft strategy will be presented to the Trust Board in March for feedback and intended ratification.
- ✓ The CEO and CSO have defined "year one deliverables," shared with senior leadership in January to ensure alignment with local delivery plans.
- ✓ To maintain focus, care groups will prioritise "signature moves" and enablers within the existing Plan for Better Care rather than creating separate unit-level strategies. The PMO is integrating these elements into a single oversight and accountability framework.
- ✓ Six strategic service reviews are planned for 2026/27, with preparatory data gathering, including SLR and productivity benchmarking, already underway.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Ratification of final strategy by Board (in February as agreed by Executive Oversight Group in January)	N/A	Original Target Jan 2026. Moved to Feb 2026 in line with agreement	Expect completion by Feb 2026	⇔
Commence strategy communications with organisation and relevant information available online and through other relevant channels	N/A	Complete / underway	Comms commenced about the draft strategy in Nov	⇔

Next Steps

- ➢ Review outstanding deliverables (relating to the integrated delivery plan and unit-level strategies) for inclusion in the 2026/27 delivery framework.
- ➢ Finalise draft strategy for presentation to Board in March.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

EPIC

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Delivered

- ✓ The programme remains at a status of Watch. Overall configuration, data migration, and super user identification are on track, but delays in training registration and Oncology Protocol validation pose a risk to the Beacon go-live for TSD and RDUH.
- ✓ **Beacon:** Validation of 718 chemotherapy regimens is behind schedule for the 23 February cutover, placing the 3 April go-live at RDUH and TSD at risk.
- ✓ **Training Registration:** 90% of staff across the three operational care groups are booked on at least one training course. Focus continues on registering the remaining staff, including review of training requirements for Corporate Services.
- ✓ **TSD Blood Transfusion LIMS Integration:** At risk due to validation delays and technical feasibility concerns.
- ✓ **Staffing & Certification:** Several configuration teams are impacted by unexpected analyst outages; only 18 of 24 net new application roles have completed certification. Support plans are being implemented to mitigate this risk.
- ✓ **Benefits:** Governance and tracking processes are in place, with emergent benefits monitored and no build issues impacting delivery.
- ✓ Successful 90 Day Go-Live Readiness Assessment completed on 13 January; 60 Day GLRA due 3 February.
- ✓ Development of performance and activity reporting continues across the One Devon footprint.
- ✓ The administrative backlog had been substantially reduced by putting external capacity in place to eliminate remaining delays, enabling a shift of focus onto resolving outcome backlogs.

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 Full Business Case (FBC) submission and workgroup change plans	As per FBC	Current from FBC £164M – 10 years	Benefits realisation remains at watch as the team has not completed a review of the financial re-baselining of all Cash Releasing benefits to ensure they are accurate and up to date.	⇔
Quality & Safety indicators	To be confirmed 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	TBC prior to rollout	Papers on elective activities and how Easter weekend will be handled from UEC perspective have been agreed with Epic. Shared with Care Groups in December.	⇔
Training for Trainers	Baseline is 0 to be trained trainers	49 trainers by 30 November 2025	All trainers are prepared for End user training which begins early February.	★

Next Steps

- ➢ Continue the 'User and System Readiness' phase through to 23 January 2026.
- ➢ Complete activity planning for Go-Live.
- ➢ Finalise registration for Super-User training and monitor progress against End-User training.
- ➢ Prepare for the 60 Day Go-Live Readiness Assessment (GLRA) on 2 February.
- ➢ Complete and implement performance and activity reporting plans across the One Devon footprint.
- ➢ Progress round 2 of the Full-Scale data validation.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Limited

Adult Social Care

Torbay and South Devon NHS Foundation Trust

Delivered

The ASC programme continues to progress across its nine key deliverables, key updates are:

- ✓ **Case Management System (CMS):** Core technical delivery is progressing, including data migrations, early user testing, and form development. High-risk areas remain around NHS Mail/Jira integration, capacity constraints, and concurrent system go-lives. Confidence will improve as dependencies are resolved and capacity secured.
- ✓ **Operating Model Review:** Off-track but recoverable. Recruitment and benchmarking support delivery; workforce redesign discussions are delayed. Case for change is 80% complete, consultation expected May/June.
- ✓ **Service Line Reporting (SLR):** Steady progress; draft report completion slipped to 6 February. No new risks identified; delays are recoverable.
- ✓ **Practice Model:** Stakeholder engagement and system integration progressing. Risks from leadership and capacity changes are mitigated through revised ownership and prioritisation.
- ✓ **Timely Intervention:** Data quality and governance milestones on track. Workforce capacity and competing demands remain challenges, recorded on the Trust risk register.
- ✓ **Direct Payments:** Off-track but recoverable. Progress includes strengthened support, additional capacity, and revised processes nearing go-live. Risks around workforce, market fragility, and oversight are actively mitigated.
- ✓ **Front Door:** On track. Referral volumes have stabilised; strengthened leadership and triage support timely referrals. Capacity and transformational progress continue to be affected by staffing pressures and system changes.
- ✓ **Home First:** On track. Analytical work informs long-term placement and discharge pathways. Delivery constrained by limited staff availability and operational pressures.
- ✓ **ASC Cost in ICO Model:** Complete. Finance have completed the analysis to correlate the gap between ASC income and costs

Risk	Mitigation
Reduced DPO capacity in CMS for TSDFT and the Council, due to prioritisation of EPIC and the end of Channel 3 support, may cause project delays.	Prioritise DPO tasks, plan work in advance, and escalate issues when needed.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Direct Payments: Proportion of adults receiving long-term community support who receive a Direct Payment (%)	18.5%	25%	18.0% 27/01/2026	⇔
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%	59.7% 27/01/2026	↓
Operating Model: Proportion of roadmap milestones delivered to agreed dates (%)	0%	100%	15%	⇔
Front Door: Contacts resolved at first point without onward referral (%) (updated at end of month)	277/832= 33% (avg across Nov. weekly data points)	Not set yet	34.5% for the month of January	↓
Home First: Permanent admissions to residential/nursing care homes per 100,000 of population	866	600	729.7 27/01/26	⇔
Average monthly Growth In People Supported by quarter 3	9.75	<6	18 Q3	⇔
Forecast Outturn Mn 9	£86,608	<£90,026	£89,969 (-£57k)	↑

Next Steps

- ➢ **CMS:** Resolve integration issue and progress UAT.
- ➢ **Operating Model:** Complete key documentation and workforce redesign.
- ➢ **SLR:** Finalise draft report.
- ➢ **Practice Model:** Recruit interim PSW and progress stakeholder engagement.
- ➢ **Timely Intervention:** Complete reviews and finalise improvement plans.
- ➢ **Direct Payments:** Align audits, simplify processes, and run engagement.
- ➢ **ASC Front Door:** Improve referral processes and implement safeguarding model.
- ➢ **Home First:** Track bed utilisation and reablement opportunities.

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
ASC Client Reviews	£4,282	£4,038	£4,135	-£147	
ASC Transformation	£3,700	£3,700	£3,700	£0	

Assurance	Rating
Executive Sponsor Rating	Limited

Continuing Health Care

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The CHC workstream continues to deliver against its core KPI's but is experiencing delays outside of its control, notably; Short-term issues relating to finance systems and payments have been managed using Paris and TFM. However, future management is affected by multiple IT changes across the organisation and the ICB.
- ✓ Oversight noted the ongoing IT system risks arising from the ICB's implementation of the new end-to-end CHC system (BroadCare), the continued need to retain access to historical CHC data held on the legacy Paris system, and the separation of ASC case-management within LiquidLogic (for which CHC is not in scope) Together these factors create significant operational, financial and patient-safety risks, with staff required to work across multiple systems and a heightened risk of data gaps and incorrect payments. In response, a regrouping of the CSPO, COO and CFO has been commissioned to coordinate a Trust-wide review of these IT interdependencies and agree mitigating actions.
- ✓ CHC governance is in place within the Trust but has not advanced withing the ICB due to ongoing reorganisation. Weekly meetings are in place and reports are shared but no formal reporting structure is in place at present.
- ✓ New CHC division with a dedicated cost centre has been established within the Trust
- ✓ Capacity and demand modelling is completed with the Trust, including workforce plan, based on current operating model. However, there are emerging risks linked to ASC integration, specifically case management, which will require further review.
- ✓ Strategic and commissioning discussions completed operationally; ongoing oversight through commissioning networks.

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 long waits 85.2%	↑
Reduction in overdue FNC reviews	196	60	186	↑
CIP target reached 25/26	0	£2.2m	£3.2m	⇔
CHC Forecast (performance against expenditure budget)	£56,086	£56,086	£55,946	⇔

Next Steps

- ➢ Revise the trajectory for reducing the backlog of reviews, reflecting increased workforce capacity.
- ➢ Further develop CIP plans for 2026/27.
- ➢ Draft timelines for IT system changes and complete supporting process maps with HIS input.

Risk or Escalations	Mitigation
IT systems risks	Regrouping of the CSPO, COO and CFO has been commissioned to coordinate a Trust-wide review of these IT interdependencies and agree mitigating actions

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	£3,112	£3,150	£1,023	

Assurance	Rating
Executive Sponsor Rating	Satisfactory

Child & Family Health Devon

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ IM&T transfer completed (31 October 2025), but there are still outstanding decisions regarding IT recharges between TSD and DPT.
- ✓ Fortnightly single provider planning group continues with dedicated action plan.
- ✓ Estates SLA is being developed for DPT use of TSDFT buildings, now including CFHD; affordability discussions ongoing between Estates leads.
- ✓ The review of financial implications and provision of assurance report to Finance Performance Committee remains off track. CFO assurance statement in progress.
- ✓ Staff side engagement ongoing; consultation and 1:1 meetings underway. Measure letter issued 23 December 2025.
- ✓ Contract negotiations between DPT and ICB progressing, with CFHD included.
- ✓ Meeting between DPT and TSDFT Medical Device Teams held 13 January 2026 to support transition planning.

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	Commenced and ongoing	★

Next Steps

- ➢ Complete review of financial implications and clarify associated risks.
- ➢ Continue staff engagement throughout the consultation process.
- ➢ Maintain fortnightly TSDFT programme meetings to identify, map and resolve transfer issues.
- ➢ Progress Estates discussions between TSDFT and DPT to confirm affordability of provision.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

NHS
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

- ✓ Netcall functionality has been approved to enhance Patient Hub messaging, stabilise validation processes, automate backlog management (including signposting to alternative providers), and support Q4 RTT recovery while strengthening the Trust's longer-term RTT position.
- ✓ TAIRU and programme management support are in place to progress Musculoskeletal and T&O service redesign; however, physiotherapy and T&O capital developments are not currently prioritised due to higher clinical demands, and there is a risk of delay should relocation be required to accommodate Cancer and MRI expansion, which would trigger a formal option appraisal.
- ✓ Anaesthetics Business Case approved with the consultant post out to advert; stakeholder workshop completed to inform service optimisation; and a nine-week anaesthetic timetable implemented to strengthen theatre planning and resource utilisation.
- ✓ Peri-operative posts have been approved and are progressing through HR processes, with the changes expected to reduce fallow theatres and same-day cancellations.
- ✓ Engagement is underway with RDUH to explore non-medical workforce models for Urology, with further local clinical engagement required to assess suitability for adoption within TSD.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Theatre in list Utilisation	82%	85%	85.1%	↑
Fallow Lists	79%	85% (90% local target)	80%	↑
Same Day Cancellation	10.1%	5% (3% avoidable)	7%	↑
Validation of waiting lists	70.3%	90%	87%	↑

Next Steps

- ➢ Progress recruitment to peri operative posts.
- ➢ Complete shortlisting and interviews for Anaesthetic Consultant post.

Risk	Mitigation
Limited resource to deliver these workstreams operationally.	Reviewing milestone delivery in light of Epic.

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	£1.242m	£1.242m	-£0.758m	

Assurance	Rating
Executive Sponsor Rating	Limited

Diagnostics DM01

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The Community Diagnostic Centre (CDC) has signed a Contract Change Notice with InHealth, increasing capacity to stabilise Non-Obstetric Ultrasound and move MRI to a slots-based model, with further options being developed to reduce backlog and strengthen DM01 performance
- ✓ The Non-Obstetric Ultrasound Service (NOUS) redesign has updated trajectories to reflect new CDC capacity, with service stability improving despite ongoing workforce pressures. ICB funding discussions on demand growth remain unresolved and are expected to move into business planning.
- ✓ Sonographer Team Lead recruitment is progressing, and cultural issues are being addressed with OD and the People Directorate to strengthen psychological safety, leadership, and performance monitoring.
- ✓ Business intelligence dashboards to support the Reduction in Non-Elective Imaging programme are progressing, though they are not yet ready for publication

Key Performance Indicators	Baseline	Target	Current Position	Trend

Community Diagnostic Hub (CDC) achievement of patient activity volumes against contract plan:
This data is for January 2026.

Threshold	CT	MRI	Xray	U/S	Echo	PM	Respiratory	Phlebotomy
100%	80%	69%	77%	139%	164%	138%	19%	91%

Ultrasound:

DM01	56% breach rate	*Cultural insights KPIs being worked-up. At 31/1/2026 it was predicted that of 3152 pts waiting, 1526 would be beyond 6 weeks equating to 56% of the total

MRI:

New KPIs measuring non-elective performance for MRI based on the CCN updates for MRI 'slots' rather than 'patients', are still in development and will be progressed during the next month reporting cycle.

Next Steps

- ➢ Develop KPIs for non-elective MRI performance and DM01.
- ➢ Formally establish workstream risk register.
- ➢ Progress recruitment for Lead Sonographer role and schedule interviews following advert closure.
- ➢ Commence induction and training for Governance Lead post, anticipated April 2026.
- ➢ Finalise project scope, stakeholders and leads for reduction in non-elective imaging.
- ➢ Confirm alternative option regarding endoscopy insourcing.

Risk	Mitigation
Growth in NOUS demand following ICB contract cessation at the start of the year, with no associated funding uplift.	Continue discussions with the ICB to seek funding redress.
Reduction in non-elective and acute imaging demand requires significant senior clinical input from ED and Radiology. Capacity will be constrained during EPIC deployment. In addition, project leads and key stakeholders are not yet confirmed.	Limited mitigation available unless this work is prioritised alongside EPIC deployment.

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	Work is progressing as planned; however the realisation of benefits has been moved to the next financial year. The timeline has been adjusted to reflect this.			Financial Benefit 2026/27
Mobile Scanning Unit	£500k	£504	£504	£4	

Assurance	Rating
Executive Sponsor Rating	Limited

Outpatients Transformation

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ As EPIC go-live approaches, a number of outpatient operational risks have become critical. Capacity has been diverted to mitigate these risks, impacting progress against wider deliverables.
- ✓ Short-term outpatient transformation activity will prioritise resolution of key operational risks, with the Outpatient Steering Group now meeting weekly and twice-weekly operational huddles established to support issue resolution and progress tracking
- ✓ The proposed direction of travel for a single management structure has been discussed and agreed in principle with the Chief Operating Officer and Deputy Chief Operating Officer.
- ✓ GIRFT-aligned clinic templates are in development for Trauma & Orthopaedics and ENT, and a review of standardised outpatient pathways is underway as part of the EPIC implementation.
- ✓ Baseline data collection for on-site and off-site working and service collocation is ongoing across sites, and manual clinic-space management is already delivering improved utilisation
- ✓ Work is underway with Finance to strengthen the accuracy of coding for outpatient procedures and follow-ups, alongside ongoing collaboration with the EPIC Reimbursement Working Group to optimise system configuration and improve financial outcomes.

Key Performance Indicators	Baseline	Target	Current Position	Trend

Updated KPI's to align to the refreshed deliverables will be progressed in the months following Epic go live.

Currently using the ICB outpatient deep dive metrics which is published separately: see below table
https://app.powerbi.com/groups/me/reports/b230890e-d85f-4146-a47f-d3d42ab000ed/ReportSection?ctid=37c354b2-85b0-47f5-b222-07b48d774ee3&experience=power-bi

KPI	Performance	Target if agreed	Movement	RAG
First / Follow up ratio (Jan 26)	1:2.5			
Non- Face to Face	13.1%	ICB target: 25%		
Discharge at First Appointment (Jan 2026)	35.1%			
PIFU (Nov 2025)	8.9%			
DNA	4.9%	Target 5.0%		

Next Steps

- ➢ Prioritise resolution of key outpatient operational risks as part of EPIC go-live stabilisation.
- ➢ Progress Single Management Structure through workshops with community, clinical and administrative staff.

Risk

Short-term operational pressure to clear backlogs in CPS, clinic letters and outcomes ahead of EPIC go-live.

Mitigation

- External contractor to transcribe letters backlog.
- Trust-wide overtime offered to reduce risk.
- CPS and outcome backlogs must be cleared before Epic go-live.
- Live dashboard and performance analysis supporting operational teams.

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	£500	£0	£0	£-500	Closed not progressing

Assurance	Rating
Executive Sponsor Rating	Limited

Cancer Services

Building a Brighter Future

NHS Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The Skin AI Teledermatology business case is nearing final approval, but delivery is off track due to the need for an EPIC-enabled imaging workflow and unresolved funding, creating a risk that procurement may slip into the next financial year with associated delivery and reputational impacts.
- ✓ The 2026/27 work plan for the Breast One-Stop Model has been submitted to the Peninsula Cancer Alliance to support the trial of new ways of working
- ✓ MRI capacity remains under significant pressure, with additional sessions and enhanced nursing support included in the 2026/27 submission to the Peninsula Cancer Alliance.
- ✓ Work is progressing to align treatment protocols and develop new outpatient and day-case workflows for oncology services across Devon..
- ✓ Radiotherapy programme delivery is progressing, with procurement of the treatment-planning system on track for completion by 31 March 2026, and high-level LINAC costings presented at the Capital Prioritisation Meeting; business-case development is underway to assess financial and estates options.

Key Performance Indicators	Baseline	Target	Current Position	Trend
% of pathways through telederm	0%	Awaiting go live	0%	
% of suitable referrals utilising the BCC pathway	0%	Awaiting go live	0%	
Breast - Waiting time for first appointment	18 days	10 days	14 days	↑
Breast - % of first appointments which offer triple assessment	30%	TBC (>80%)	30%	↔
Urology - MRI referral to report turnaround	20 days	10 days	17.5 days (81 scans) – Jan 2026	↑
Urology - Biopsy referral to appointment time	20 days	10 days	16 days	↑
Cancer oversight - NHS Key Fundamentals with Green Assurance	5 Green 5 Amber	10 Green	5 Green 5 Amber	↔

Next Steps

- ➢ KPI's to be approved and confirmed by Executives.
- ➢ Deliverables 2 and 3: Await confirmation from Peninsula Cancer Alliance to support the workplan, including recruitment and staff modelling.
- ➢ Operational focus on EPIC/EPR delivery.
- ➢ Continue recruitment for Clinical Director for Cancer Services (CDCS) post.
- ➢ Finalise Skin AI Teledermatology business case and arrange ratification.

Risk	Mitigation
The Trust may not meet the national expectation to implement the Teledermatology solution by April 2026.	Ongoing discussions with Finance and Contracting to agree full costings and secure funding for years 1–3.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Limited

UEC Flow

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Medical Workforce business case approved, enabling development of a patient-aligned workforce plan.
- ✓ Patient-Centred Discharge programme progressing well, with processes being embedded across wards. Senior-leader Go Sees underway, initial tests of change in development, with full engagement from SROs, Care Group Directors and the Executive Sponsor.
- ✓ Surgical Patient Streaming progressing, with infection-control measures preventing breaches, protected ultrasound capacity improving flow, direct SWAST transfers easing ED pressure, the SRU nurse project paused pending UEC Recovery Group decision, and SAU swap implementation underway
- ✓ Medical Patient Streaming progressing, with the ED coordinator test delayed due to staffing, AMAP streaming under review with supportive GP engagement, and consultant/SAS recruitment advancing ahead of February interviews.
- ✓ Paediatric improvements progressing, with Criteria-Led Discharge live and breach-free, the 7-day Green Pathway now established, SSPAU relocation scoping ongoing, and wider paediatric objectives remaining active.

Key Performance Indicators	Baseline	Target	Current Position	Trend
4-hour performance	70.09	78%	70.8% (Dec)	↑
Average Ambulance handover time	47 mins	45 mins	27 mins (Dec)	↑
45 min Max handover per ambulance	659	0	339 (Dec)	↑
No Mental Health patient over 24hrs in ED – Data not available in formal report). Will need to be developed.	8	0	15 (Dec)	↑
Paeds 4hr Performance 95%	86%	95%	85.5% (Dec)	↑
Max 12 hrs in the ED	8.71% ED	10%	7.4% (Dec)	↓
No criteria to reside – No December data	6.7%	5%	8.2% (Nov)	↑
Average pre noon discharges – No December data	21.8%	33%	19.5%	↓
Non elective length of stay		Target TBC – Requested support from Planning & Performance Team.	6.3 days (Dec)	↓
Community Hospital length of stay No update yet for November	13.9 days		12.9 days (Nov)	↑
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 Dec 24 to Nov 25) P0: P1 - P3:	 1398 428		 1435 416 (Nov)	 ↓ ↓

Next Steps

- ➢ Complete Go See walks; hold kick off meeting and agree Tests of Change for each ward.
- ➢ Continue surgical streaming data review and test of change impact.
- ➢ Finalise SOPs and outcome measures for Acute Medical Single Coordinator trial.
- ➢ Agree CYP workstream initiatives to meet 90% trajectory target.
- ➢ Roll out UEC Internal Professional Standards.
- ➢ Review AMU pathway in detail.
- ➢ Develop GP communications on Acute Medicine pathways and suitability.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Limited

Community Services Redesign (Frailty)

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ 308 patients referred to the Harbour over the first 9 weeks. 158 patients avoided secondary care, representing 51% of patients receiving an alternative service provision 46% (143) of which stayed in their own home with 5% (15) being admitted direct into a bed at Newton Abbot hospital. 11% of patients (33) were unable to avoid an attendance due to of lack of community provision to support additional care needs, identified as a missed opportunity.
- ✓ Stage 2 remains on track for the Frailty same day emergency care service (FSDEC) go-live on 23rd February 2026, with workforce recruitment the only area off-track as key roles continue to be filled. Recruitment to the previously appointed substantive posts remain secure and ready for the go-live date; however, several key roles have required re-advertisement, including LED, Nursing (EOIs), Frailty Co-ordinator, and a GP post. Recruitment activity is ongoing with planned interview and shortlisting dates throughout early February
- ✓ Operational readiness is strong, with all SOP's and clinical pathways for FSDEC undergoing final review. Patient stories are in development, and engagement work with SWAST to improve call-before-convey is scheduled for early February.
- ✓ IM&T and Estates preparations are on track with all equipment orders placed, with phased deliveries expected across February. Clinical activity in the small gym has ceased to allow estates works to begin in early February. These works are coordinated to support the operational readiness of the FSDEC environment.
- ✓ Preparations for signage installation, fire safety measures, evacuation planning, and associated safety assessments are all scheduled to be completed ahead of the planned go-live date to ensure full compliance and service readiness
- ✓ The Stage 3 business case review for the Frailty expansion is scheduled with Finance in early February

Next Steps

- ➢ Conclude Workforce EOIs and confirm recruitment to posts.
- ➢ Stock and prepare treatment room for go-live.
- ➢ Complete signage installation.
- ➢ Submit Stage 3 Frailty Expansion business case to Executive Team.
- ➢ Deliver induction and training programme.
- ➢ Complete pathway mapping and finalise SOP development.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Reduced ED attendances (clarification required on baseline measurement e.g. per day, week or month)	4	6	*158 patients were not transferred to secondary care . (Baseline refers to the total avoidable attendances per day since go live).*	↑
% of CGAs completed	30%	80%	30%	↔
Occupied bed days	140	210	*N/A – metric will be reported once dataset becomes available in March 26.*	↔
80% of patients seen in the Harbour Service have a Comprehensive Geriatric Assessment (CGA)	25	80%	*N/A – metric will be reported once dataset becomes available in March 26.*	↔
Transfer rate from the Harbour 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 May 26.*	↔
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 March 26.*	↔
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 May 26.*	↔
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 May 26.*	↔

Risk	Mitigation
Inability to recruit Band 5 nursing workforce following unsuccessful interviews.	Executive approval secured to progress an Expression of Interest process and utilise temporary staffing to support SDEC at go-live.

CIP Scheme Name	25/26 Original Plan £000's	Transacted £000's (FYE)	Forecast £000's	Variance from plan to forecast £000's	Delivery RAG
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

Elective Centre of Excellence

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The GIRFT Theatre Accreditation visit was completed on 14 January 2026. The outcome is expected by 23 March 2026.
- ✓ Refurbishment of the two replacement theatres remains on track, with the additional decant-support theatre has been confirmed for delivery on 18 April 2026.
- ✓ the Business Case to support additional activity and income from the new theatre is being developed, with plans underway for its formal sign-off and for ensuring current theatre capacity is fully optimised through appropriate staffing.
- ✓ External capital funding for OMFS expansion approved by NHSE.
- ✓ Ophthalmology unit opening planned for Q3. Further strategic conversations to take place with regards to the utilisation of the new theatre including potential elective or non-elective expansion (SRU is at capacity) and support for the theatre maintenance programme. This also links to discussions around the future of community sites such as Teignmouth.

Key Performance Indicators	Baseline	Target	Current Position	Trend
KPIs in development. Will include OMFS additionality and Ophthalmology plan against NHS England business case.				

Next Steps

- Agree revised milestones and timeframes with Workstream Lead.
- Care Group to determine strategic options for Teignmouth and SRU within the theatre replacement programme.
- Submit Theatre Replacement Programme Business Case for approval to enable additional activity and income from December 2026.
- Develop Business Case for Day Case Centre of Excellence.
- Confirm lead metrics and KPIs.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Limited

Maternity and Neonatal Safety Improvement Programme

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Draft project aims, KPIs and deliverables have been completed, with final approval and sign-off anticipated in the coming weeks.
- ✓ The Maternity Safety Support Programme (MSSP) 'Review and Reset' meeting held on 8th January 2026 confirmed the conclusion of the programme. The Trust has subsequently entered a six-month NHSE targeted support programme with the Maternity and Neonatal Improvement Support Team (MatNeoIST), with priority areas and milestones now agreed. The MNIP workstreams are currently being aligned and prioritised, and the associated milestones will be incorporated into OPFBC reporting once they are confirmed.
- ✓ The inaugural MatNeoIST, Executive and Regional meeting was held on 29th January 2026, with monthly meetings scheduled through to June.
- ✓ The safety standards for the Maternity Incentive Scheme under the Clinical Negligence Scheme for Trusts (CNST) were approved by the Quality People Committee on the 27th January 2026, and the CEO declaration is expected on 5th February 2026, which will complete this KPI.
- ✓ The Birthrate Plus (BR+) establishment review was presented to the Executive Committee on 18th December 2025. The required uplift is now progressing through the Care Group business planning process. The midwifery establishment remains below the advised level pending the conclusion of this planning work.

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 December2025	See comment below in escalation box	⟷
Maternity Safety Support Programme (MSSP) Exit Criteria	See comment below in escalation box			⟷
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

- ➢ Identify and prioritise projects aligned to MatNeoIST areas of focus.
- ➢ Finalise project detail including aims, actions, KPIs and due dates.
- ➢ Extract critical project KPIs to define overarching workstream KPIs.
- ➢ Progress the midwifery leadership structure interface with Child Health.
- ➢ Update and share Consultant roles and responsibilities policy.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Limited

NHS
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

- ✓ Workstream progressing well; only one open deliverable remains relating to introduction of SLR and productivity reporting, analysis, and support.
- ✓ Due diligence on SLR Quarter 2 data completed; reports published with summary of highest loss-making services to focus follow-ups.
- ✓ Opportunity matrix developed combining productivity data, Model Hospital metrics, and SLR to highlight improvement areas; further validation underway prior to publication.
- ✓ Dedicated Productivity workstream being established to prioritise and drive delivery of this programme.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Introduction of SLR	Reporting unavailable	Reporting available & embedded	SLR Q2 published – Finance to attend care group meetings to present findings and discuss service areas to be prioritised for a deep dive review.	⬆

Next Steps

- ➢ Finance to attend Care Group meetings to present SLR Q2 summary findings and agree service areas for deep dive review.
- ➢ Complete due diligence and validation of the opportunity matrix.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

Sustainable Financial Improvement Programme Delivery

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Delivery for Month 10 was £3.65m against a plan of £5m, a variance of £1.35m under plan. Year-to-date delivery £28.8m against a plan of £31.2m, a variance of £2.4m under plan.
- ✓ Total CIP Transacted is £33.7m, representing 81% of the £41.5m plan. The Forecast outturn remains £41.5m, in line with the Original Plan.
- ✓ The value of Red RAG Rated Schemes has decreased to £110k from £1.27m in Month 9, reflecting improved delivery confidence.
- ✓ Recurrent Delivery is 51.5% of the total forecast outturn against a target of 79%. Review of non-recurrent schemes has been completed with several expected to be reclassified as recurrent following ULP assessment.
- ✓ The WTE CIP Plan as of Month 10 was 452.52 WTE of which 143.67 WTE was transacted. Underperformance is primarily due to non-delivery of compulsory redundancy (205 WTE) and vacancy factor schemes across Care groups. The forecast shows expected delivery in Month 12 of 174.42 WTE, leaving a gap of 278.98 WTE against the full-year target of 452.52 WTE.
- ✓ Four CIP schemes with a total value of £280k were approved by EOG in January. Seven schemes remain outstanding. These schemes are being scoped with finance and operational colleagues to develop project outline documents for progression through the CIP governance process

Key Performance Indicators	Baseline	Target	Current Position	Trend
Total CIP target (£) vs. delivered (£)	£41.5 m	£41.5 m	£33.7m transacted full year	↑
% of recurrent vs. non-recurrent savings	79% of plan recurrent	79% delivered recurrent	51%	↓
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	↔

Next Steps

- ➢ Prioritise development and approval of EQIA/PODs to convert non-recurrent schemes to recurrent throughout February.
- ➢ Further develop mitigations for CIP and wider financial risks; draft CIP PODs and progress through governance as appropriate.

Risk	Mitigation
There are 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

- ✓ The consultation on the Senior Finance Team restructure has now closed, and the feedback is currently under review
- ✓ The vacant Band 8c role adverts have now closed and have been shortlisted, with interviews scheduled for the final week of February 2026
- ✓ The budget holder training pack has been completed, and the rollout will commence following the Month 10 accounts closedown.
- ✓ The deliverable to build a sense of a 'valued Finance Team' has been completed, as evidenced by the award of Level 1 finance accreditation, and Finance Teams have been re-signposted to the HFMA mentoring programme while senior internal posts are recruited
- ✓ The completion of all PDRs are scheduled by 31 March 2026, meaning they will be 100% compliant at that date.
- ✓ A monthly Finance Briefing Pack has been agreed, and it will be developed into a screensaver and added to ICON.
- ✓ Second operational planning return submission completed.

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%	⇔
% of non-finance staff trained in finance essentials	250 budget holders	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. Will be updated at M12	⇔

Next Steps

- ➢ Finalise feedback from Senior Finance Team consultation and commence advertisement/slotting of posts.
- ➢ Appoint to vacant Band 8c roles.
- ➢ Commence rollout of budget holder training.
- ➢ Triangulate Finance Operational Plan with workforce and performance data and further develop.
- ➢ Complete all PDRs as scheduled.
- ➢ Finalise content of monthly Finance Briefing Pack for ICON.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

One Devon Shared Services (Finance)

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ Shared Business Services (SBS) have confirmed the 1 April 2026 go live date will not be achieved. Systems testing has not yet reached the required 95% success threshold. A revised go live date is expected to be agreed across Devon within 2 to 3 weeks, following detailed replanning.
- ✓ Outline FTOM provisionally agreed by Devon CFOs with queries regarding consistency and outputs remaining under review.
- ✓ The Treasury Team TUPE consultation is due to close during the week commencing 9th February 2026. The timing of any TUPE transfer remains uncertain pending confirmation of the revised go-live date. Three of the five affected staff have now left the organisation, and temporary cover is in place through bank staffing..
- ✓ Chart of Accounts and Reporting meetings remain ongoing with all Trusts and SBS to progress data provision, within the constraints created by continued uncertainty around the go-live date.
- ✓ Financial and Management Accounts and Leadership Engagement sessions are continuing with SBS and Trusts to progress data requirements where possible.
- ✓ The Devon-wide review of recommendations for Charitable Funds is ongoing, with the timeline now impacted by the delay to the go-live date.
- ✓ Several planned activities have been paused whist a detailed review and revised project plan are developed as a priority.

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 originally planned to complete June 26. Until we have confirmation as to when the SBS go live date will be, we cannot confirm this date	N/A	100%	0	⇔
Successful migration of data onto new system	N/A	100% by 01/04/26. This date will now change but is yet to be confirmed	0	⇔

Next Steps

- ➢ Complete detailed review of remaining work and agree revised SBS go live date, subject to confirmation of at least 95% successful systems testing.
- ➢ Continue Treasury and Chart of Accounts transfer meetings with all Trusts and SBS to progress data provision where possible.
- ➢ Progress SBS “Get Ready” and “Solution Design” workshops to provide clarity, system visibility, and training for Finance teams.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Limited

One Devon Shared Services (Procurement)

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ The workstream RAG status is assessed as limited, reflecting that activity has been focused solely on 2025/2026. The Devon Procurement Service is continuing to develop the CIP plan for 2026/2027.
- ✓ The Devon Procurement Service has presented a forecast of savings for the Procurement function in 2026/2027 to the Devon Chief Finance Officers. The current forecast indicates a minimum savings opportunity of £142k and a potential maximum of £284k for Torbay and South Devon. Further work is required to understand the detail underpinning these figures and to assess whether the total savings opportunity can be increased.
- ✓ Capita continues to progress work to deliver the outstanding supported savings projects with weekly meetings between Torbay and South Devon, the Devon Procurement Service and Capita being held to review Capita's project pipeline. At Month 10, project CIP savings transacted total £167k with a total forecast outturn of £170.5k against a plan of £338k. Capita has also delivered an End User Devices project, generating full-year effect savings of £382k, which will support Torbay and South Devon's capital plans in 2026/2027.
- ✓ The Peninsula Procurement Savings Alliance (PPSA) 2025/2026 savings position shows that two schemes have been carried forward into 2026/2027. At Month 10, £50k has been transacted. The Planned Care Group Finance Team is undertaking further work to confirm whether a further three PPSA contract savings, valued at approximately £15k, can be delivered within 2025/2026
- ✓ A summary of the current status of all contracts has recently been issued to Care Group Directors and their Finance Business Managers. They have been asked to review the summary and identify any contracts requiring a focused review or where Procurement support may be beneficial, with responses expected by the end of February. Fortnightly Procurement Working Group meetings between Devon Procurement, Finance and the PMO continue.

Next Steps

- ➢ Devon Procurement Service to develop 2026/27 workplan.
- ➢ TSD Finance to review investment requirements of Devon Procurement Service and assess whether additional financial resources can be committed.

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 £160k revenue CIP savings at Month 10.. *(Peninsula Procurement Savings Alliance contract savings unrelated to Capita delivered are £50k at Month 10.)*	⬆
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		

Risk	Mitigation
There are 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	£167	£171	-£167	Forecast
Workplace - Laundry	£0	£50	£50	£50	

Assurance	Rating
Executive Sponsor Rating	Limited

Torbay and South Devon NHS Foundation Trust

People Programme

Senior Responsible Owner – Jess Piper, CPO

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

- ✓ **E-Rostering Dashboard -** Working group has been established to finalise the dashboard and progress Viridian recommendations. Currently scoping options to feed vacancy data into dashboard.
- ✓ **E-Rostering Medical:** Implementation agreed to start May, post-EPIC launch. Recruitment of E-Rostering Project Manager in progress.
- ✓ **Strengthening Workforce Controls:** A paper with options for strengthening workforce controls to support the financial recovery plan has been presented to Execs with the following recommendations: Consider full vacancy freeze, stopping overtime and Agile Incentive payments; Endorse full implementation of Viridian e-rostering improvements; Approve in principle the reduction of AfC bank rates to mid-point of pay bank (subject to required notice periods); Support the development of a voluntary redundancy scheme for 26/27 subject to business case approval
- ✓ **People Digital:** Progress on process mapping, multi-team engagement, and early testing preparation for Wave 2. Key challenges remain; Low EVA adoption, insufficient staffing, gaps in training/change management, unresolved Wave 1 issues, and Wave 2 timeline pressures due to EPIC.

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)	M10 Plan: 6411 M10 WTE worked: 6644	↓
Total Recurrent Workforce CIP reduction (WTE)	6812.08	Planned target: -329 Revised target: -136 (removal of 205 CR plus break glass vacancies)	At M10, -83 WTE recurrent vacancies were removed from the baseline establishment	↑
Pay Cost Reduction	£365.9m	£20.4m (reduction) £15.88m (rebase removal of CR)	Forecast: 18.4m Delivered: 14.4m	↑
MARS Scheme (50WTE reduction)	0	50 WTE	26.04	↔
Reduction in Agency spend by 30%	£10.1m	£7.1m total spend (reduction £3m)	Forecast: 6.3m YTD: 5.3m	↑
Reduction in Bank spend by 10%	£21.1m	£19m total spend (reduction £2m)	Forecast: 19.3m YTD: 16.8m	↑

Next Steps

- ➢ Progress People Digital wave 2 milestones
- ➢ Finalise e-rostering dashboard
- ➢ Progress recruitment of E-rostering project manager

Risk	Mitigation
There are 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	£14.4m	£18.4m	-£2m	

Assurance	Rating
Executive Sponsor Rating	Limited

People & Education Capability & Capacity

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ **Directorate Wide Development Plan:** Survey analysis complete. Development plan proposal report expected 9 March 2026.
- ✓ **Improved and Updated Policies:** 60.76% of policies now in date; work ongoing to achieve 100% by end of March 2026.
- ✓ **Leadership, Governance, Reporting and Team Structure:** Governance, reporting and leadership structures in place and embedded in BAU. Directorate restructure plans ready for sharing February 2026.
- ✓ **Talent, Career and Succession Pathways:** Survey analysis complete; development plan proposal report due 9 March 2026. Alignment with new People Services model in progress.
- ✓ **Workforce Performance Dashboard:** KPI automation data due 13 February 2026; dashboard build to start thereafter. Focus groups underway; governance and feedback process in development. Potential risk from ICB restructure and ongoing consultation.
- ✓ **Refreshed Workstreams for People & Education directorate**: Draft plan due 13 February 2026 incorporating strategic aims; further refinement required to align with People Services model, due February/March 2026

Key Performance Indicators	Baseline	Target	Current Position	Trend
% of People and Education policies reviewed within review period.	44%	100% by 31/03/2026	60.76%	⇔
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	Report available 9 March 26	100%	0	⇔
Number of risks reported and % mitigated through effective governance.	8	4	5 (tbc)	↑
Number of open formal ER cases per 1000 organisation headcount.	7.5 (May 2025)	7.5	6.62	↑
Reduction in the number of open long term sickness absence cases.	266 (May 2025 – previously reported as 189)	245 cases	256	↑
Governance structure in place.	50%	100%	100%	★
Stakeholder satisfaction with directorate governance framework using monthly Likert scale survey.	3.5	> 3.5/5.0	3.74	⇔
Customer services satisfaction rating.	3.74 (Dec – 21 responses)	> 3.5/5	3.74 (Limited responses)	⇔

Next Steps

- ➢ Directorate development plan proposal report to be finalised
- ➢ Draft refreshed directorate work plan incorporating strategy workshop outputs and aligned to restructure proposals.
- ➢ Design and build of Workforce Performance Dashboard, including all automated KPIs.
- ➢ Progress directorate restructure plans; ready for sharing February 2026.
- ➢ Ensure all policies are in date by end of March 2026.
- ➢ Use workplan and skills plans to inform ongoing strategy and restructure work.

Risk	Mitigation
ICB Re-structure affecting completion of dashboard.	Exploring in-house options of creating the dashboard.

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
8 People & Education CIP Schemes	£403	£581	£581	£178	

Assurance	Rating
Executive Sponsor Rating	Limited

Culture, Organisational Development & Learning

Torbay and South Devon NHS Foundation Trust

Delivered

- ✓ **Reasonable Adjustments:** Manager-targeted survey completed (13 responses). Findings indicate mixed confidence and delays in support, particularly for complex and neurodiversity cases. Next step: establish focus group to explore themes in more detail. Staff-wide survey developed; awaiting final feedback before release via staff bulletin.
- ✓ **Feedback Mechanisms & Staff Voice:** Staff Networks established; Freedom to Speak Up Guardian function embedded. Wellbeing Stakeholder Group, Staff Survey, and People Pulse Survey provide structured feedback channels. Digital feedback app in approval process prior to development and launch.
- ✓ **Leadership & Management Framework:** Leadership newsletter in preparation with links to career development and NHS Leadership Academy resources. Managers induction programme progressing; first session booked May 2026. Essential-to-role review meeting scheduled 17 March to finalise content and messaging.
- ✓ **Organisational Design & Development:** Change management support framework and compassionate leadership redesign progressing. Communications plan being developed to promote change support offer and resources for managers.
- ✓ **Restorative, Just & Learning (RJLC) – Phase 1:** CEO is the Executive Sponsor for this work and a wider implementation plan is now in place. Phase 1 planned for Q4 this financial year, with remaining implementation continuing onward.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Staff Feedback: National Staff Survey	39%	45%	39% (Next results in March)	↔
Staff Feedback: Pulse Survey Response Rate	1.96% (Q1)	45%	2.58% (Q4)	↔
Recommend as a Place to Work Staff Survey People Pulse	62% 34% (Q1)	66% 66%	62% (Next results in April) 68.75% (Q4)	↔
Compliments Received	332 (2024/25) 76 (Q4 2024/25)	20% increase	70 Compliments (Q3 2025/26)	↓
Datix closure from last annual period	801 (2024/25)	20% decrease	189 remain open from 24/25	↑
Workforce and Retention data Workforce and Stability data	88.90% 79.41%	90% 81%	87.21% 80.36%	↔
Clinical Supervision	Under Development	Under Development	Under Development	New KPI
CPD Funding NHSE Trust Funding	 252 (2024/25) 73 (2024/25)	Under Development	 342 applications YTD 71 applications YTD	New KPI
Freedom to Speak Up Case Numbers	25 (Nov 25-Dec 26)	Under Development	14 – Jan 26	New KPI

Next Steps

- ➢ Further strengthen KPIs across the workstream.
- ➢ Progress Occupational Health tender and associated actions.
- ➢ Provide update on Enhanced Care for Staff initiatives.

Risk	Mitigation
There are 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
There is no CIP aligned to this workstream.					

Assurance	Rating
Executive Sponsor Rating	Satisfactory

Torbay and South Devon NHS FT MATERNITY BOARD REPORT

NOVEMBER – DECEMBER 2025

Control

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

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Introduction

Purpose

To align the required reporting as set out by NHS England Perinatal Oversight Surveillance Model (2025) and Three-Year Delivery Plan (2023). This will strengthen Trust Board and Local Maternity and Neonatal System oversight into the operational safety and quality of the maternity service provided, ensuring intelligence and learning is shared and concerns are addressed.

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

Glossary

Maternity and Newborn Safety Investigations Programme (MNSI)

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

Clinical Negligence Scheme for Trusts (CNST)

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

Avoiding Term Admissions into Neonatal Units (ATAIN)

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

Perinatal Mortality Review Tool

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

Essential Reporting: Trust Board & LMNS Oversight

Item	Source	Frequency (Min.)
Minimum Data Set 1. CQC rating (as updated) 2. MSSP status 3. Findings of PMRT & HSIB reviews 4. Incident reports moderate & above 5. Training compliance 6. Minimum safe staffing 7. Service user feedback. 8. Staff feedback 9. HSIB/NSHR/CQC concerns or requests for action. 10. Coroner Reg 28 11. CNST progress 12. Staff survey (Midwives & Obstetricians)	Implementing a Revised Perinatal Quality Oversight Model	Monthly
All Maternity SI Reports	Ockenden Interim (IEA1)	Quarterly
Maternity Dashboards	Ockenden Interim (IEA1)	Quarterly
Multidisciplinary training	Ockenden Interim (IEA3)	Quarterly
Minimum staffing levels (if not nationally agreed levels)- to be locally agreed with LMNS	Ockenden Final (IEA1)	As required
Sustained inability to meet staffing levels	Ockenden Final (IEA2)	As required
Learning from reviews of maternal deaths	Ockenden Final (IEA6)	As Required
Content of Human Factor Training	Ockenden Final (IEA7)	Annually
Neonatal care outside agreed pathways- *including births <27 weeks at units <Level 3 NICU* Care outside agreed pathways must be monitored & reviewed by Trusts, the LMNS & the ODN	Ockenden Final (IEA14)	Quarterly

Trusts to ensure that there is proper representation of maternity care on their boards	Reading the Signals	Ongoing
SDP Outcomes: 1) Staff Survey	Single Delivery Plan	
SDP Progress	Single Delivery Plan	As required
SDP Evidence	Single Delivery Plan	As required
SDP Regulation & Incentivisation: 1) CQC 2) CNST	Single Delivery Plan	

1.0 Introduction and background

1.1 This report will provide oversight of the safety and quality of perinatal services and will inform the Committee of present and/or emerging safety concerns within maternity and neonatal services. It will reflect the required reporting as set out by NHS England via The Perinatal Quality Oversight Model (PQOM) (2025) and the three-year delivery plan. The PQOM is designed to proactively identify NHS trusts that require support before serious issues arise. It ensures consistent, methodical oversight of maternity and neonatal services, enabling early intervention and continuous improvement. This model integrates perinatal clinical quality into Integrated Care System (ICS) structures, with clear lines of responsibility and accountability at trust, ICS, regional, and national levels.

1.2 At present a summary of perinatal quality and safety is presented at the quality assurance committee (QAC) meeting with a committee's chair report being presented at the Trust Board meeting. Perinatal safety dashboard metrics are also included in the monthly integrated performance reports as well as through both Families and Communities Care Group governance and the Safety and Quality assurance group to continue to meet the requirements of MIS as well as ensure good oversight of perinatal safety and quality.

2.0 Listening to Women & Families with Compassion

2.1 User Feedback

FEEDBACK	Comments	Impact	Ongoing Actions	Timescales
Service User Feedback: 1) Compliments	Significant numbers of MNVP compliments. **What Went Well** • Staff consistently praised for kindness, compassion, professionalism. • Clear communication and reassurance throughout care. • Strong antenatal, labour, and postnatal support. • Clean wards and surprisingly positive feedback on food. • Many staff named individually for exceptional care. **What Could Improve** • Occasional inconsistent information between staff. • Communication challenges with other hospital teams. • Car parking issues (size, cost). • Clearer expectations around waiting times. **Worries / Risks**	Celebrate the positive work that is done daily.	Continually share feedback with staff, work with staff to increase the rates of returns. Work with MNVP to increase feedback from more diverse population.	Ongoing

	• Very few concerns raised. • Minor issues around communication consistency. • No safety concerns identified. **Demographics** • Ages 19–42. • Almost disclosed = White British. • Broad postcode spread across Torbay, Teignbridge, South Hams.			
2) Themes of complaints	Documentation in relation to safeguarding concern.	Investigation ongoing.	Complete response either following meeting or by letter dependent upon woman's wishes.	Dec 2025
3) Devon Maternity & Neonatal Voice (MNVP) projects/ additional comments	DMNVP have employed a neonatal lead and increased the hours for the other members of the team and are now fully established	From Jan 2026 DMNVP will be quorate members of the Maternity and Neonatal governance meetings, as well as attending QUAD meeting, PMRT review and safety walkarounds.	DMNVP to strengthen the engagement and feedback mechanisms to ensure they are representative of all members of our population	Ongoing

4) CQC Maternity survey 2025	Report released in December 2025	Results show a significant improvement across all areas of care. The maternity service performed better than other trusts for 38% of the questions, with 60% of answers aligning with other Trust responses.	Action plan for improvement has been produced in collaboration with the DMNVP including analysis of free text feedback.	Results to be presented to Trust board and Feedback and Engagement group

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2.2 Additional Service User Feedback

Debriefs / Birth Afterthoughts

Annual audit of the Birth afterthoughts service was presented at clinical effectiveness meeting in December 2025. Action to work with the DMNVP to review themes and develop an action plan for improvements.
Pathways to access debriefs and birth afterthoughts service currently under review to ensure appropriate referrals and improved access for service users.

Friends and Family test

Capacity challenges within the organisation to enable robust data collection and circulation of feedback so not assured of validity of returns received. This is being addressed through Trust Feedback and Engagement Lead. Other feedback mechanisms utilised as alternative

mechanisms of gaining service user feedback such as MNVP monthly feedback cards.

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

3.1 Staff Feedback-

FEEDBACK	Comments	Impact	Ongoing Actions	
Staff Feedback. Safety Champion Walkaround- November 2025	There was feedback around the positive experiences around recruiting consultants recently as well as finding the unit a popular, friendly place to work.	Assurance that recruitment pipeline for consultant posts is positive.	Continue focusing on culture.	Ongoing
2) Listening events with Executive team in December	Discussion with executive colleagues around the challenges associated with current maternity care	Maternity staff felt heard and gave examples of areas of focus.	Psychological support is being organised by the clinical psychology team for staff groups.	

Individual confidential listening events in progress	particularly in smaller units. Session held as part of “reading the signals” that is a focus as part of national reports. Listening events being offered by independent practitioner		Prioritisation of work associated with culture in progress. Themes and feedback to be shared once listening exercise completed with SCBU team	
3) Score culture Survey	The remaining actions associated with the SCORE survey will be included within the perinatal improvement plan	This will provide assurance and oversight of the actions and will enable continuing progress around cultural safety.	The communication strategy and continuing work with civility toolkit will also support the work to continuously improve culture.	

Safety Champions meetings - Table 1

Table 1

Date	Attendees	Feedback
November 2025	Board Safety champion- NED. Maternity Safety Champion Executive Board safety champion	Outpatient Visit Met with education lead to reflect on the challenges associated with multidisciplinary PROMPT training. Discussion around thoughts around the change in the midwifery role with the increase in operative deliveries and any contention this causes between the professions. Discussion around challenges

that sometimes occur with women choosing to birth at home outside of guidance and the impact this can have on individuals.

Triage model and medical cover discussed. Some challenges with women waiting for long periods for obstetric review and then self-discharging. This can be explored via triangulation of triage audit data against outcomes and incidents.

3.2 Minimum Safe Staffing Exception Reporting.

Minimum safe staffing events	Occurrence	Actions taken
Midwifery (CNST Safety Action 5 Red Flags)		
Redeployment of staff to other services/sites/wards based on acuity.		Our workforce is multi-skilled and able to flex across the system to account for times of high acuity within a specific area. This is the way the service operates and not a red flag.

Delayed or cancelled time critical activity.	1	This was a cancelled planned caesarean section that was reorganised following a peak of unplanned activity needs.
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).	2	This was during a period of high acuity and an inability to fill vacant shifts with bank staff. Senior leaders were called to work clinically to support. At this time there was sustained pressure across the Devon Wide system.
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).	0	
Delay of more than 30 minutes in providing pain relief.	0	
Delay of 30 minutes or more between presentation and triage.	1	The BSOTs model of care will be implemented following estates works completion and the roll out of the EPIC EPR, this will improve the process for immediate triage.
Full clinical examination not conducted when presenting in labour	0	
Delay of two hours or more between admission for induction and beginning of process.	4	There have been delays in the IOL process, due to needing to balance the needs of planned / unplanned work, women are counselled about this antenatally and

		communication around delays with women if necessary is maintained.
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).	0	
Any occasion when one midwife cannot provide continuous one-to-one care and support to a woman during established labour.	0	
Labour Ward Coordinator (LWC) is not supernumerary	3 – not providing 1:1 care 0 – providing 1:1 care	These are for short periods where acuity raised quickly, all LWC's limit any times having to provide 1:1 care to the minimum to maintain safety.
Retention Issues	0	No concerns.
Obstetric cover on Labour Ward	Quarterly audits are performed on consultant attendance when called for clinical support. This data has been presented at Quadrumvirate/ safety champion meeting	All gaps were filled within the existing Obstetric workforce.
Gaps in obstetric rota		Further absence has resulted in consultants being required to cover at short notice increasing the required number of on calls and intensity of work. This impacts on the capacity to complete non-clinical work and

		administrative tasks that the consultants are required to do.
Neonatal unit staffing Nursing -	There is a requirement for a minimum of 1 Qualified in Speciality (QIS) Nurse per shift to support stabilisation of pre- term / term unplanned admissions. QIS as % of registered workforce is 61% (BAPM min 70%) Despite some challenges with short notice absence and long-term sickness, we have managed to ensure minimum safe staffing numbers and QIS cover. Lack of suitable resource (QIS/neonatal experience) via NHSP.	2 Band 5 RN to commence QIS course in December 2025. Further two candidates in pipeline for courses in 2026. Unit Manager has passed QIS course and currently consolidating learning. B6 vacancies have been advertised with no uptake. Linking in with attraction and recruitment lead to look at creative attraction approaches. B5 recruited – to start April 26 QIS % will drop in next quarter (retirement) Ongoing workforce establishment review for consideration of structure redevelopment to ensure it meets the service needs now and in the future. Organisational change paper and process underway. Use of Practice Educator, Enhanced Neonatal Nurse Practitioner (ENNP) and Unit Manager in clinical numbers and staff picking up additional hours and bank shifts. Some additional support available on bank which is being utilised. Request for agile incentive payments for substantive staff to support roster sustainability in short term has been made to exec team.

Medical staffing	Meets BAPM standards for level 1 special care unit. Revised BAPM medical staffing standards released in Nov 25 which will have future implications for the organisation meeting medical staffing requirements	Meetings in place with senior leadership team to review and identify additional requirements and implications (resource). Escalated to Medical Director

3.2.1 Safe Maternity Staffing- Fill rates – planned verses actual

Area	Day		Night	
	Midwives %	MSW's %	Midwives %	MSW's %
November 2025	67.9	91.9	74.8	75.5
December 2025	66.9*	93.6	91.8	90.3

*This information is taken from the Trust CHPPD data distributed; Maternity have concerns about the use of this information in providing an accurate representation of staffing with our integrated service. This data is based on the inpatient ward setting and does not include the staff from the integrated team that are used to staff the service.

Fill rates can vary for a variety of reasons, these include gaps caused by sickness absence, ongoing vacancies or staff who are working in a supernumerary capacity. Utilising an integrated model of midwifery care means that we can mitigate less than 100% fill rates by redeploying staff flexibly across the midwifery service. Integrated midwives can work cover community work, intrapartum care as well as inpatient, antenatal and postnatal care.

When staffing is below optimum levels, the following measures are taken, in line with the maternity escalation policy:

- Temporary staffing solutions – bank staff or staff working additional hours.
- Request midwifery staff undertaking specialist roles to work clinically.
- Workload prioritisation exercise undertaken to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Request additional support from the maternity matrons/managers.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for women and their babies.

3.2.2 Birthrate plus report

The finalised Birthrate Plus midwifery workforce report has been presented at the Executive Committee meeting in December 2025. The report evaluated midwifery staffing needs for the Maternity Services at TSDFT and included hospital and community teams, The midwifery staffing needs were calculated to include annual activity data, case mix analysis, staffing requirements, and comparisons with the current funded establishments. Whilst there has been a fall in the annual birthrate there has been an increase in case mix

acuity with a shift from lower risk to higher risk categories, this has been driven by factors such as diabetes, mental health, high BMI, and increased induction and operative deliveries.

The finalised calculations were based on both a 23% uplift and a 25% uplift. Calculations for a 23% uplift demonstrate an overall deficit of 1.11 WTE. If a 25% uplift is applied the overall deficit is 3.81 WTE.

The executive committee noted the report and recommended that the uplift requirement will form part of the business planning process for the Care Group. Business planning requirements are in the process of being signed off. This will then enable to service to consider how they address the establishment uplift.

3.3 Multidisciplinary Training Compliance

TRAINING COMPLIANCE	PROMPT (All staff included)	PROMPT (excludes new rotation Drs)	Fetal Monitoring (All staff included)	Fetal Monitoring (excludes new rotation Drs)	Safeguarding (All staff included)	Safeguarding (excludes new rotation Drs
All Staff	92%	94%	92%	95%	89%	92%
Midwives	99%		99%		93%	
Maternity Support Workers	94%		NA		94%	
Obstetric Consultants/ Registrars	88%	100%	77%	100%	68%	75%
Anaesthetists	98%		NA		NA	

Actions required	To continue to book all staff on training in advance and closely monitor compliance. Liaise closely with the medical team and anaesthetic consultant lead for Obstetrics to ensure staff attend within a 12-month period. 3 Additional PROMPT MDT mop-up sessions took place during October and November to improve anaesthetic compliance. Monthly meeting with the medical		This training is delivered in line with MIS standards and is a full face to face day's training, with assessments, as per HEE standards. Currently K2 is used for the assessments and staff are required to achieve over 85% to be deemed competent in this training. All staff are booked onto the training in advance, and attendance closely monitored to ensure compliance levels. Monthly meetings with the medical administrator ensure that any medical staff who have been taken off training due to clinical demands		Staff are notified when their training is due – ensuring attendance within a 3-year period, wherever possible Regular meetings between the Operations Manager and Education Lead Midwife continue to take place to look at ways of mitigating the risk regarding the lower compliance numbers within obstetrics. All new starters receive a 1:1 session with the Safeguarding Lead Midwife and an agreement has been made that no further	

	administrator ensures that any medical staff who have been taken off training due to clinical demands are re-booked within 2 weeks. The medical service manager is given a full report of medical compliance every month and follows up on those who have not completed their training, copying the Education lead into email trails. The Education lead midwife and medical		are re-booked within 2 weeks. The medical service manager is given a full report of medical compliance every month and follows up on those who have not completed their training, copying the Education lead into email trails. Percentages include both with and without new rotation Doctors. As the Education Lead is also the Fetal Monitoring Lead Midwife, and is absent at present, the Fetal monitoring lead Obstetrician has been delivering the training with the support of the practice educator to ensure ongoing compliance		CPD will be authorised for the Drs, until they can evidence completion of or booking of mandatory training – including. The medical service manager is given a full report of medical compliance every month and follows up on those who have not completed their training, copying the Education lead into email trails. The Education lead midwife and medical administrator meet monthly to re-book any medical staff	

	administrator meet monthly to re-book any medical staff who were unable to attend mandatory training on their allocated month. The percentages used above show both new rotational resident Drs and statistics when these Drs are not included, as agreed by MIS reporting standards. Those new Drs have been given an additional 6 months to				who were unable to attend mandatory training on their allocated month. The percentages used above include both new rotational Doctor and the statistics when these Drs are not included, as agreed by MIS reporting standards.	

	complete their training.					

4.0 Standards That Underpin Safer, More Personalised & More Equitable Care

4.1 CQC Rating

Overall	Safe	Effective	Caring	Well-Led	Responsive	MSSP
Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Formally entered the programme June 2024 - see below

4.2 Neonatal care outside agreed pathways -

In this reporting period there were no babies born in Torbay and South Devon at less than 27 weeks' gestation. These babies must be delivered in a level 3 Neonatal intensive care unit. Exceptions are reviewed and reported on monthly to provide rationale, with oversight of the SW Neonatal network.

4.3 Safety Improvement Plan -Maternity Safety Support Programme (MSSP)

The MSSP has now transitioned to Maternity and Neonatal Improvement Support Team (MatNeoIST). The Trust entered a six-month period of Targeted Maternity and Neonatal Improvement Support starting 8th January 2026.The ask is for the Trust to:

- **Accept and participate in a six-month targeted support programme focused on:**
  - Obstetric leadership and capacity
  - Culture and leadership
  - Governance and board effectiveness
- **Work with the allocated Midwifery and Obstetric Improvement Advisors.**

The Trust are required to ensure an executive sponsor. The CEO has agreed to undertake the role. Project support will assist in coordination of the meetings and the plan. Monthly meetings will be held with the improvement advisors and senior leaders with milestones at 3 and 6 months. A closure report will be needed summarising progress and recommendations. The Perinatal Improvement Board (PIB) with CNO as executive lead will maintain oversight and assurance of all workstream progress.

4.4 Three Year Delivery Plan Measuring Success: Regulation (CQC)

Summary of progress with CQC MUST DO actions.

Although progress has been made against the CQC action plan, there are still estates works required to facilitate service improvement. This work is reliant on external contractors, building regulations and capital funding. These factors may impede timely progress.

CQC MUST DO actions	Achievements	Action for Improvement
Maternity Triage	• Dedicated phone line in place. Net call now installed and working well. • Consistent documentation process embedded in the electronic record includes a standardised risk assessment mechanism. • Allocated midwife to answer the phone line, day and night. • Reconfiguration of staffing establishment to increase Triage team complete, staff in place and service now running 8-8 in the Day Assessment Unit. • Monitoring via audit process • Estates work almost complete- some minor delays experienced. • All staffing appointed to and opening hours increased.	• Progress needed to implement full Triage risk assessment model using the national model (BSOTS). This will be embedded in full as part of EPIC rollout so this action should be closed by end of April 2026.

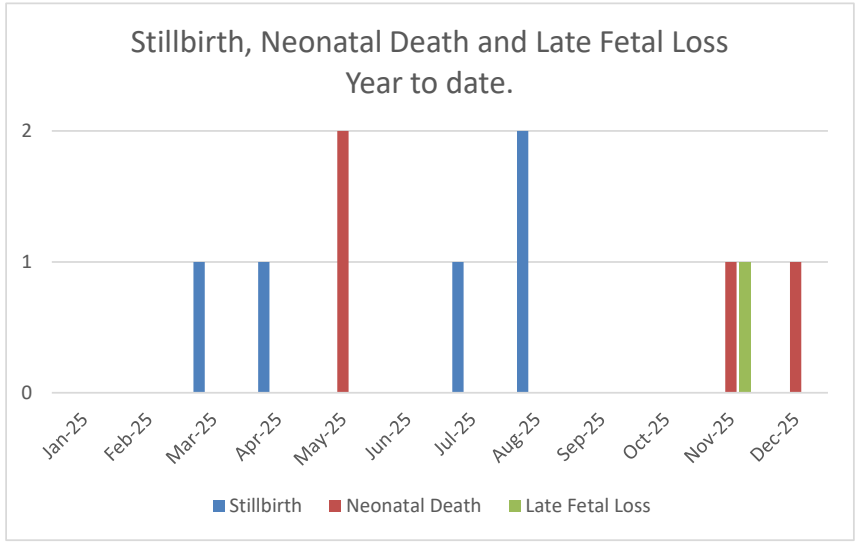
Obstetric theatre	• Dedicated emergency theatre • Improved process for out of hours theatre provision • Formal regular review meetings between leads • Ongoing audit of theatre cases and decision to delivery intervals. • Review of DATIX if delays to theatre noted in practice. • Progress with recruitment of ODP (Operating Department Practitioners) / theatres staff. • Consultation period with staff planned for January to staff second team.	• The Trust wide transformation team and local team working on a Quality Improvement project to review both elective and emergency pathways. • Regular monthly update meetings held with maternity and theatres. • Quarterly progress meeting with both care groups to provide oversight of actions. • Ongoing discussion re scoring of risk around this action on the Maternity risk register.
Fetal Monitoring oversight	• Audit of “fresh eyes” – now quarterly. • Full day fetal monitoring training for all midwives and doctors commenced in 2024 and is ongoing. This includes an assessment – which is currently being completed on K2. • Action Closed on action tracker	
Use of Electronic MEOWS system	• Increased surveillance and support of system to improve the completion. • New digital midwife now in place to ensure work can continue in this area. • QI project complete, no on regular audit cycle • Action Closed on action tracker	

Medical staffing	• Business case to increase the number of FTE consultants progressed via Trust and ICB processes. Recruitment of 2 FTE completed and now working within the trust. • Action closed on action tracker	
Provision of Emergency Equipment	• Replacement CTG's and resuscitaires in place; staff trained to use.	• Department recognises that there is no suitable dedicated area to store resuscitation equipment on postnatal ward. This is under consultation with estates to create a bespoke space. Resucitaire is stored in ward corridor.
Medical staffing – safeguarding children training compliance	• Improvement in compliance figures. Practice educator collaborating with clinical director to support attendance. • Safeguarding support in place within unit as part of day to day working. • Bespoke, local safeguarding input as part of induction	• Safeguarding Children level 3. An additional e learning module for doctors is being considered to improve safeguarding compliance.
Governance oversight and assurance	• New governance structure embedded following internal audit recommendations.	• Terms of reference being completed for all meetings delivering on governance. • Governance forms part of the MNIP. • Recommendations from deep dive to include more oversight of policies and guidelines and the audit programme – Clinical Effectiveness midwife now in place.

		• Implement NHSE governance tool kit.

4.5 Patient Safety

4.5.1 Perinatal Morbidity and Mortality Summary for the period



1st November 2025 – 31st December 2025

November 2025

- 1 x Late Fetal Loss - Spontaneous Labourer with probable infection at 22 weeks' gestation. - DCIQ 30963

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 five of life and baby passed away. DCIQ - 30224

	December 2025 Neonatal Death at 18 weeks' gestation, maternal infection following a CVS - DCIQ - 32974

4.5.2 Patient Safety Incidents

PATIENT SAFETY Incidents (PSI)	Number	Key themes/ trends/ escalations
Serious Incidents	**4 in total**	**1st November 2025 – 31st December 2025** **November 2025:** • 1 x Death Caused by the incident - Late Fetal Loss - Spontaneous Labourer with probable infection at 22 weeks' gestation – DCIQ – PMRT Review – DCIQ 30963 • 1 x Death Caused by the incident - 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 five of life and baby passed away. – MNSI Case 049022 – DCIQ - 30224 **December 2025:**

		• 1 x Death Caused by the incident - 1 x Neonatal Death at 18/40 following CVS, showed signs of life at birth – DCIQ - 32974 • 1 Severe – Incident reported around harm caused to baby due to maternal mental health following DPT decision to leave family at home. – DCIQ - 31411
Moderate Incidents	1 in total	**November 2025: 1 Moderate Incidents reported.** • 1 Moderate – Bowel Obstruction following LSCS. - DCIQ - 31985 **December 2025 – No Moderate Incidents reported.**

PATIENT SAFETY	Number	Key themes/ trends/ escalations
New referrals to MNSI	1	1 Referral Initially for HIE, then subsequently Neonatal Death in higher level unit – MNSI case no: 049022 – Datix No: 30224 – Staff interviews completed, Awaiting Draft report.

Findings of final MNSI reports returned (themes only)	0	No reports were received by MNSI in November or December 2025.
Findings of cases reviewed under PMRT. **(themes only)**	1	**1 PMRT case was reviewed in this period.** • Datix No: 26398 - CNST SA1 (a) met, (b) met (c) met. There were no external panel members available for the meeting – PMRT MDT was held on 4th December 2025, Report completed 5th December 2025. The MDT were unable to identify a cause of death. One care issue was discussed at the meeting in relation to an unnecessary measurement of symphysis fundal height at 28 weeks, but it was determined that this made no difference to the outcome for the baby (See table 4). **3 PMRT reviews are pending from Deaths in 2025** Dates due for completion: • Datix No: 26900 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held date tbc, Report due by 13th February 2026. Will be met once PMRT MDT meeting held. • Datix No: 27496 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held date tbc, Report due by 28th February 2026. Will be met once PMRT MDT meeting held. • Datix No: 30963 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held date tbc, Report due by 14th May 2026. Will be met once PMRT MDT meeting held. **PMRT Reviews led by other trusts for babies that delivered in Torbay in 2025**

		• Datix No: 30224 - PMRT MDT meeting to be held 20th January 2026. (This is also referred to above as MNSI case 049022.

SI's, MNSI Referral and PMRT's - Ethnicity and Deprivation* Table 3

Table 3

Datix Number	Ethnicity	Deprivation Score
26398	White British	6
26900	White British	5
27496	White Other (Finland)	3
30963	White British	2
30224	White British	3
32974	White British	3

*An IMD score refers to the Index of Multiple Deprivation score, which is an official government measure used in England to identify and rank small geographic areas (Lower-layer Super Output Areas or LSOAs) by their relative levels of deprivation. A higher IMD score indicates a greater degree of deprivation, with rank 1 being the most deprived and the highest rank being the least deprived. The IMD is calculated by combining and weighting data from seven different domains of deprivation, such as income, employment, health, and the living environment.

Learning from completed PMRT reviews (Table 4)

Table 4

Case No:	Theme	Issue	Actions	Responsible role	By when
Datix No: 22060	Fetal Growth monitoring	Period for measuring subsequent symphysis fundal heights following a scan.	GAP institute contacted for response to issue, discussion of whether to include follow up scan as additional intervention. Not to be progressed as not a national mandate from NICE.	Antenatal Clinic Lead Midwife	Completed
Datix No: 22736	Decision making and escalation	This mother had an operative delivery, but this was not carried out with appropriate urgency	Discussion to be held with staff members involved to reflect on the care given and identify any learning points or additional training requirements from the care given.	Supervisors of relevant staff.	Completed
Datix No: 22736	Decision making and escalation	The mother should have been asked to attend the unit after her first call to the triage line	BSOTs implementation, when full triage works are complete to help with the situational awareness of women that are high risk e.g. multiple pregnancy versus amber flags for singleton pregnancies.	Outpatient Matron	31.01.2026
Datix No: 22736	Record Keeping	The review group felt that some aspects of the documentation in this case were lacking in detail. This is to be	Continue with updates to polices around record keeping in maternity, continue with ongoing notes audits and highlight importance of documentations as part of EPIC launch. Consider documentation	Inpatient Matron and Clinical Governance Coordinator(s)	30.04.2026

		addressed as part of a wider project around improvements in documentation.	workshop/learning session in conjunction with litigation team?		
Datix No: 22736	Staff Debrief	It is not possible to assess from the notes whether following the resuscitation of the baby a rapid safety focused resus de-brief with the staff involved was carried out	Senior team to ensure that debriefs are held following a serious incident. Implementation of SWARM huddles as planned should help with this as it will be part of the initial actions. Continue work to progress implementation of SWARM Huddles, this should include the process of booking a debrief.	Inpatient Matron and Clinical Governance Coordinator(s)	30.04.2026
Datix No: 22736	Equipment	The portable scanner on Labour Ward was faulty and not working properly	Scanner has now been upgraded and replaced.	Labour Ward Manager	Completed
Datix No: 22736	Labelling Error	Due to the placentas not being correctly labelled, the genetics for Deceased twin reported his sex as female, additional	Action plan produced by bereavement midwives. Correct labelling protocol to be updated in relevant guidelines.	Bereavement Midwives	Completed

		distress was caused to parents.			
Datix No: 22736	Record Keeping	"Sepsis Six" proforma not used. Therefore, it is difficult to determine if the requirements around this were met.	Reminders to be sent to all staff regarding use of sepsis proforma. Education midwife to provide reassurance that all midwives are up to date with Sepsis training on the HIVE. Sepsis to be a focus for PROMPT mandatory training next year. Labour ward coordinators to be reminded to highlight the use of the Sepsis proforma if Sepsis is suspected.	Inpatient Matron, Labour Ward Manager and Education Lead Midwife	Completed
Datix No: 22736	Communication	The review group found that the paediatricians would have preferred to be more prepared for a potential twin delivery.	Labour ward coordinator to be reminded to be mindful to notify paediatrics when a woman attends the unit preterm with complications in her pregnancy. Inpatient matron to highlight at next Labour Ward coordinators meeting.	Inpatient Matron	Completed
Datix No: 22736	Record Keeping	The review group felt it would have been easier to determine the facts of the case if memory captures had been sought	Governance team to ensure that memory captures are sent to staff who are involved in serious events, shortly after the event. This will help with gathering facts for the case as well as prove to be good	Maternity and Child Health Clinical Governance Coordinators.	Ongoing

		from the staff involved at the time of the event.	practice for those involved in reflective practice.		
Datix No: 26398	Fetal Growth monitoring	It was overlooked that due the woman's bicornate uterus she did not need to be measured at 28 weeks.	Reminder to go out to all staff that a uterine anomaly should be treated as a risk factor for preterm birth and care should be consultant led.	Outpatient Matron	Completed

Learning from MNSI reviews (No reports received in this period)

Outstanding reports due from Coroner Table 6

Table 6

Identifier	Date Listed	Summary
Maternal Death	02.06.2025	Woman found deceased at home at 9 days postnatal. Multiagency report being finalised by ICB.

TOP for medical reasons	21.01.2025	A woman undergoing a termination of pregnancy (TOP) due to the baby having a congenital abnormality. Baby born at 22+5 weeks gestation showing signs of life. Died shortly afterwards.

Triangulation of NHS Resolution Scorecard – Quarter 3

To facilitate learning from feedback, incidents and litigation claims a quarterly review of Trust's claims scorecard alongside incident and complaint data should be presented by the maternity, neonatal and Trust Board level safety champions at a Trust level quality meeting. The claims scorecard below details obstetric claims received in the last ten years. The number of claims received is fifteen; of these only six remain open. Of the nine closed claims, a third did not pay any damages.

Claims Scorecard April 2015 – March 2025

Top injuries by volume: • Unnecessary pain • Stillborn • Hypoxia • Loss of baby • Brain Damage	**Top injuries by value:** • Hypoxia • Brain damage • Downs Syndrome • Add/unnecessary operation • Bowel Damage/Dysfunction
Top causes by volume: • Fail/delay in treatment • Failure to recognise complication • Fail/Delay Diagnosis • Fail antenatal screening • Forceps Delivery	**Top causes by value:** • Delay /Fail treatment • Fail antenatal screening • Failure/Delay Diagnosis • Fail to warn – informed consent • Forceps Delivery

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

NHS
Torbay and South Devon
NHS Foundation Trust

Complaints and Concerns - Q3 2025 - 26

- Inadequate documentation of birthmark leading to safeguarding investigation.

Themes - Q3 2025 - 26

- Inadequate Documentation
- Incomplete emergency proformas
- Cultural Practice During Emergencies
- Escalation of concerns, Failure to recognise a complication
- Awareness and Identification of an emergency
- Hypoxia, brain damage leading to loss of baby

Incidents (moderate or above) - Q3 2025 - 26

- Late Fetal Loss (1)
- Neonatal Death (2)
- Hypoxia (1)
- Harm to Neonate – Safeguarding (1)

Learning - Q3 2025 - 26

- Communication within the unit via LASER and posters around escalation of concerns and use of the emergency bell.
- Include in PROMPT training the use of closed loop communication and the use of the emergency bell.
- Documentation and body mapping of marks on babies

When reviewing TSDFT scorecard v. complaints and incidents for Q3 we can see that two themes of hypoxia and escalation of concerns triangulate with the incidents that occurred in this quarter, but the complaint around documentation does not triangulate.

4.6 Saving Babies Lives Care Bundle -

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

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

Narrative by exception

Element	Areas of non-compliance	Actions Required
1	Recording CO levels within 3 days of a maternity booking appointment	Increase capacity for face-to-face booking appointments.
2	GAP and GROW training for measuring fundal height.	Action plan to ensure 90% of staff are compliant
5	Slight rise in preterm birth rate. Change to requirement to use regional born in the right place data. Magnesium Sulphate administration to babies <30 weeks Thermoregulation for preterm babies	Audit of preterm birth rate completed. Continue with the PERI Prem quality improvement project.

The 2025-26 Q2 (June 25 - August 25) data has been reassessed by the DLMNS against the updated SBL audit Tool and we are now 91.3% compliant. The DLMNS are satisfied that Torbay & South Devon Foundation Trust is continuing to make sufficient progress against the improvement trajectory and action plans are in place where trajectories have not been met.

4.7 Quadrumvirate (QUAD) – Culture and Leadership

QUAD working is deemed to be the best way to improve collaboration and develop psychologically safe cultures within the perinatal teams. The QUAD consists of the director of midwifery, obstetric lead consultant, operational lead, and neonatal lead. The QUAD, as a team, meets monthly with an invite extended to the maternity improvement advisors and the clinical lead. Bimonthly meetings also occur with the QUAD and the safety champions including the Board level champions and Maternity and Neonatal Voices Partnership (MNVP) lead. Although no formal QUAD/board level safety champions meeting have been held in this reporting period, there has been frequent informal QUAD engagement as a perinatal leadership team. There has also been collaboration with the Trust MNVP lead with attendance at Quality meetings and PMRT meetings. They have also contributed to the improvement work and have reviewed the national maternity survey findings to support the action plan.

Topics addressed included.

- MOSS alert- discussions and review around the incidents leading to the alert (4.8)
- Improvement Work: Cultural improvement initiatives underway; obstetric leadership visit completed in November 2025 and actions from this visit captured within the work associated with the improvement plan.
- Updated membership and scheduling to strengthen governance participation. This included a change in obstetric leadership as well as a slight increase in allocated professional activity (PA)
- Drove and assured key aspects of the Perinatal Improvement Programme (communications, KPIs, culture, workforce, governance).
- Provided leadership oversight to case reviews, regional safety learning, and service-level governance. This includes sharing at the Southwest Perinatal safety and transformation group.
- Offered core evidence for QAC, Board, LMNS/CNST reporting.

4.8 Maternity Outcomes Signal System (MOSS)

MOSS is a national safety surveillance tool developed by NHS England. MOSS presents trend data on term stillbirths and neonatal deaths in maternity units in a new way. It uses AI and data analytics to detect safety signals in maternity services based on reported incidents, outcomes, and expected benchmarks for unit size and complexity. Signals of potential safety issues are flagged in units when there has been a recent doubling in the rate of these events compared to what would normally be expected, given the total numbers of births at a given site.

In November 2025, the Trust received a MOSS alert from NHS England identifying three maternity cases within the previous six months that exceeded expected thresholds for perinatal harm, triggering a national safety signal. Although the CQC was automatically notified, the Trust took proactive steps to inform them directly and escalated the alert to the Executive Committee for discussion on 2 December. The Perinatal Leadership Team began the required critical safety review in line with the newly issued national MOSS SOP, including ensuring appropriate leadership access to the MOSS dashboard. Importantly, the Trust had already identified and commenced work on the cases ahead of the alert, demonstrating early recognition and action.

4.9 Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (MIS) – separate paper

Year 7 commenced on 2nd April 2025. Trusts are required to submit their declarations for year 7 by 3rd March 2026. Full details of the compliance assessment are included in a separate paper to be presented to the Committee. The CNST compliance position will also be presented at the Trust Board meeting on the 5th of February 2026.

5.0 Actions to improve care for women and families.

5.1 Neonatal Deaths – Safety Measures and Escalation

During the last six months, the Trust experienced three neonatal deaths, each of which has been subject to full review in line with national standards. These cases have triggered enhanced scrutiny from both internal governance mechanisms and the wider maternity and neonatal oversight structures across the ICS and region. The actions that have been taken are as follows:

1. **Overview of Incidents and Immediate Response**

All neonatal deaths were promptly entered into PMRT, MNSI, and where indicated, PSR processes. Early review findings highlight issues relating to:

- Escalation mechanisms
- Communication quality and clarity during acute deterioration

Across all cases, duty of candour was completed, and immediate actions were implemented at ward level.

2. T**hematic Review and External Scrutiny**

Given the clustering and nature of the incidents, a thematic review has been commissioned, supported by the Chief Nurse and NHSE regional teams, to assess cross-cutting issues and ensure learning is independently validated. This escalated review aligns with national scrutiny of maternity services and early feedback around culture and leadership raised by the national team.

3. **Operational Safety Measures Implemented**

A range of targeted mitigating actions have been enacted, including:

- Re-audit and re-communication of emergency call bell protocols and fetal monitoring processes
- Strengthening multidisciplinary escalation pathways.

4. **Governance, Oversight and Executive Escalation**

Repeated concerns regarding neonatal and maternity safety have been formally escalated to:

- Exec Huddle,
- Trust Board,
- ICB/ regional team
- NHSE Maternity Safety Support Programme (MSSP).

6. **Culture, Leadership and Learning**

National colleagues have highlighted cultural and leadership challenges that may be constraining improvement pace. In response, the Trust has:

- Intensified Executive visibility on the unit,
- Strengthened governance participation.
- Initiated leadership development and psychological safety intervention.

These actions support the Trust's commitment to strengthening safety culture and transparent learning. The three neonatal deaths have prompted a robust and multi-layered organisational response. The Trust has acted swiftly through statutory review processes, commissioned a thematic review with external oversight, strengthened governance routes, escalated risks appropriately to system partners, and initiated targeted operational and cultural improvements. A full update on progress will be presented at the next Committee meeting in February 2026.

5.2 Maternal care bundle: a care bundle for reducing maternal mortality and morbidity.

NHSE published the Maternal Care Bundle on the 6th of January 2026. This toolkit strengthens our approach to reducing preventable harm by standardising evidence-based practice across five high-impact clinical areas: **venous thromboembolism (VTE)**, **hypertension in pregnancy**, **sepsis**, **mental health**, and **haemorrhage**. By embedding consistent risk assessment, early recognition tools, and clear escalation pathways for each of these conditions, the bundle aims to improve safety, reduce unwarranted variation, and address persistent inequalities in maternal outcomes. Implementation will require coordinated leadership, staff training, and robust measurement, but it positions the organisation to deliver safer, more reliable, and more equitable maternity care across all services. It is likely that organisations will be required to complete an initial benchmarking of current provision so that plans can be made for full implementation.

5.3 Homebirth Provision - Prevention of Future deaths

NHS England (NHSE) has strengthened expectations on all maternity providers to formally assess the safety, sustainability, and governance arrangements relating to homebirth provision. This followed the publication of a prevention of future deaths report into the

death of a woman and her baby during a homebirth in Manchester in June 2024. These requirements follow national findings highlighting variation in homebirth service models, workforce resilience, escalation pathways, and operational decision-making.

A paper was presented to the executive committee in January 2026.The homebirth provision paper provided a formal assessment of the safety, sustainability, and governance of the Trust's homebirth service following strengthened NHSE expectations and recent national learning. The review confirms that the service is valued by women, and aligned with personalised care principles, with robust safety processes, sound governance foundations, and strong training compliance. However, it highlights operational fragility—primarily workforce resilience, particularly the ability to guarantee 24/7 cover, consistent two-midwife attendance, and out-of-hours senior support. Additional strengthening is required in governance escalation triggers, audit visibility, MDT communication, and transfer pathways. The service is broadly compliant with NHSE requirements, with a 'Satisfactory' assurance rating, and targeted actions are recommended within the maternity and neonatal improvement plan to ensure long-term sustainability and full assurance.

6.0 Conclusion.

The maternity and neonatal teams continue to ensure that systems are in place to provide assurance in relation to safe midwifery care. They continually review and can evidence progress against several trajectories to improve the quality of care delivered. The perinatal team will embed the strategic aims of the Devon LMNS to ensure that care is personalised and responsive to the needs of women, families, and staff. The requirements for assurance continue to increase and place additional demands on the team.

5.1 Assurance and Recommendations
Overall, there is a satisfactory level of assurance around perinatal surveillance for quality and safety.

Recommendation:

- Note the overall progress in maternity safety, quality, and culture, including improved CQC maternity survey results and multidisciplinary training compliance.
- Continue the oversight of quality and safety risks, including PMRT findings and MNSI investigations,
- Support implementation of the Maternal Care Bundle, with continued focus on the five clinical priority areas: VTE, hypertension, sepsis, mental health, and haemorrhage.
- Note actions to strengthen midwifery workforce sustainability, including progressing the Birthrate Plus-identified uplift of 1.11–3.81 WTE through the business planning process.
- Acknowledge neonatal workforce risks and support recruitment, QIS training expansion, and structural review to meet BAPM medical and nursing standards.
- Support ongoing culture and wellbeing initiatives, including listening events, psychological support, and embedding SCORE survey actions into the perinatal improvement plan.
- Note the strengthening of service user engagement through the enhanced role of the Devon MNVP in governance and efforts to increase representation from diverse communities.

The Committee are asked to agree the recommended assurance rating noting the mitigations around assurance.

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Finance and Operations Committee

Electronic Patient Record (EPR) Progress Report

Date of meeting	Date report produced
25th February 2026	12th February 2026

Author(s)		Report approved by	
Name and title:	Kevin Pirie EPR Operational Director	**Name and title:**	Adel Jones - SRO
		Date:	16th February 2026

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

Executive summary

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

As of 13th February the overall program status has been maintained at “Watch”, measured as 7/10 compared to an average Epic customer score of 6.8 / 10 at this stage of the program. TSD hosted a successful 60 day Go-Live Readiness Assessment on 3rd February in preparation for go-live on 3rd April.

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.

We are in a strong position with overall configuration, data migration, training, and readiness activities. However we remain behind with full training registration, and there continues to be significant work to do to go live successfully with the current scope of Oncology Protocols. *See additional details in Appendix 1 (Executive Summary Report).*

Issues needing Executive oversight

Protocol validation coverage is projected to reach 75% by 21 March, risking clinician satisfaction and operational efficiency at go-live because incomplete second-check reviews may delay treatment plan conversion.

TSD's go-live date for Haemonetics SafeTrace integration with Epic is not defined resulting in incomplete cutover plans for clinical and technical teams.

Super user readiness is at risk, with only 300 of 966 identified super users having completed their Week 1–2 activity track requirements. To address this and prevent impacts to post-live stabilisation and system adoption, Katrina Stockton (SU Lead) will drive focused follow-up to ensure at least 80% of identified super users complete their outstanding activity track items—prioritising high-impact groups such as nursing, medics, and administrative staff—by 20 February. We also remain behind with full training registration, detailed data on staff still needing full registration is now available to enable Care Group Directors to drive registration.

The expansion of community phlebotomy services to replace GP blood collection at Torbay and South Devon (TSD) is unlikely to fully be in place prior to go-live, requiring a mitigation plan to be implemented to support GP blood collection at go-live.

In addition to the above issues admin backlogs clearance (Clinic letters and appointment outcoming) is receiving Executive oversight. Failure to remove admin backlogs before the end of March will create a serious data quality challenge post go live. A plan is in place to fully clear the letters and outcoming backlogs by our go-live date. This is driven through daily Silver Command meetings.

Backlogs have reduced as follows	**2nd February**	**16th February**
Clinic letters –	8,840	6,932
Outcomes -	11,988	10,483
Total –	20,828	17,415

This clearance rate will increase significantly when Clinic letter backlogs are outsourced to an external organisation in the week ending 20th Feb. Doing this will accelerate clearance of the letters and allow us to focus our admin workforce on our outcoming backlogs. Full clearance of all Clinic letters and Outcoming backlogs is expected by 20th March for PAS uploads. These will be followed by further smaller uploads of letters and outcomes generated between 20th March and 3rd April.

Key Decisions –

- Expansion of community phlebotomy service
- Go live activity plans sign off

Key Program risks –

- Current recruitment controls may impact programme activity.
- Visibility of Trust and Regional interdependent projects / competing priorities.

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 (Jan – Feb 26)
included in the Finance and Operations Committee Information Pack

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

N/A

Key recommendations and actions requested

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

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

How does this report further our Trust strategy?

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**
Quality, Safety and Patient Experience	The networked EPR enables standardisation of pathways across Devon based on best practice.
Leadership and Governance	An efficient and effective EPR will support Leadership decisions within the Trust, and offer improved 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. Greatly improved insight from our data.
Finance	Critical enabler for the development of best practice standardised pathways and reductions in variation.

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

Risks lodged on Datix:

As detailed above.

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.

Integrated Performance Focus Report (IPR)

Torbay and South Devon NHS Foundation Trust

February 2026: Reporting period January 2026 (Month 10)

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1.	National Oversight Framework (NOF) Introduction NOF 4 Performance Summary - Urgent and Emergency Care Exception reports -Urgent and Emergency Care NOF 4 Performance Summary - Elective Recovery Exception reports - Elective Recovery	2 3 5 8 10
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Working with you, for you

Oversight Framework - Introduction

National Oversight Framework:

The Oversight Framework was published in April 2025. Quarterly assessments against the Framework reflecting performance in Q1 and Q2 has been published. The overarching score and national ranking across the six domains for the Trust in Q2 is Segmentation 3 and ranked 87 out of 134 Trusts; the six domains are:

- Access to services
- Finance and productivity
- Effectiveness and experience
- Patient safety
- People and workforce

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

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.

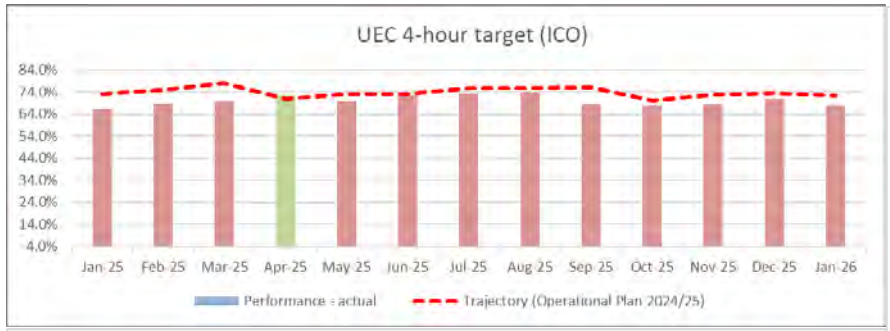
National Oversight Framework– Urgent and Emergency Care Performance Summary

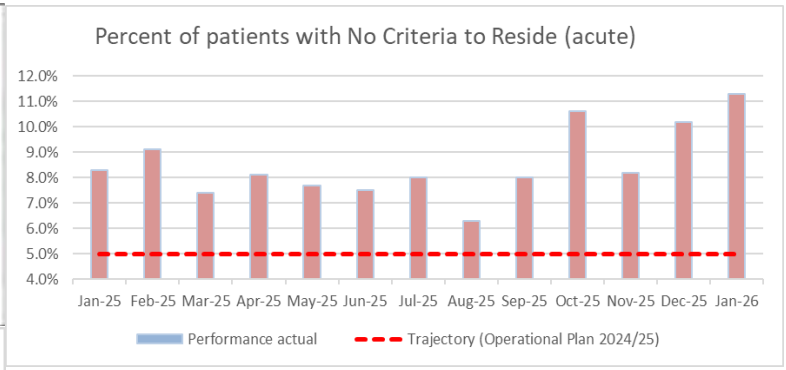
NHS Torbay and South Devon NHS Foundation Trust

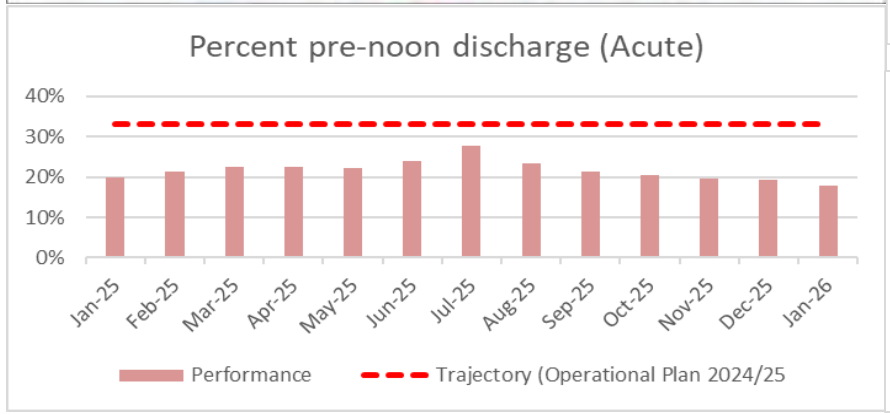
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Operational Plan trajectory Jan 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1981		2532	1625	1268	839	1530	1159	725	943	1823	810	624	559	1283	2034
Average handover time (mins)	45 mins		84	62	47	36	52	45	32	38	60	33	29	27	45	42
Total average time in ED (hours/minutes)			06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		818	677	615	415	688	494	457	426	655	585	549	520	918	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.7%	7.4%	13.3%	7.0%
UEC 4-hour target (RAG against local trajectory to national target)	78%		66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	72.3%
% patient discharges pre-noon	33%		19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		8.3%	9.1%	7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	5%

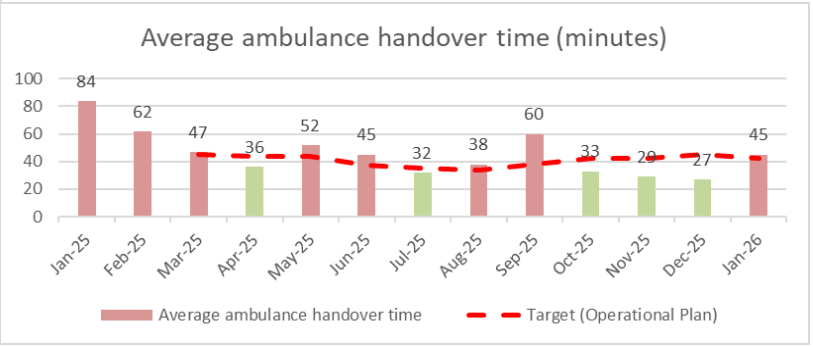
RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

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

NHS 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 117 out of 123 trusts (as of 28 December 2025) from rank 86 last month.

NHS England South West

Organisation: Torbay and South Devon

Metric Focus: UEC

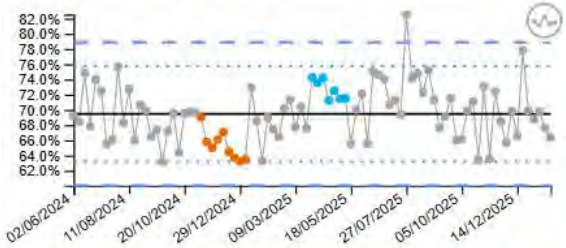
Week Ending: 25 January 2026

✓ Above plan ! Below plan

Note: 12 hour ED plans are subject to revision centrally to account for both types 1 & 2 activity. Original plans presented in this dashboard

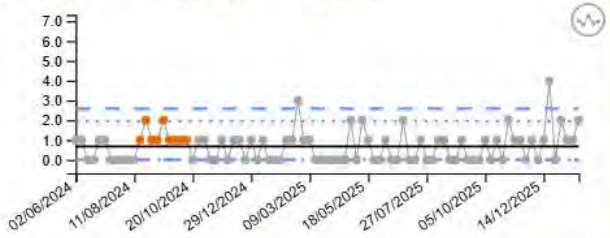
A&E 4hr Performance - All Types (inc booked)

Latest Week: 66.4% !
Plan: 74.8% (-8.4%)
Rank: 93
YTD: 70.7%



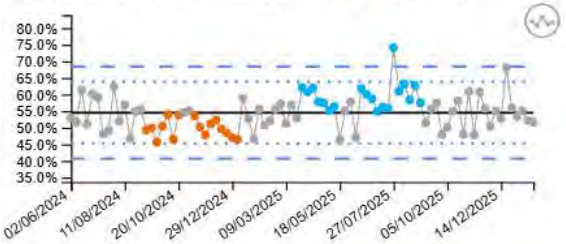
21+Day Post Discharge Ready Date

Latest Week: 2
Rank: 61
YTD: 30



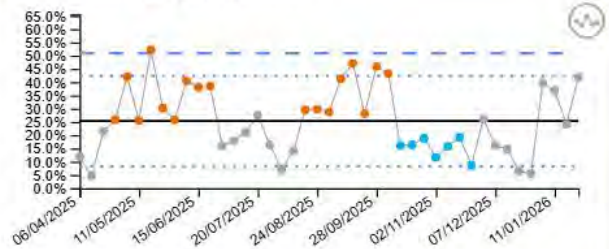
A&E 4hr Performance - Type 1 (inc booked)

Latest Week: 51.7% !
Plan: 64.1% (-12.5%)
Rank: 84
YTD: 56.4%



Ambulance Delays >45mins

Latest Week: 41.9%
Rank: 117
YTD: 25.1%



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 January was 2543 which is the third highest number of conveyances by SWAST the organisation has seen in a month period. January's handover average was 44mins 44secs; it was 27mins and 04 secs in December and 28mins and 34 secs in November. The number of handovers over 45mins has increased to 797 in January from 339 in December.

Average handover time – rolling 30 day (as at 1 February

Rolling 30-day position as at **01 February 2026**

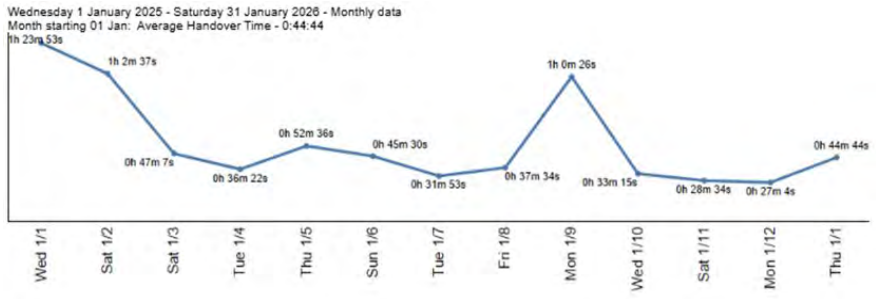
click on a bar to highlight site on the trend chart

Ambulance Trust	Site Name	
South Western	Derriford Hospital	1:29:40
South Western	Royal Cornwall Hospital (treliske)	1:22:45
South Western	Royal United Hospital	1:09:20
South Western	The Great Western Hospital	0:47:01
South Western	Torbay Hospital	0:45:33
South Western	Southmead Hospital	0:36:46
South Western	Royal Bournemouth Hospital	0:36:05
South Central	Royal Bournemouth Hospital	0:35:56
South East Coast	St Helier Hospital	0:29:49
South Western	Yeovil District Hospital	0:29:14
South Western	Poole Hospital	0:28:11
South Western	Royal Devon & Exeter Hospital (w..	0:28:08
South Western	North Devon District Hospital	0:27:54
South East Coast	Croydon University Hospital	0:27:25
South Western	Bristol Royal Infirmary	0:27:22
South Western	Salisbury Health Care NHS Trust	0:26:56
South Central	Basingstoke And North Hampshire..	0:26:28

Operational update

Ambulance handovers remain a key focus for the Trust and Timely Handover Process (THP@45); although it has caused unprecedented challenge across the whole organisation it has had a positive impact on the Category 2 response times.
The number of handovers over 45mins has increased to 797 in January from 339 in December.
This indicates the organisational strain on flow due to high demand and acuity, meaning the use of additional escalation spaces for prolonged periods of time.

Average ambulance handover time



Actions to complete next month

- The organisation's senior operational team, have reinvigorated the UEC improvement programme and associated workstreams. They fulfil the SRO roles with close I&I support.
  - ED Demand and Capacity Recovery and Improvement
  - ED Demand Management
  - Internal Urgent Care Streaming
  - Ward Flow and Improvement
- 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

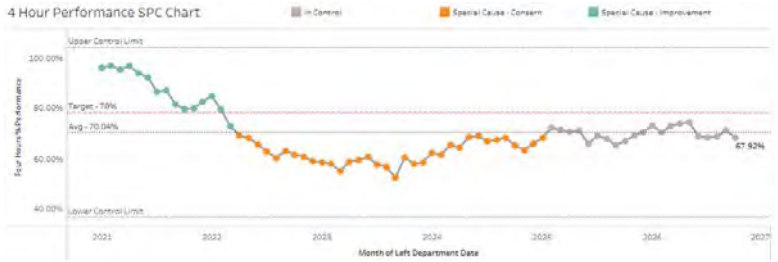
Exception report: 4-hour ED target: - Urgent and Emergency Care

Torbay and South Devon NHS Foundation Trust

Performance

	Jan 2025	Jan 2026
MIU/UTC attendances	3020	3268
MIU/UTC performance	99.5%	99.9%
ED (type 1) attendances	6191	6893
ED (type 1) performance	50.7%	52.8%
ICO attendances	9216	10161
ICO performance	66.7%	67.9%

ED (Type 1) SPC



Opel score

January 2026

Mon	Tue	Wed	Thu	Fri	Sat	Sun
			1 L4	2 L4	3 L4	4 L4
5 L4	6 L4	7 L3	8 L4	9 L4	10 L4	11 L4
12 L4	13 L3	14 L4	15 L4	16 L3	17 L4	18 L3
19 L3	20 L3	21 L3	22 L4	23 L4	24 L4	25 L4
26 L4	27 L3	28 L4	29 L4	30 L4	31 L3	

January 2025

Mon	Tue	Wed	Thu	Fri	Sat	Sun
		1 L3	2 L2	3 L4	4 L4	5 L4
6 L4	7 L4	8 L3	9 L4	10 L3	11 L3	12 L3
13 L3	14 L4	15 L4	16 L3	17 L3	18 L3	19 L3
20 L3	21 L3	22 L3	23 L3	24 L3	25 L3	26 L4
27 L4	28 L3	29 L3	30 L4	31 L4		

Operational update

4hr performance for the month stands at 67.9% against a trajectory of 72.3%, meaning a deterioration improvement and 4.4% below trajectory. The ICO had 10,161 attendances, the Emergency Department recorded 6,893 attendances. January has seen highs of >260 patients in the ED department; and although lower numbers during other days this has not been felt due to the acuity of the patients, the age of those attending and IPCC issues. Infection has also impacted on substantive and bank staff.

Resus is still seeing more than 275 patients in the last month denoting the acuity and complexity. Patient experience, safety, and risk metrics. 918 patients experienced an ED stay longer than 12-hours; this is a deterioration from December at 520 patients.

January paediatric 4-hour target is 87.9%, up 2.4% 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.

The main workstreams have been refreshed with senior operational and CGD colleagues leading the programmes of work: ED Recovery and Improvement / Internal Streaming / Ward Flow & Improvement.

- 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 GLRA60 commenced on 03/02/26- 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.

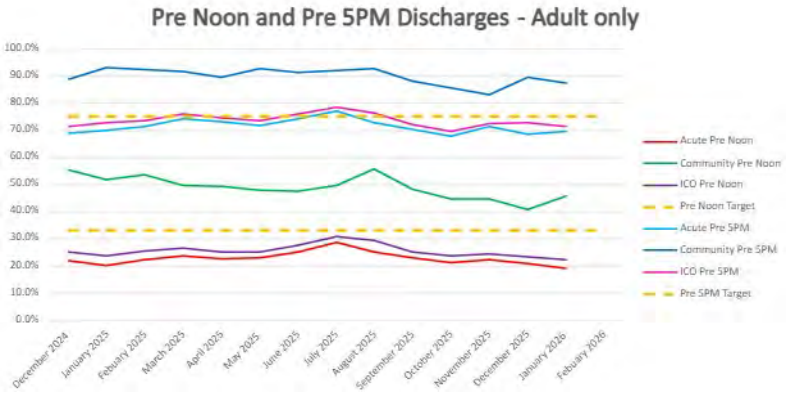
Exception report: Percent of pre-noon discharges: NOF 4 Exit Criteria - Urgent and Emergency Care

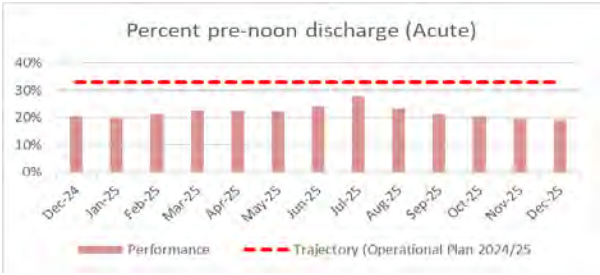
Torbay and South Devon NHS Foundation Trust

Performance

Performance Analysis: December 2025 vs January 2026

- **Pre-Noon:** Overall decline, but an improvement with Community Hospital pre noon discharges.
- **Pre-5PM:** Slight improvement across Acute, but minor decline across Community and overall ICO





Operational update

During January, the Discharge Lounge supported 745 patients, demonstrating strong utilisation. However, this cohort is experiencing an increasing Length of Stay, patients are arriving later in the day and with greater complexity, reducing the effectiveness of the Lounge in supporting early flow, as mortality of patients arrive without CPS and TTAs.

Planned Care nursing teams have highlighted a negative impact on early discharges following the change to the RD workforce model. This has resulted in discharge milestones being actioned later in the day, delaying patient readiness and contributing to reduced pre-noon and pre-5PM discharges.

There has been an increase in unnecessary OT/PT referrals for discharge, adding pressure to therapy capacity and introducing avoidable delays where patients could be discharged without therapy input.

The Length of Stay review programme continues twice weekly; however, we are seeing a rise in patients with LOS between 7–21 days. The majority of these patients, clinical need remains the primary reason for their acute stay, limiting short-term improvement opportunities.

As a result of the overall increase in LOS, the Trust has had to utilise super-surge escalation more routinely to maintain safe patient flow and safety.

Actions to complete next month

- Continue with launch of the TOC across 4 wards as part of ward flow and improvement programme.

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.

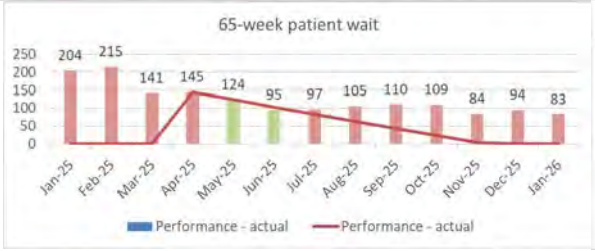
National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

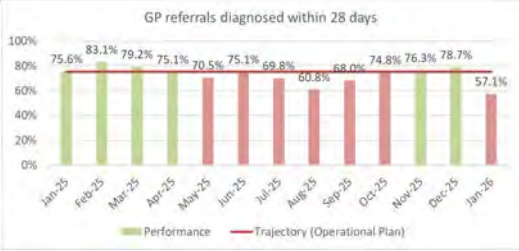
NHS Torbay and South Devon NHS Foundation Trust

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Operational Plan trajectory Jan 2025
Oversight Framework																
RTT 65 week wait incomplete pathway	0		204	215	141	145	126	95	97	105	110	109	84	94	83	0
RTT 52 week wait incomplete pathway	268		1238	1209	931	914	805	740	615	618	615	647	607	663	604	383
RTT % Incomplete pathways <18 wks	66.8%		61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	66.2%	65.9%
RTT Wait for first appointment <18 weeks	70.3%		63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	69.9%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	78.7%	57.1%	75.8%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	77.7%	78.1%
Cancer: No of patients waiting >62 days to start treatment	138		95	94	111	133	225	223	220	257	176	132	91	119	159	138
Cancer: % of patients > 62 days to start treatment	tbc		6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	5.9%	7.6%	tbc

Trajectories have been agreed as part of the 2025/26 Operational Plan submission. The latest month trajectory is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories; 2 of the 8 trajectories in Month 10 have been met.

RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory





Actions on-going this month

- Detailed 65-week focus on clearing all remaining patients and to achieve the reduction in 52 week wait to 1% of PTL by ed of March 2026. This will require targeted additional capacity with sprint funding, flexing of consultant job plans and priorities.
- Focus on all undated new outpatients greater than 52-weeks wait.
- Q4 elective sprint – plan agreed and now being operationally mobilised.

Risks and Barriers

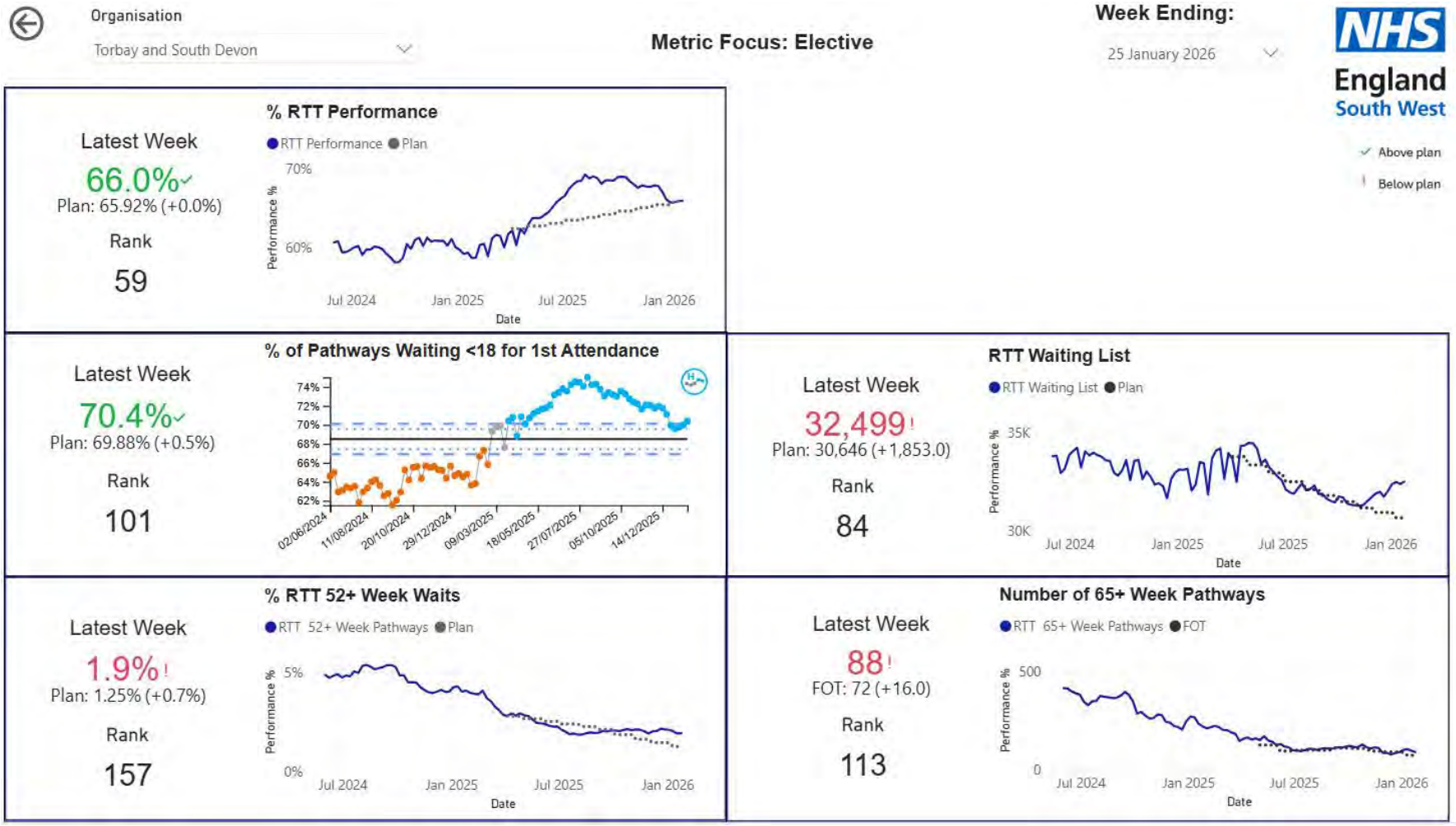
- Workforce – enough surgeons and anaesthetists to meet demand (hip and knee). Admin (secretary / booking) to cope with additional demand. Burnout risk of staff able to do extra weekends.
- Epic – training and focus has made completing the sprint actions more challenging.
- Balance of recovery of cancer/urgent/long waits continues to pose pressure on long-waiters.
- Trauma and anaesthetics capacity continues to be critical for clearing long waits and maintaining trauma service.

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.

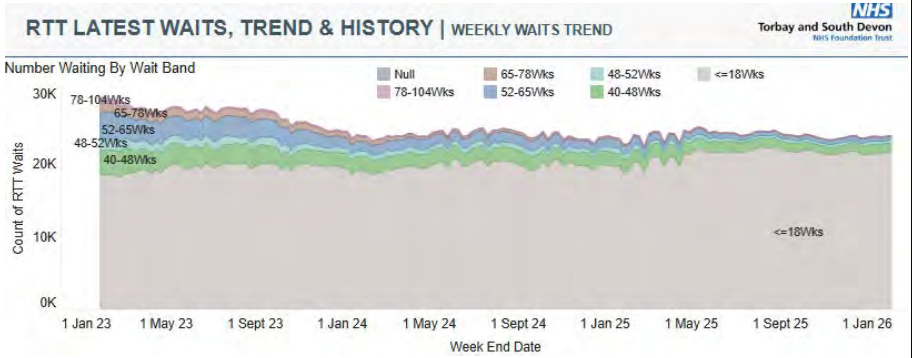
Exception report: 78-Week and 65-Week Clearance: NOF 4 Exit Criteria – Elective Recovery

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.

	January 2025	January 2026
78 weeks	10	13
65 weeks	119	83
52 weeks	1238	604



Operational update

78 week: At the end of January (provisional figures) there are 13 breaches - 10 admitted orthopaedic patients (due to specialty capacity for hip and knee surgery) and 1 Orthopaedic non-admitted.

65 week: In January (provisional figures) there were 83 breaches – with the majority sitting within T&O.

New Tri-weekly Trauma and Orthopaedic huddles are exploring patient by patient actions including reviews into new trauma consultant, job planning, outsourcing and insourcing. An internal review of T&O service has been completed and will form the basis of plans and recommendations to target improved productivity.

Up to 20 patients are being transferred to North Bristol hospital to help long-waiting T&O patients; this should help bring the forecast for the end of February to circa 45 over-65-week wait patients.

Actions to complete next month

- Elective sprint
- Continued insourcing in key areas.
- Theatre recovery programme.
- Recruiting agreed posts to exit insourcing reliance on insourcing as part of business planning.
- Implement outpatient improvement programme with detailed plan milestones agreed by service area.
- Elective delivery reports being developed for 2026/27.

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 01/02/2026 (based on current wait)

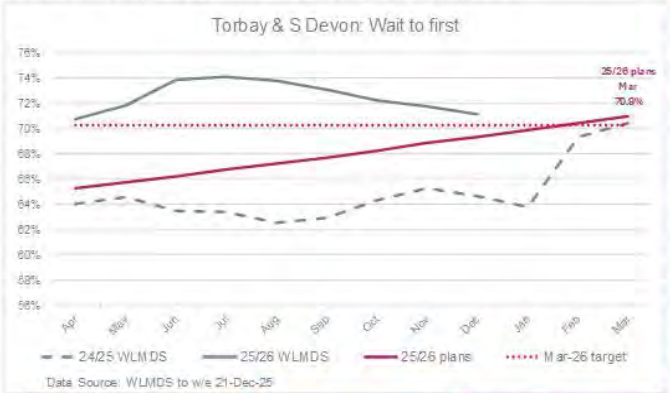
FILTER
Module: (All)
Local Treat. Functn.: (All)
Clinic or List: (All)
WLMDS Pathway: (All)
NAVIGATE
Cover Page
All New Waits
Follow Up Pending
IPDC
OP Trends
OP Totals

Treatment Function	00-18 weeks	>18-26 weeks	>26-52 weeks	>52-65 weeks	>65-78 weeks	>78 weeks	Grand Total
120 - ENT	1,541	439	834	44	10	16	2,884
130 - OPHTHALMOLOGY	1,564	448	589	34	5	7	2,647
140 - ORAL SURGERY	947	229	440	8	2		1,626
110 - TRAUMA & ORTHOPAEDICS	865	254	396	31	18	44	1,608
330 - DERMATOLOGY	1,133	201	224	2			1,560
340 - RESPIRATORY MEDICINE	820	136	180	93	65	177	1,471
302 - ENDOCRINOLOGY	452	157	506	179	49	9	1,352
101 - UROLOGY	901	204	176	3			1,284
320 - CARDIOLOGY	1,048	58	53	16	6	28	1,209
420 - PAEDIATRICS	901	126	130	3	1	1	1,162
410 - RHEUMATOLOGY	904	129	63	2	3		1,101
650 - PHYSIOTHERAPY	731	72	130	2	4	1	940
104 - COLORECTAL SURGERY	632	111	159	6			908
400 - NEUROLOGY	555	136	128	30	24	10	883
502 - GYNAECOLOGY	716	48	22				786
191 - PAIN MANAGEMENT	490	100	167	10	3		770
301 - GASTROENTEROLOGY	619	35	41				695
840 - AUDIOLOGY	496	24	29	7			556
401 - CLINICAL NEUROPHYSIOLOGY	314	5	3				322
106 - UPPER GASTROINTESTINAL SURGERY	270	15	12	2	5	1	305
430 - GERIATRIC MEDICINE	149	51	90	7	1		298
655 - ORTHOPTICS	238	22	30	2	3		295
103 - BREAST SURGERY	201	1					202
143 - ORTHODONTICS	65	24	32	9	4	1	135

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, 3066 patients on an RTT pathway. 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 66.8% of patients waiting under 18 weeks from referral to treatment. The end of January RTT position is 66.2% against a January trajectory of 65.9%.

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 Nov-24	WLMDS w/e 21-Dec-25	Target Mar-26
65.3%	71.1%	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	1,239	2,292	54.1%	-11.2%	-16.2%
Trauma & Orthopaedics	705	1,232	57.2%	-8.0%	-13.0%
Oral Surgery	975	1,638	59.5%	-5.7%	-10.7%
Elderly Medicine	195	318	61.3%	-4.0%	-9.0%
Ophthalmology	1,798	2,751	65.4%	0.1%	-4.9%
Neurology	502	707	71.0%	5.7%	0.7%
Other - Medical Services	1,056	1,450	72.8%	7.6%	2.6%
Other - Surgical Services	927	1,252	74.0%	8.8%	3.8%
Other - Other Services	40	54	74.1%	8.8%	3.8%
Plastic Surgery	23	31	74.2%	8.9%	3.9%
Urology	852	1,128	75.5%	10.3%	5.3%
General Medicine	24	31	77.4%	12.1%	7.1%
Dermatology	1,173	1,512	77.6%	12.3%	7.3%
Rheumatology	673	818	82.3%	17.0%	12.0%
Cardiology	1,347	1,570	85.8%	20.5%	15.5%
Gastroenterology	715	808	88.5%	23.2%	18.2%
Respiratory Medicine	476	524	90.8%	25.6%	20.6%
Gynaecology	726	795	91.3%	26.0%	21.0%
Other	17	18	94.4%	29.2%	24.2%
Cardiothoracic Surgery	4	4	100.0%	34.7%	29.7%
	-	-			
	-	-			
	-	-			
	-	-			
Total pathways	**13,467**	**18,933**	**71.1%**	**5.9%**	**0.9%**

Data Source: WLMDS for w/e 21-Dec-25
Baseline is the WLMDS w/e 01-Dec-24
Below baseline | Above target

The Trust is achieving 70.4% against the end of year target of 70.3% of patients being seen at first outpatient appointment in under 18 weeks from referral.

Exception report: Cancer Waiting Time Standards

Torbay and South Devon NHS Foundation Trust

Performance

	October 2025	November 2025	December 2025	January 2026
28-day FDS	75.8%	76.3%	77.8%	57.1%*
31-day treatment	92.4%	94.7%	93.3%	92.7%*
62-day cancer RTT	70.1%	70.9%	79.9%	77.9%*
62-day backlog	152 (6.8%)	108 (4.8%)	142 (6.3%)	159* (7.6%)

***as at 02 February 2026**

Faster Diagnosis Standard (FDS): The Trust is currently reporting 57.1% (as at 02 February 2026) against the 75% FDS target. This position is undergoing validation ahead of submission at month end.

62-day Cancer Referral to Treatment: January's provisional performance is 77.9% against the January trajectory of 75.8%.

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 02 February 2026 the backlog is 7.6%.

Risks/issues

- 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.
- Winter pressures, EPR workload and RTT performance pressures increasing limiting operational and clinical availability for additional sessions.

Actions to complete next month

Dermatology

- FDS Performance in January is currently at 50% as forecast in last month's report.
- Continued insourcing and locum activity to maintain and improve performance. Consultant sickness and availability of additional work during December caused performance decline in January (consultant now returned).

- February FDS due to be >90%.

Quality and Safety Indicators – Changes to key performance indicators

This month the following changes have been made to the quality key performance indicators. These changes have been made to bring awareness to reflect the NHS Oversight Framework, Board Assurance Framework, and Fundamental standards of care and Better Care. The metrics that have been removed from this report are still reviewed at service and care group level.

Summary of changes for IPQR quality metrics

	Added	Removed
Safety	• Total numbers of incidents with moderate, severe and death harms • Number PSIIs	• Total number medicines incidents • Number STEIS
Other	• SHMI • Nutrition assessment	• VTE • QUESTT
Infection control	• Number of E-coli • Number of MSSA	• Rate of C-diff • Hand hygiene • Bed closures due to infection control
Stroke	• % patients admitted to stroke unit within 4 hours	• % patients spending 90% of their time on a stroke unit spending
Safe staffing	• CHPPD: day • CHPPD: night	• CHPPD: registered • CHPPD: skilled non registered

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

HSMR		↓
SHMI – to be collated		
Never events		↓
Reported incidents: death		↑
Reported incidents: severe		↓
Reported incidents: moderate		
Number Patient Safety Incident Investigations		
Medication incidents resulting in mod or more severe harm		↑
Falls per 1000 bed days		↓
Number of Healthcare Assoc Infection: MRSA		↔
Number of Healthcare Assoc Infection: E-Coli		↑
Number of Healthcare Assoc Infection: MSSA		↑
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)		↓
Formal complaints		↑
Compliance with complaints acknowledge in 3 days		↑
Compliance with complaints closed in 6 months		↑
Mixed sex accommodation breaches (0)		↑

Safer Staffing - ICO – Daytime (90% - 110%)		
Safer Staffing - ICO – Night-time (90% - 110%)		
Care Hours Per Patient Day (CHPPD): Day – to be collated		
Care Hours Per Patient Day (CHPPD): Night – to be collated		
Follow-ups 6 weeks past to be seen		
Nutrition audit compliance		↓
Admission to stroke unit within 4 hours		↓
Fracture Neck Of Femur - Time to Theatre <36 hours (>90%) - one month in arrears		↓
Maternity: 1:1 care in labour *		
Maternity: Admission to SCBU (full term)*		
Maternity: Stillbirths and perinatal deaths*		
Maternity: Smoking at time of delivery*		
Maternity: 3rd and 4th degree tears*		
Maternity: PPH>1500mls*		
Maternity: Birth rate*		

*to be collated for IQPR

Quality and Patient Safety Summary -

Torbay and South Devon NHS Foundation Trust

Areas of deterioration and risk

Non clinical spaces (corridor care)
The Trust are strengthening reporting of the use of non clinical spaces (Corridor care) and are updating the Trust Escalation Policy to account for the new CQC guidance. There are currently no specific incidents of harm related to corridor care.

Stroke care
Performance in stroke remains inconsistent. Performance in % of patients reaching the stroke unit within 4 hours deteriorated and is below the national mean. The care group reports a coming meeting with ED and SWASFT to map the acute part of the pathway.

Maternity
In January, there was one neonatal death, one stillbirth and one late fetal loss (with identified chromosomal abnormality). The Trust central safety team have commenced a thematic review of recent cases.

Patient safety incidents
The Trust received a Regulation 28 notice focused on a historic case with a focus on improving rates of incident reporting. However there is a continued upward trend in incidents linked to moderate harm with a particular increase in (no harm) falls. The Falls steering group will take a deeper dive into this

Feedback and engagement
The backlog of email and telephone contacts to the Feedback and Engagement team which has not yet been heard has reduced significantly but further work is needed with a focus towards acknowledging all complaints within 72 hours.

Infection Control
Rates of MSSA and e-coli remain above target thresholds. The Infection, Prevention and Control (IPC) team will present the results of a deeper dive into this at next SQAG

Areas of stable or improving performance

Safer Staffing
December data is within the NHSE suggested tolerance of 80-120% and also within the TSDFT tolerance of 90-110% fill rates.

Regulatory Compliance 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. These actions are incorporated as workstreams within the Better Care Plan programme and oversight is monitored by the Better Care Plan Board.

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 remaining actions are due to be completed by the end of April 2026 as they align with the implementation of the Electronic Patient Record EPIC.

Regulatory Compliance and readiness

An **MHRA inspection** of blood laboratory services took place on 03/12/2025 and noted some areas that did not meet good practice standards. A response and action plan was shared with MHRA in January 2026, which followed a request for more information. The final version of the action plan once accepted by the MHRA will report through EROG.

CQC Provider Information Return Request Notification for St Edmunds Location ID/ RA906

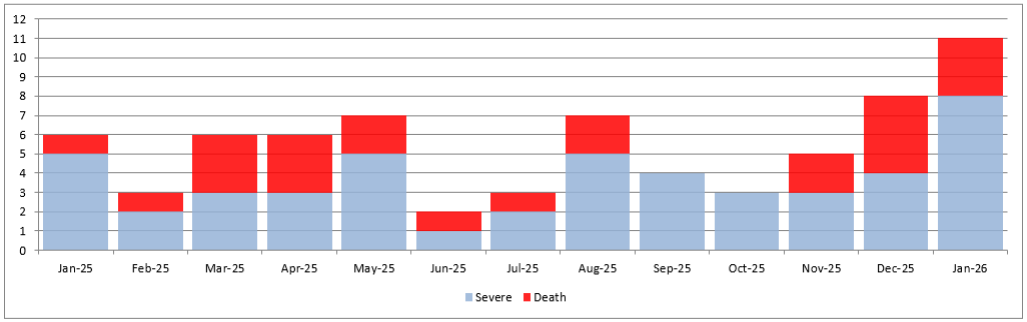
A Provider Information Request for Adult Social Care in relation to the Trust site has been received with a response date of 11th March 2026. This request is sent to the Registered Manager for completion. The Head of Compliance is currently reviewing our CQC registration in this area and has requested that all returns require Trust oversight prior to submission. St Edmunds is registered as a Care Home and not Community Services. This categorisation is currently being reviewed.

Quality and Safety exception reports – Reported incidents

Torbay and South Devon NHS Foundation Trust

Reported Incidents - Severe and Death

	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Severe	5	2	3	3	5	1	2	5	4	3	3	4	8
Death	1	1	3	3	2	1	1	2	0	0	2	4	3



Patient Safety Incident Response Framework (PSIRF) :

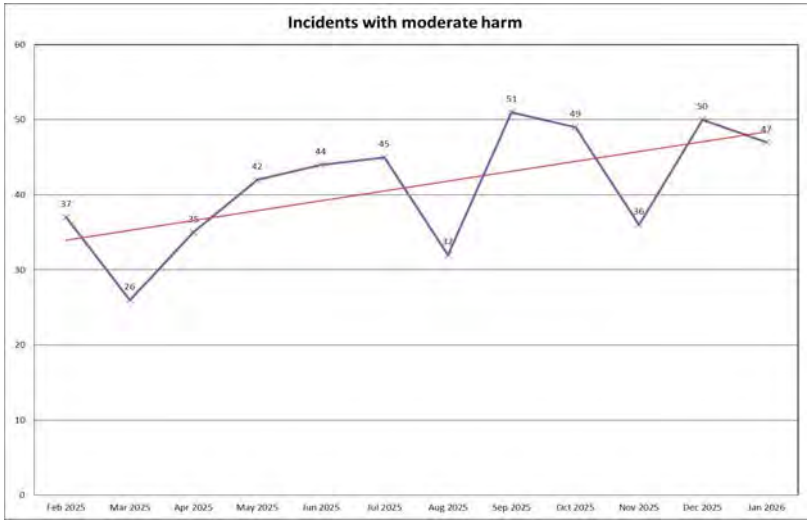
There are 8 patient safety incident investigations (PSII) underway; 5 meet national priorities and 3 meet local priorities. A further local priority PSII is deferred pending the outcome of a Maternity Safety Support Programme (MSSP) thematic review.

4 Perinatal Mortality Review Tool (PMRT) cases are awaiting completion (these are not raised as PSIIs)

Incidents reported as severe harm or death

In January 2026 there were 4 incidents of death reported, and 5 severe harm incidents reported:

[Death] - 18wk gestation neonatal death
[Death] - 29wk gestation neonatal death
[Death] - Cardiac arrest
[Death] - Deterioration and death shortly after admission to a P2 bed
[Severe] - Missed diagnosis of fractured ankle following a fall (at home)
[Severe] - Fractured neck of femur following a fall in hospital
[Severe] - Delayed escalation of EWS, patient required admission to ICU
[Severe] - Delayed follow-up appointment
[Severe] - Anaesthetic equipment malfunction



Areas to escalate

The Trust has received a Regulation 28 Prevention of Future Deaths (PFD) from HM Coroner, following an inquest into the death of a patient who died while an inpatient in May 2022. A key area identified that, while multiple staff members were aware of an event that could have impacted on this patient's clinical condition, none submitted an incident report. Consequently, the opportunity to contemporaneously review this event was lost.

Reducing the number of open patient safety incidents remains a focus for Care Group leadership and governance teams. The number of open incidents has reduced from 2,065 last month to 1,633 this month. Closing open actions linked to patient safety incidents is also a focus for Care Group teams. Oversight of this patient safety and quality work will be a portfolio responsibility of the new Directors of Nursing.

As system pressure continues, the central patient safety team continue to monitor patient safety incidents, including those associated with Corridor Care and discharge from hospital. The increase in reported incidents of moderate harm, noted in the chart above, with trend line, correlates with the increase in system pressure noted.

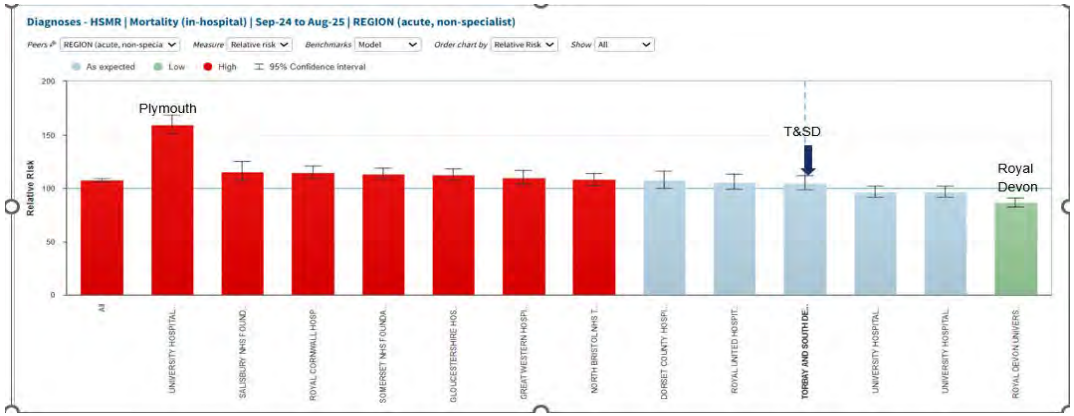
Quality and Safety exception reports – Hospital Standardised Mortality Ratio HSMR

Torbay and South Devon NHS Foundation Trust

No update since report in January 2026

Mortality data for the period of Sept 2024-August 2025
A Telstra Health report was presented to Mortality Surveillance Group on 8th January 2026. There is a high volume of R69 (uncoded) data for September 25 discharges.

HSMR+: Regional Peers (Acute non-specialist) - The Trust is 1 of 5 trusts that are within the expected range (out of 13).

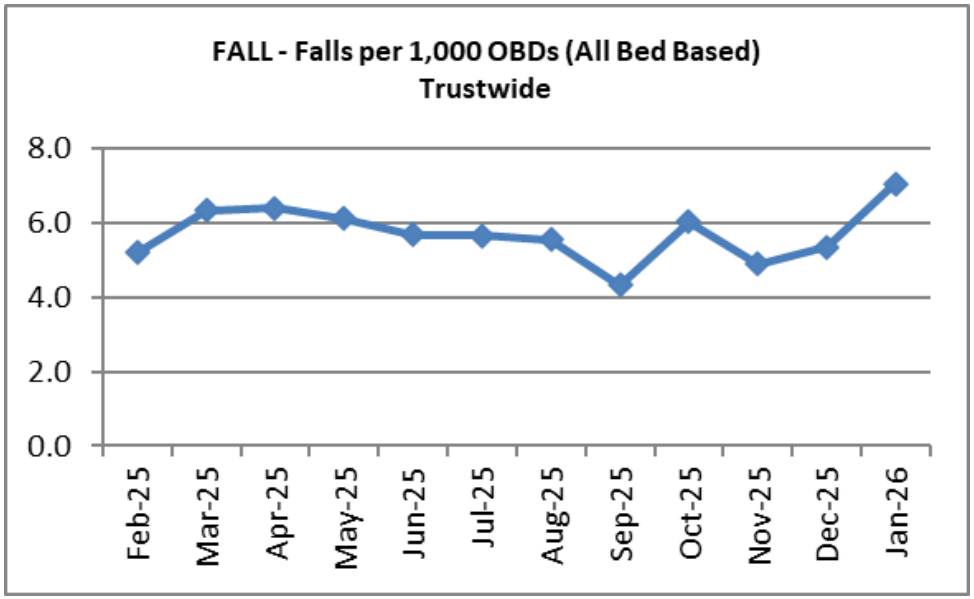


- The latest HMSR+ for September 24 to August 25 is **104.6** (98.0 – 111.4), this is statistically within the expected range.
- The HSMR+ for non-elective admissions for the current 12-month period is **104.7** and within the expected range. The crude mortality rate for the current 12-month period is 5.6% (National = 5.7%, Region = 5.6%). Overall, the non-elective rolling 12-month trend for HSMR+ has been declining but sees a level picture in latter periods.
- The HSMR for elective admissions is 96.4 and remains within the expected range. The rolling 12-month trend shows a general downward trajectory over the past 6 months
- Emergency weekend HSMR+ has changed banding and is now statistically higher than expected.
- Emergency weekday HSMR+ remains within the expected range. The increase in the emergency weekend HSMR+ is due to an increasing crude rate over the last three rolling 12 month periods and a stable expected rate, causing the gap between the two to widen.
- There are seven CUSUM alerts and one new alert for this period -residual codes, unclassified.
- Palliative deaths in hospital is also higher than National and Peers and this has also decreased by 3.5% since the last report. The Trust End of Life group will consider if provision of community palliative care services is impacting this.
- The new published SHMI value is 95.6 and statistically 'as expected'

•There are three new groups with a Relative Risk that is statistically higher than expected, that were not apparent in the previous report.
•Congestive heart failure, non-hypertensive
•Gastrointestinal haemorrhage
•Peri-, endo-, and myocarditis, cardiomyopathy

Alerts will be monitored by the Mortality Surveillance Group.

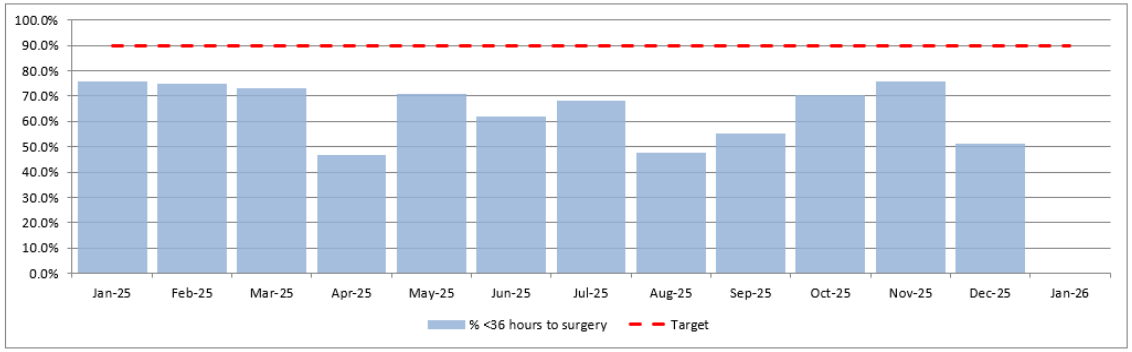
Quality and Safety exception reports – fractured neck of femur and falls



The Trust rate of falls per 1000 bed days includes both inpatient wards and bed- based intermediate care beds
The rate has been fairly steady following an improvement plan instigated due to increased rates during the pandemic.
However there was a marked increase in rate in Jan 2026, most significantly reported in community hospitals and IC. The increased falls are mostly 'no harm' or 'low harm' , but the Falls Steering Group will conduct a deeper dive into causation.

Fractured neck of femur - <36 hours to surgery

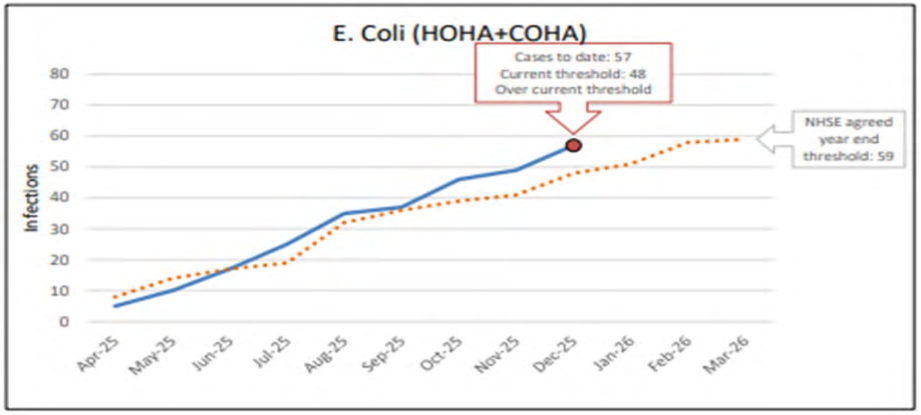
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
% <36 hours to surgery	75.6%	75.0%	73.2%	46.5%	70.7%	61.8%	68.1%	47.4%	55.0%	70.3%	75.8%	51.0%	N/A
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Fractured Neck of Femur (one month in arrears – Month 9 data not yet available on National Hip Fracture Database).

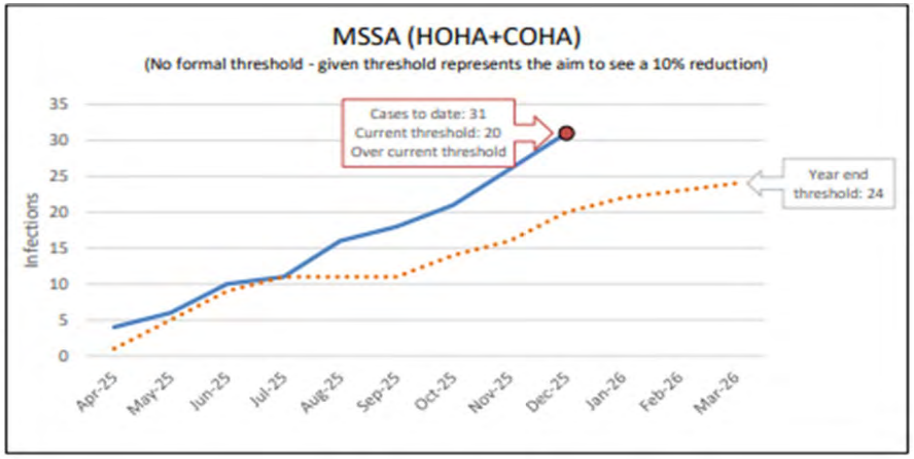
January data shows 46 hip fractures plus 4 other femoral fractures admitted. This will include the complex periprosthetic fractures. Average time to theatre for the hip fractures was 35 hours which is an improvement and within the target 36 hours from admission to theatre.

Quality and Safety exception report - Infection control



Rates of Klebsiella, C-Difficile and pseudomonas are all below target levels set at a 10% reduction against last year's infection rates.
However, rates of e-coli stand at 57 confirmed cases. This is above the monthly target level of 48 with a yearly target of 59 cases.
It should be noted that this is a national trend which has increased by 17% in 2024/25, and not just localised in TSDFT
Increased infection rates may be a consequence of:

- Increased patient acuity and complexity
- High bed occupancy
- Higher population of 65+



MSSA (Methicillin-Sensitive Staphylococcus aureus) rates have increased at Torbay and South Devon NHS Foundation Trust due to a combination of factors including patient vulnerability, procedural risks, and environmental challenges.
Key Factors Behind the Rise in MSSA Rates

- Increased patient acuity and complexity: The Trust has reported a rise in patients with complex health needs, which often requires invasive procedures like cannulation and catheterisation — both of which increase the risk of bloodstream infections such as MSSA.
- Higher volume of procedures: More surgical and interventional procedures naturally raise the exposure risk to MSSA, especially in older or immunocompromised patients.
- Staffing pressures and bed occupancy: Like many NHS trusts, Torbay and South Devon has faced staffing shortages and high bed occupancy, which can strain infection control efforts and increase cross-contamination risks.

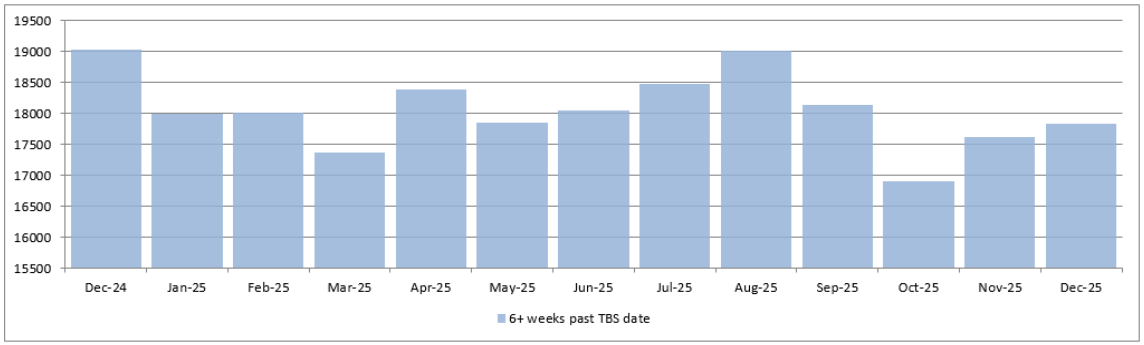
IPC Assurance:
Every MSSA HOHA and COHA are reviewed by a senior IPC team and a deep dive will be brought to next SQAG
The IPC team are exploring potential changes in skin prep for cannulation
The Team are organising spotlight checks of hand hygiene on wards

Quality and Safety exception reports – follow-ups past to be seen by date/ Pressure ulcer

Torbay and South Devon NHS Foundation Trust

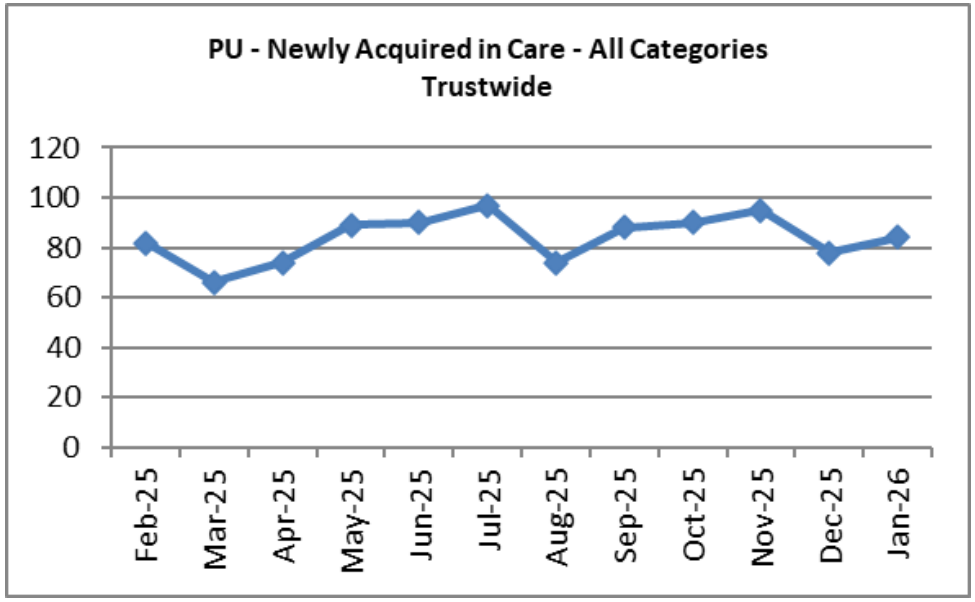
Follow ups 6 weeks past to be seen by date

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
6+ weeks past TBS date	19036	17997	18005	17361	18380	17843	18040	18486	19016	18135	16900	17610	17827



Follow-ups past 6 weeks to be seen

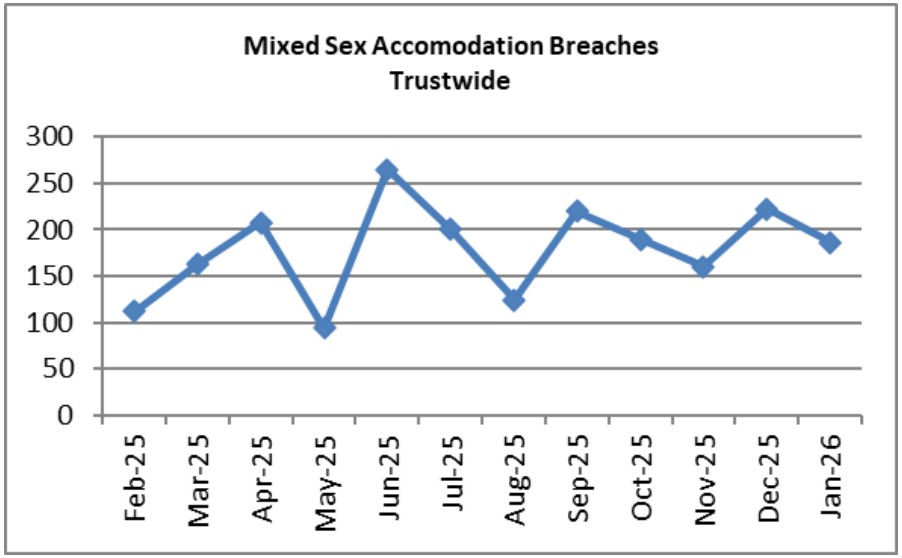
There was an overall increase in the number of patients waiting longer that 6 weeks past their to be seen by date in December. Ophthalmology has seen the biggest increase (428) due to consultant sickness, and sickness and vacancy in the Patient Access Centre.

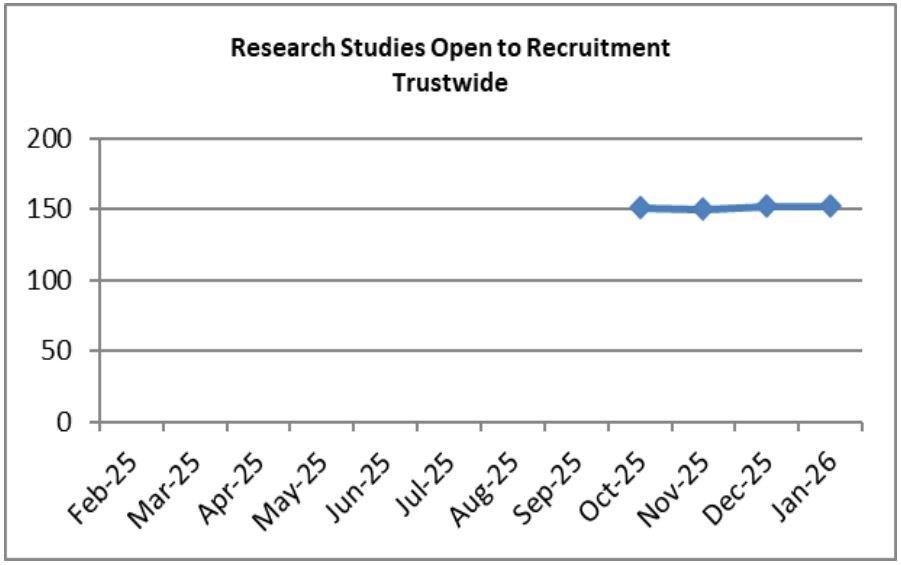


Pressure ulcer

Incidents of pressure ulcers acquired in our care shows a fairly stable picture. This will be monitored monthly moving forwards.

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





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.

From Jan 2026 we adopted guidance where we operate a 'clock stop' on breaches between 10pm and 7am in line with NHSE guidance. This has had minimal impact on our reporting to date.

Research involvement

The number of research studies open to recruitment remains steady at 152 studies

Quality and Safety exception report – TSDFT stroke standards

NHS Torbay and South Devon NHS Foundation Trust

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

Time critical Stroke Standards	Natl. average July - Sept 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	Nov-25	Dec-25	Jan-26
Number of patients (N)		42	50	46	50	46	56	55	62	54	50	58	53	57	44	51	54
% Scanned within 20 minutes **updated target**	31.4%	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%	22.7%	36.5%	37%
% Admitted to Stroke Unit within 4 hours	50.9%	31.70%	36.70%	25.00%	34.00%	24.40%	50%	37%	37%	47.30%	28%	46.40%	50%	49.1%	34.1%	52.90%	34%
Median time to reach the stroke unit (hours:mins)	03:42	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	06:55	03:43	06:23
% of patients spending 90% of their time on the Stroke Unit	83.0% (Team)	69.40%	71%	59%	71.40%	70.20%	83.60%	69.10%	77.40%	75.90%	78.90%	81%	81%	88.9%	65.9%	74.50%	59.30%
% Patients given formal swallow assessment within 24 hours	56.9%	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%	40.00%	68.40%	59.30%
% (No.) Patients that received Thrombolysis	13.2%	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)	11.4% (4)	17.3% (9)	13% (7)
Median time between clock start and thrombolysis (hours:minutes) **New target**	**00:55mins**	01:23	01:12	01:17	01:17	01:08	01:06	01:36	01:17	01:08	01:07	01:17	01:27	00:58	00:57	00:53	01:10

December performance was very positive; we were at or better than national mean in 5 performance areas, but as previously highlighted we struggle with consistency and are heavily impacted by operational pressures. This means that performance in **January** saw a dip.

January saw a deterioration in proportion of patients reaching the stroke unit in 4-hours and was below national mean; only 34% patients with a median time of over 6 hours.

The proportion of patients spending 90% of their time on a stroke unit dropped to the lowest - 59.3% - in 13 months and well below the national average

Patients receiving formal swallow assessment stayed above the national average.

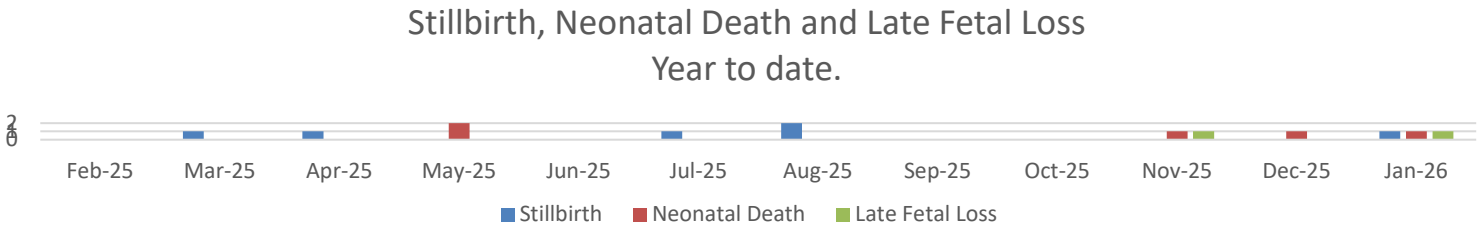
The proportion of patients receiving thrombolysis deteriorated but remained only slightly below the national average.

Stroke Actions:

- Soft launch of Capture Stroke expected in next 4-6weeks; full implementation post-July (after UHP Epic "go live" due to IT team resource)
- Further meeting planned for March to discuss hyper-acute pathway & protection of hyper acute beds.
- Facilitated meeting planned with ED, SWASFT, radiology and the stroke team to look at pre-hospital & ED to GE pathway – building on recent pathway mapping.
- Meeting arranged with Michelle Long, NHSE Special Adviser for Rehab & Juliette Dean from Southwest network to look at rehab pathway - building on pathway mapping
- Workforce modelling for specialist stroke nursing, SALT & dietetics planned over next 2-3 months.
- Regionally 24/7 thrombectomy to go live from 16th February.

Quality and Safety - Perinatal Clinical Quality Surveillance February 2026 (January 2026 data) 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:

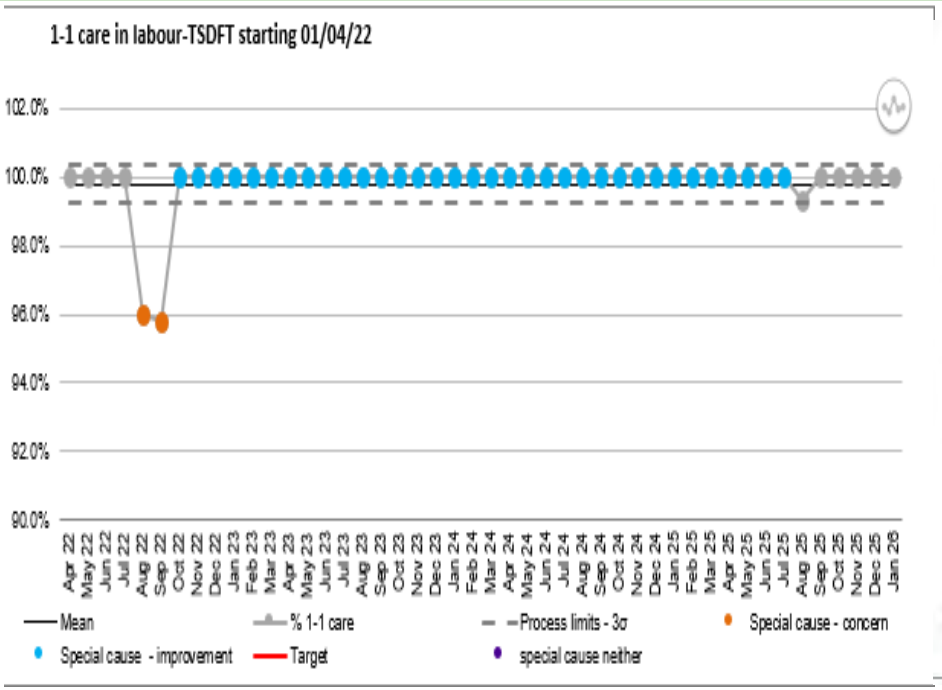
- Mar 2025 – 1 Stillbirth at 35+3
- Apr 2025 – 1 x Stillbirth at 40+5
- May 2025 – 2 x Neonatal Death – Baby born at 32+5, failed resuscitation. 1 Baby born at term with severe Hypoxic Ischaemic Encephalopathy (HIE), transferred to Level 3 Neonatal Unit for therapeutic cooling, care withdrawn on day 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 at 22 weeks - 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.
- December 2025 – Neonatal Death following spontaneous delivery at 18 weeks gestation.
- January 2026 – 1 x Stillbirth at 28+2, 1 x NND 29+1 baby died in UHP due to infection, 1 x Late fetal loss at 21 weeks – confirmed chromosomal anomaly.

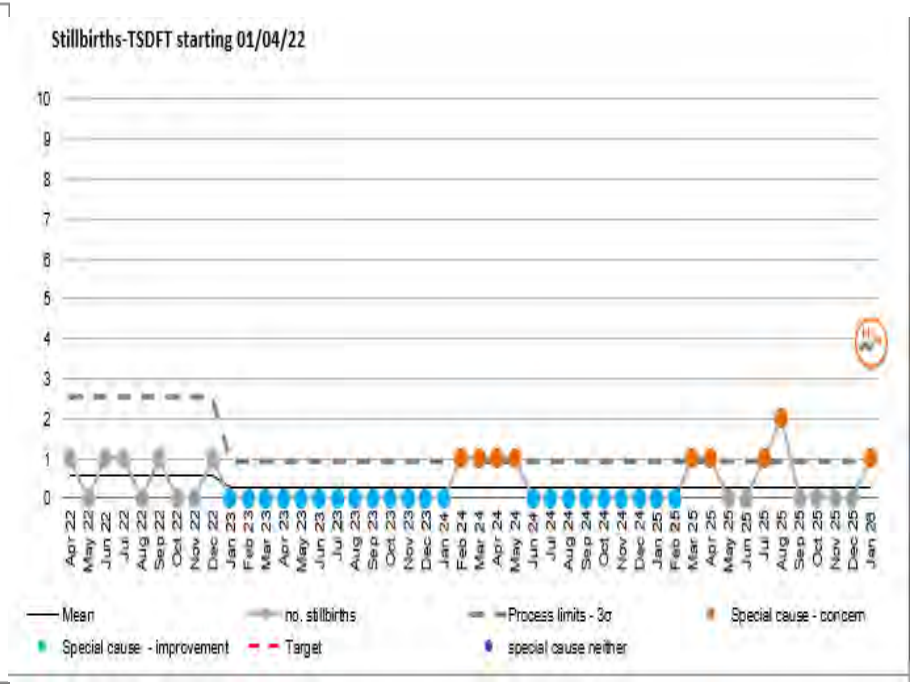
Incidents moderate and above = 2

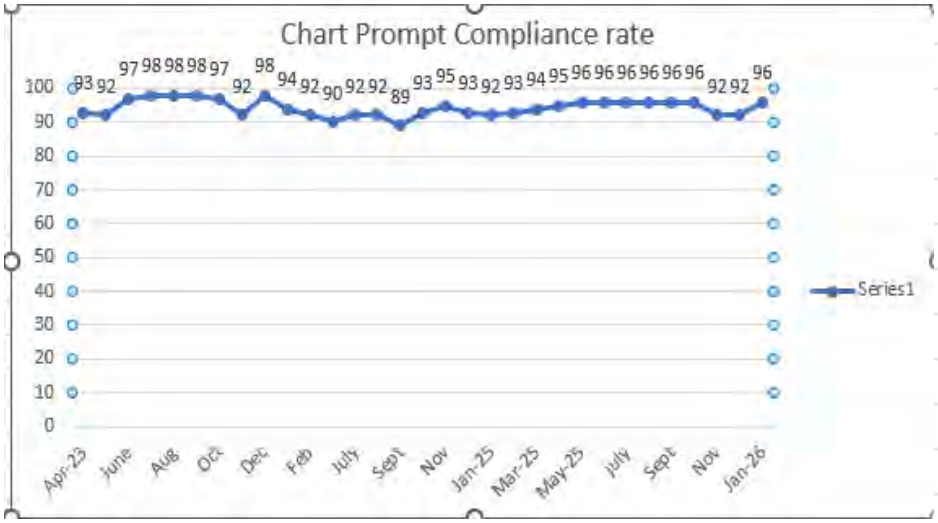
- 1 x Death Caused by the incident - 1 x Neonatal Death at 18/40, showed signs of life at birth.
- 1 Severe – Safeguarding incident reported around harm caused to baby due to maternal mental health following DPT decision to leave family at home.
- 1 Moderate – Bowel Obstruction following LSCS.

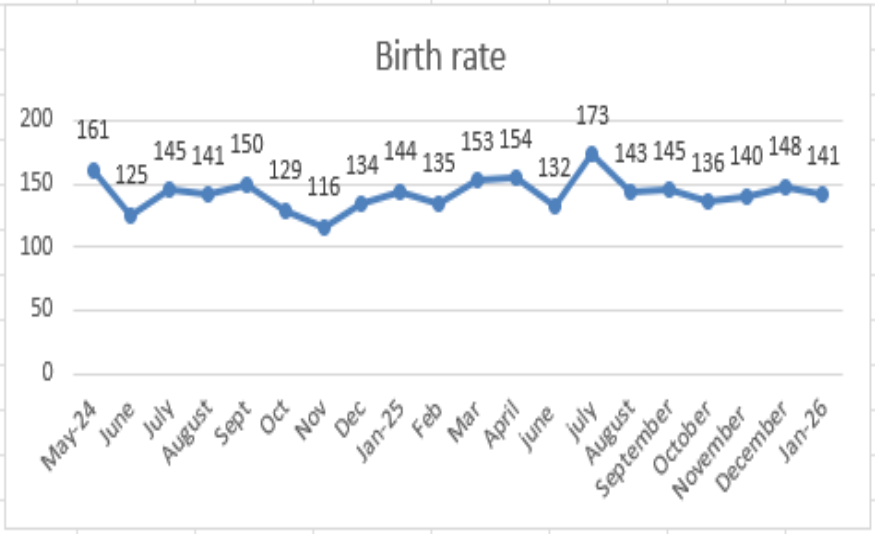
MNSI – None
CQC – None
Coroner referral – Baby born at 29+1/40, Neonatal Death, born her died at UHP (see January deaths above)

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



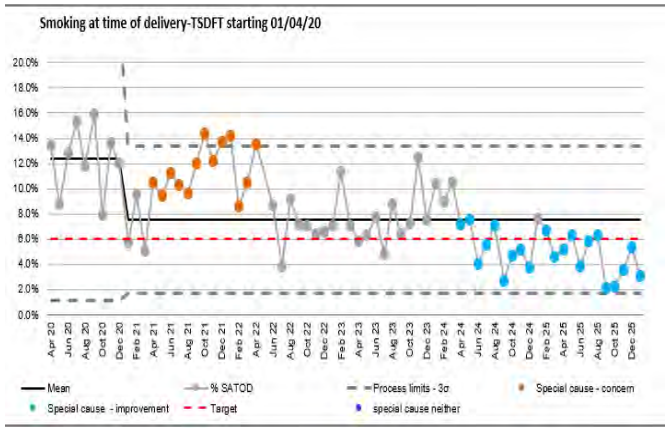


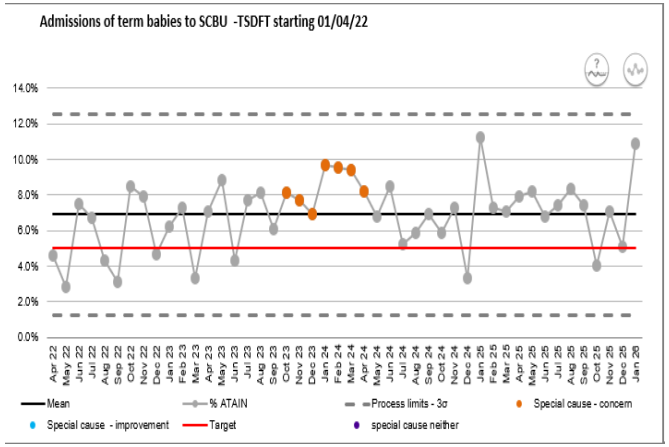


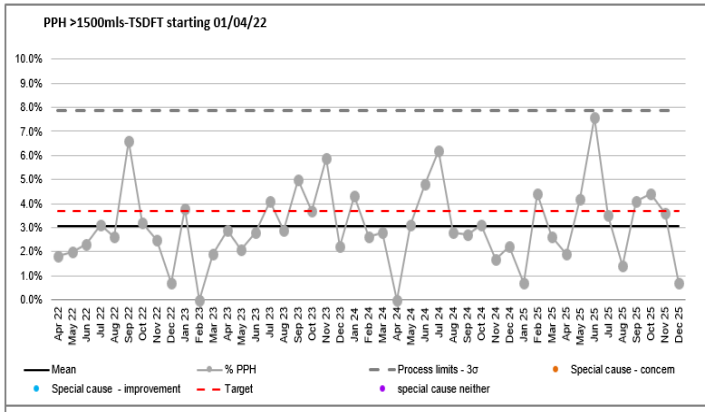


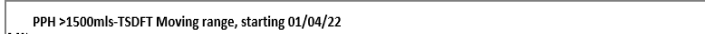
Quality and Safety - Metrics relating to the provision of quality maternity care

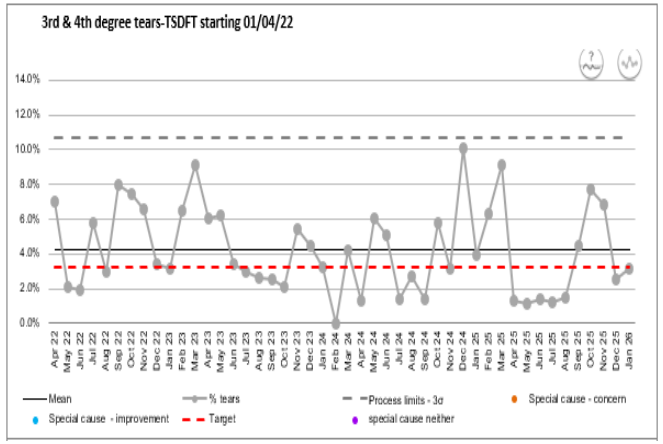
- Births in January – 141
- Significant decrease for the month of January in smoking at delivery 2.2%. Quarterly average of 4% well below the national target of 6%
- Marginal increase in the number of 3rd/4th degree tears from 2.5% in December to 3.1% in January; quarterly average of 4.13%; national target average is 3.2%
- Significant increase in the incidence of PPH>1500mls from 0.7% for December to 4.3% in January; quarterly average @ 2.86% below the national target of 3.7%
- An increase in term baby admissions to SCBU to 10.9%; national target is 5% or less. Higher rate of CS in January which can lead to more term admissions as well as higher rate of weight loss admissions. QI work in place to reduce rate- Screen and Treat at bedside as well as collaborative working with the infant feeding lead.







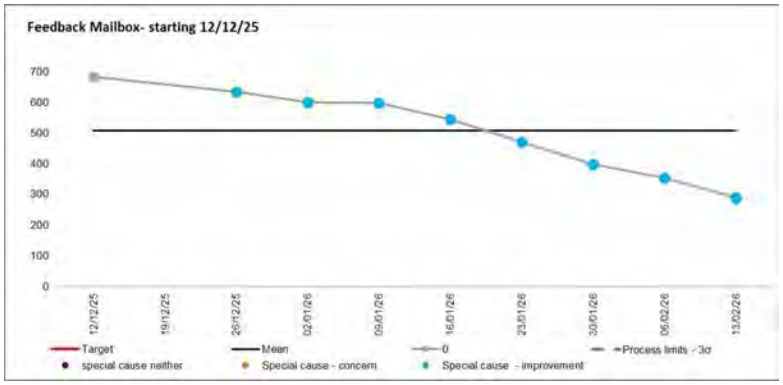




Quality and Safety exception report – Feedback and engagement

Torbay and South Devon NHS Foundation Trust

There are currently 294 (last reported 528) emails in the Feedback Mailbox. Weekly figures are collected to monitor the effectiveness of changes made to reduce the backlog.



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)

Currently, 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. The complaint formal response monitoring is tracked once completed.

Current actions in progress to improve efficiencies:

- Upcoming redevelopment of Feedback DCIQ module to reduce unnecessary admin.
- Recent DCIQ change to enable non mandated case handler field for those managed outside of the team, reducing caseload appearance to allow for more cases to be allocated.
- Removal of CEO address as first point of contact completed, the contact us form to be updated and the implementation of an online complaint form.
- The 2-step pack complaint template is being revised with a view to remove the pack and replace with key complaint points in an email (supported with new complaint contact form), the timeframes, original complaint and letter template with improved formatting. This will reduce administration time.

****Data collected 16.02.2026 – all data subject to change due to re-categorisation and delayed processing**

Quality and Safety – Safer Staffing – Dashboard December 2025

Torbay and South Devon NHS Foundation Trust

Organisational CHPPD	Days				Nights			
	Planned RN	Actual RN	Planned HCA	Actual HCA	Planned RN	Actual RN	Planned HCA	Actual HCA
	2.5	2.3	2	1.9	1.9	1.8	1.5	1.5

Inpatients

Bed Occupancy			Limited
Staffing Fill Rates	Days	RN / Midwives	Satisfactory
		Care Staff	Satisfactory
	Nights	RN / Midwives	Satisfactory
		Care Staff	Satisfactory
Care Hours Per Patient Day	Days	RN / Midwives	Satisfactory
		Care Staff	Satisfactory
		Overall	Satisfactory
	Nights	RN / Midwives	Satisfactory
		Care Staff	Satisfactory
		Overall	Satisfactory
HR Metrics	Sickness Rate		Limited
	Turnover Rate		Limited
	Vacancy Rate		Significant
Temporary Staffing	Prop. Bank Hours		Limited
	Prop. Agency Hours		Limited
Ward Accreditation			Satisfactory
Patient safety metrics			
Safety	Red Flags	EToC Red Flags	Limited
		All Red Flags	Limited
	Mod. Harm Incs and Above		Limited
	Pressure Ulcers G2+ Acq. in Our Care		Satisfactory
	Falls	No Harm	Limited
		Harm	Satisfactory
	Medicine Errors		Limited
	% Obs Completed on Time		Satisfactory
Feedback	Patient Complaints		Satisfactory
	FFT	% Pos. Resp.	Satisfactory
		No. of Resp.	Satisfactory

ED

STAFFING METRICS			Emerg. Dept
Number of Attendances			7,022
Staffing Fill Rates	Days	RN / Midwives	93.3%
		Care Staff	79.5%
	Nights	RN / Midwives	90.3%
		Care Staff	72.0%
Actual Staffing Split	Days	% RN / Midwives Hours	65.7%
		% Care Staff Hours	34.3%
	Nights	% RN / Midwives Hours	67.2%
		% Care Staff Hours	32.8%
HR Metrics	Sickness Rate (Nov-25)		9.4%
	Turnover Rate		14.6%
	Vacancy Rate		-3.9%
Temporary Staffing	Prop. Bank Hours		12.5%
	Prop. Bank Hours		11.8%
Accreditation			Silver

ED

PATIENT SENSITIVE INDICATORS			Emerg. Dept
Number of Unplanned Reattendances			257
Service Delivery Times		% Waiting > 4 Hrs	42.4%
		% Waiting > 12 Hrs	7.4%
		Avg. Triage Time (mins)	15
		Ambulance Handovers < 30 mins	68.4%
Safety		All Red Flags	0
		Mod. Harm Incs and Above	4
		Medicine Errors	2
		PUs G2+ Acquired in Our Care	0
	Falls	No Harm	2
		Harm	6
	Sepsis	% Overall Sepsis 6 Compliance	100%
		% Antibiotics within 1 Hour	100%
Feedback		Patient Complaints	3
	FFT	% Positive Resp. (Jul-25)	100.0%
		Number of Resp. (Jul-25)	28

Quality and Safety – Safer Staffing – Dashboard November 2025

Torbay and South Devon NHS Foundation Trust

CHPPD- Satisfactory Assurance

The Trust overall actual CHPPD is 7.46 this is slightly over the planned target of 7.42. The actual CHPPD for RN/Midwives in December 2025 3.98, this is slightly under the planned target of 4.13. The overall Trust actual CHPPD for HCSW is 3.98. This is slightly over the planned target of 3.27.

This increase in Care staff requirements has been to support Enhanced Therapeutic Observations of Care on inpatient wards where the role has needed to back fill the ECSO role, short term absence, staff redeployment and escalation space. Work remains underway to review the current ETOC provision and how this can be supported through SNCT establishments. During December, the number of patients requiring ETOC rose significantly with an average need of 8 ECSOs per day to cover the service requirements.

December's data remains 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 with an average of 91.5.% this number has remained stagnant since November 25. The average registered fill rate for nights is 94.1 this is a decrease of 1.5% in comparison to November 25 figures. Care staff fill rates on day shifts are 96.9 this is an increase of 1% from November 25. The care staff fill rate for nights is 106.4 % this is an increase of 3.7% from November 25. The increase in fill rates for Care Staff, reflects the increase in demand for the Care staff shifts to back fill for reasons outlined above. It also demonstrates the work that NHSP have been completing in migrating workers from Agencies to the bank. Registrant fill rate remains at the lower end of the 90% tolerance as set out by NHSE. Lower fill rate is concentrated to our fragile services where recruitment of staff is complex. This is due to areas such as ICU, SCBU and cancer Services requiring experienced staff with extended clinical skills to support a service. In these areas there is a focus on recruitment strategy and developing our own staff to ensure a sustainable workforce for the future. Strategic recruitment plans are underway with services such as ED with the aim to improve their workforce pipeline alongside understanding areas wider workforce metrics.

Other drivers for low tolerance in fill rate are Organisational absence this currently resides at 5.9% this is a 0.6% improvement upon November 25. Turnover rate has also increased by 0.4% since October 25 now residing at an Organisational average of 9%. Vacancy rate now reside at 3.4% holding a steady decline. Focused work is being done to reduce the on-boarding timeline which has seen a significant reduction in the number of on boarding days residing at an average of 90 days from time of authorisation. The reduction in the onboarding timeline will support our fill rate and reduce our current requirement of using the temporary workforce to back fill the on-boarding timeline while areas hold vacancies. This is reflected in the current proportion of temporary workforce hours supporting pipelines currently residing at: bank hours resides at 10.7% (an improvement of 2.1%) and agency at 3.2% (an improvement of 0.7). This is an improvement upon November 25 and indicates the work being completed within the recruitment team to reduce the onboarding lag. Focused work remains a high priority as part of the Senior Nurse/ Midwifery weekly Bank and Agency Meeting.

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		↑
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

NHS Torbay and South Devon NHS Foundation Trust

Key

↑ = Performance improved from previous month ↓ = performance deteriorated from previous month ↔ = no change

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

Cancer – 2 week wait from referral to date first seen – regional reporting		↑
Cancer – 28-day faster diagnosis standard		↓
Cancer - 31-day wait from decision to treat to treatment - national reporting		↓
Cancer - 62-day wait for treatment - national reporting		↓
Cancer - Patient waiting longer than 104 days from 2 week wait		↓
Referral to treatment - % Incomplete pathways less than 18 weeks		↓
RTT 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	M9	↓
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	M9	↓

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Torbay and South Devon NHS Foundation Trust

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Operational Plan trajectory Jan 2025
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1981		2532	1625	1268	839	1530	1159	725	943	1823	810	624	559	1283	2034
Average handover time (mins)	45 mins		84	62	47	36	52	45	32	38	60	33	29	27	45	42
Total average time in ED (hours/minutes)			06:20	05:53	05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		818	677	615	415	688	494	457	426	655	585	549	520	918	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		13.8%	9.6%	9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.7%	7.4%	13.3%	7.0%
UEC 4-hour target (RAG against local trajectory to national target)	78%		66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	72.3%
% patient discharges pre-noon	33%		19.9%	21.2%	22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	33%
Elective recovery																
RTT 78 week wait incomplete pathway	0		12	14	7	4	8	8	9	16	13	16	9	9	13	0
RTT 65 week wait incomplete pathway	0		204	215	141	145	126	95	97	105	110	109	84	94	83	0
RTT 52 week wait incomplete pathway	268		1238	1209	931	914	805	740	615	618	615	647	607	663	604	383
RTT % Incomplete pathways <18 wks	66.8%		61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	66.2%	65.9%
RTT Wait for first appointment <18 weeks	70.3%		63.8%	69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	69.9%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		75.6%	83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	78.7%	57.1%	75.8%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	77.7%	78.1%
Cancer: No of patients waiting >62 days to start treatment	138		95	94	111	133	225	223	220	257	176	132	91	119	159	138
Cancer: % of patients > 62 days to start treatment	tbc		6.0%	5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	5.9%	7.6%	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 - January 2026

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Year to date
QUALITY LOCAL FRAMEWORK																	
Reported Incidents - Moderate	Trustwide	Trend		54	38	29	39	50	46	49	36	53	51	38	56	50	
Reported Incidents - Severe	Trustwide	<6		5	2	3	3	5	1	2	5	4	3	3	4	8	38
Reported Incidents - Death	Trustwide	<1		1	1	3	3	2	1	1	2	0	0	2	4	3	18
Medication errors resulting in moderate or more severe harm	Trustwide	<1		0	0	0	2	1	0	0	0	0	1	2	3	1	10
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)	Trustwide	Trend			25	24	24	36	26	29	20	27	29	20	27	29	
Never Events	Trustwide	<1		1	0	0	1	0	0	0	0	0	0	0	0	1	2
Number of Patient Safety Incident Investigations (PSII)	Trustwide	Trend		1	0	2	4	2	0	0	1	3	1	0	0	1	
Formal complaints - Number received	Trustwide	20		18	11	20	20	30	33	46	30	23	20	10	14	6	232
Formal complaints - not acknowledged in 3 days	Trustwide	Trend		1	0	2	6	25	28	30	20	18	7	7	8	4	
Formal complaints - closed in 6 months	Trustwide	Trend		11	9	8	11	5	10	10	11	18	14	13	18	16	
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		106.2	106.5	104.7	104.6	103.7	104	103.6	104.6	105.1					
Safer staffing fill rate - ICO - Day time	Trustwide	90% - 110%		88.2%	87.8%	89.6%	93.6%	91.5%	92.4%	93.0%	90.9%	91.2%	90.2%	92.1%	92.0%	91.5%	
Safer staffing rate - ICO - Night time	Trustwide	90% - 110%		91.5%	93.1%	94.1%	93.2%	91.8%	94.0%	94.6%	94.4%	95.1%	95.3%	96.6%	95.6%	94.1%	
Number of Healthcare Associated Infection: MRSA	Trustwide	Trend		1	0	0	0	0	0	0	0	0	0	0	0	0	
Number of Healthcare Associated Infection: E-Coli	Trustwide	Trend		3	7	2	5	5	7	8	10	2	9	3	8	6	
Number of Healthcare Associated Infection: MSSA	Trustwide	Trend		2	1	2	4	2	4	1	5	2	3	5	5	2	
Nutrition risk assessment within 24 hours	Trustwide	>95%		92.6%	93.0%	93.9%	94.9%	94.4%	94.4%	94.3%	93.7%	92.1%	92.3%	92.3%	92.5%	92.6%	
Falls for 1000 bed days	Trustwide	<5.5		5.8	5.2	6.3	6.4	6.1	5.7	5.7	5.6	4.3	6.0	4.9	5.4	7.0	
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		75.6%	75.0%	73.2%	46.5%	70.7%	61.8%	68.1%	47.4%	55.0%	70.3%	75.8%	51.0%		
Stroke - % patients admitted to stroke unit within 4 hours	Trustwide	>50%		34.0%	25.0%	50.0%	37.0%	37.0%	47.3%	28.0%	46.4%	50.0%	49.1%	34.1%	52.9%	34.0%	
Mixed Sex Accommodation breaches	Trustwide	Trend		125	112	163	208	94	265	200	124	220	190	160	222	186	1869
Follow ups 6 weeks past to be seen date	Trustwide	6400		17997	18005	17361	18380	17843	18040	18486	19016	18135	16900	17610	17827		
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%	5.1%	5.1%	5.1%	5.2%	5.3%	5.3%		
Appraisal Completeness	Trustwide	>90%		78.8%	78.5%	79.6%	78.9%	79.8%	79.5%	80.2%	80.5%	80.5%	80.5%	78.8%	78.9%	78.7%	
Mandatory Training Compliance	Trustwide	>85%		88.6%	88.7%	89.0%	89.0%	84.7%	85.3%	85.0%	85.4%	85.5%	86.2%	86.2%	87.9%	85.9%	
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.9%	11.2%	11.1%	11.3%	11.0%	11.0%	10.9%	10.9%	10.8%	10.8%	11.1%	12.8%	12.9%	
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		17.9%	18.1%	18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.0%	18.1%	18.1%
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%							5.7%			6.9%			6.7%		
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET							631	612	568	526	515	503	506	472	

Torbay and South Devon NHS Foundation Trust

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Performance Report - January 2026

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Year to date
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		329	270	273	239	240	223	235	199	215	264	229	207	242	2293
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		194	193	221	204	202	204	211	166	190	241	208	208	231	2065
Community Hospital Length of Stay (days) - (general)	Community Hospital	NONE SET		14.8	14.0	13.2	13.9	14.2	13.4	14.3	15.5	15.7	13.9	12.9	14.2	14.5	14.2
Community Hospital % patient discharges pre-noon	Community Hospital	33%		52.0%	55.0%	50.0%	50.0%	47.0%	47.0%	49.0%	50.0%	48.0%	45.0%	47.0%	44.0%	45.0%	
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	80% ICB target		91.5%	89.5%	87.4%	87.7%	88.8%	87.8%	89.9%	85.8%	90.4%	91.3%	94.5%	91.8%	92.2%	90.1%
Urgent Community Reponse (2 hour) - Number of referrals	Trustwide	157		236	181	215	219	197	172	227	232	251	299	220	243	230	2290
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		28.7	28.7	30.0	26.1	23.5	20.9	31.1	24.6	24.6	24.6	24.6	22.1	23.4	23.4
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		820.3	830.8	907.3	772.8	778.1	783.4	750.6	721.9	687.9	737.6	742.8	729.7	753.3	753.3
Proportion of clients receiving direct payments	Trustwide	25%		17.9%	18.1%	18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.0%	18.1%	18.1%
% reablement episodes not followed by long term SC support	Trustwide	83%		87.0%	86.6%	86.2%	86.1%	86.9%	88.3%	89.1%	88.8%	88.9%	88.6%	88.9%	89.1%	89.1%	89.1%
PERFORMANCE FRAMEWORK																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		59.4%	65.4%	62.6%	38.5%	33.5%	31.7%	31.7%	24.9%	30.9%	38.0%	38.9%	37.0%	37.6%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		92.3%	91.1%	91.7%	89.9%	93.3%	90.7%	91.4%	88.9%	91.4%	91.1%	93.1%	92.9%	92.7%	
Cancer - 62-day wait for treatment - national reporting (2024/25 target 70%) (2025/26 target 75%)	Trustwide	75%		74.3%	68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	77.7%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		18	17	19	26	22	52	24	28	29	21	21	20	27	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		61.3%	62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	66.2%	
On the day cancellations for elective operations	Trustwide	<0.8%		0.9%	1.4%	0.8%	0.9%	0.8%	1.3%	1.3%	1.1%	0.7%	0.8%	0.7%	0.9%	0.9%	
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		1	0	3	3	5	11	21	11	11	17	17	14	11	
Theatre Utilisation	Trustwide	85%		80.7%	84.6%	83.1%	82.7%	83.2%	81.1%	76.7%	82.3%	82.7%	83.2%	81.8%	80.3%	82.8%	
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		17.5%	16.5%	16.3%	17.0%	15.7%	16.2%	15.9%	16.7%	15.9%	14.6%	15.6%	15.5%	16.9%	
Bed Occupancy	Acute	90%		96.7%	96.0%	95.8%	95.2%	95.9%	96.1%	96.0%	95.3%	96.8%	96.7%	96.5%	95.2%	97.5%	
% patient discharges pre-5pm	Acute	75%		69.9%	70.4%	73.0%	71.8%	71.0%	72.6%	75.3%	71.4%	68.3%	66.0%	68.8%	69.5%	68.9%	
Percentage of inpatients with No Criteria to Reside (Torbay GP registered patients)	Acute	<5%		7.7%	10.9%	6.9%	7.8%	8.7%	7.6%	8.8%	6.5%	9.3%	11.9%	7.8%	9.0%	10.7%	
Percentage of inpatients with No Criteria to Reside (South Devon GP registered patients)	Acute	<5%		12.6%	10.8%	10.0%	10.4%	8.4%	9.9%	9.7%	8.3%	10.0%	12.8%	10.6%	14.0%	14.4%	
Average length of stay (days) - discharges from main acute wards	Acute			6.3	6.5	5.8	6.0	5.9	5.9	5.9	5.9	6.1	5.9	5.6	6.3	7.0	
Number of patients >7 days LoS (daily average)	Acute	153		160.6	161.4	139.2	151.5	144.2	148.0	149.2	149.2	159.6	158.3	161.9	169.6	178.2	
Number of extended stay patients >21 days (daily average)	Acute	35		38.2	34.0	32.3	35.7	32.5	31.5	28.4	38.8	42.5	39.3	43.7	47.7	48.9	
Ambulance handover delays > 30 minutes	Acute			1243	1098	966	720	1122	951	716	804	1250	933	957	813	1277	9543
Ambulance handover delays > 60 minutes	Acute	0		850	679	521	307	601	531	302	390	764	203	121	103	450	3772
UEC - patients seen within 4 hours (2025/26 plan target 78%)	Trustwide	78%		66.7%	68.8%	70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	70.7%

Torbay and South Devon NHS Foundation Trust

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

Performance Report - January 2026

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Year to date
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute			66.7%	67.6%	60.0%	63.3%	58.0%	58.7%	60.9%	63.7%	60.4%	65.3%	65.1%	66.4%	62.7%	
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute			27.6%	26.2%	24.2%	25.7%	28.3%	23.6%	22.0%	19.7%	25.6%	21.8%	21.3%	22.5%	25.5%	
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute			04:19	04:01	04:00	03:52	04:10	03:54	03:48	03:50	04:07	04:10	04:03	03:59	04:14	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute			10:12	09:51	08:25	07:12	08:59	08:04	07:08	07:05	08:58	08:15	08:05	08:16	11:37	
Diagnostic tests longer than the 6 week standard	Trustwide	5%		40.0%	31.7%	31.8%	32.4%	37.8%	34.0%	37.0%	37.0%	37.0%	29.0%	28.0%	30.0%	36.0%	
Dementia - Find - monthly report	Trustwide	>90%		95.7%	97.2%	97.3%	96.2%	96.5%	96.8%	93.6%			94.9%	96.9%	94.6%		95.9%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		83.0%	76.5%	77.5%	83.6%	81.9%	75.7%	80.0%	77.5%	77.8%	77.5%	71.4%	73.8%	75.8%	77.5%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		69.6%	64.0%	65.2%	67.5%	61.0%	64.6%	62.5%	60.8%	58.0%	60.6%	67.2%	63.5%	60.6%	62.7%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		75.4%	76.5%	65.6%	71.9%	68.1%	74.9%	76.0%	79.3%	72.2%	72.1%	74.4%	63.2%		
ERF activity 2025/26 vs 2019/20 baseline																	
Day cases										117%	112%	120%	109%	99%	101%	105%	112%
Elective inpatient admissions										79%	94%	86%	87%	69%	78%	88%	84%
Admitted Patient Care Total										112%	110%	116%	106%	96%	98%	103%	108%
Outpatient - first appointment										97%	99%	114%	108%	109%	104%	100%	104%
Outpatient - first appointment with procedure										155%	172%	131%	130%	131%	143%	141%	146%
Outpatient - follow-up with procedure										136%	120%	117%	126%	141%	118%	104%	133%
Outpatient Appointment Total										117%	114%	117%	117%	123%	113%	106%	119%
ERF Income Grand Total (% above 2019/20)		114%								113%	112%	124%	113%	109%	109%	105%	116%
Non-ERF activity 2025/26 vs 2024/25																	
Non-elective admissions											102%	110%	110%	104%	100%	100%	105%
UEC attendances (Type 1 and 3)											105%	105%	106%	109%	94%	109%	104%
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%		

Safer Staffing Dashboard - Emergency Care (ED Only) - December-2025

Torbay and South Devon NHS
NHS Foundation Trust

STAFFING METRICS			Emerg. Dept
Number of Attendances			7,022
Staffing Fill Rates	Days	RN / Midwives	93.3%
		Care Staff	79.5%
	Nights	RN / Midwives	90.3%
		Care Staff	72.0%
Actual Staffing Split	Days	% RN / Midwives Hours	65.7%
		% Care Staff Hours	34.3%
	Nights	% RN / Midwives Hours	67.2%
		% Care Staff Hours	32.8%
HR Metrics		Sickness Rate (Nov-25)	9.4%
		Turnover Rate	14.6%
		Vacancy Rate	-3.9%
Temporary Staffing		Prop. Bank Hours	12.5%
		Prop. Bank Hours	11.8%
Accreditation			Silver

PATIENT SENSITIVE INDICATORS			Emerg. Dept
Number of Unplanned Reattendances			257
Service Delivery Times		% Waiting > 4 Hrs	42.4%
		% Waiting > 12 Hrs	7.4%
		Avg. Triage Time (mins)	15
		Ambulance Handovers < 30 mins	68.4%
Safety		All Red Flags	0
		Mod. Harm Incs and Above	4
		Medicine Errors	2
		PUs G2+ Acquired in Our Care	0
	Falls	No Harm	2
		Harm	6
	Sepsis	% Overall Sepsis 6 Compliance	100%
		% Antibiotics within 1 Hour	100%
Feedback		Patient Complaints	3
	FFT	% Positive Resp. (Jul-25)	100.0%
		Number of Resp. (Jul-25)	28

Safer Staffing Dashboard - Emergency Care (ED Only) - December-2025 - Assurance

Torbay and South Devon NHS
NHS Foundation Trust

Measure			Assurance Summary[1]	Narrative	Mitigation	Actions
STAFFING METRICS						
Staffing Fill Rates	Days	RN / Midwives	Satisfactory	Care staff fill rate for both days and nights remain below the 90% tolerance in the department. This reflects the current vacancy rate for HCSW which remains elevated. Strategic work is underway to support ED recruitment and pipeline planning with focused ED adverts and the relaunch of the HCSW new to care pathway.	Twice daily staffing meetings ensure all areas staffing levels are reviewed. To manage risk where there are short fall in staffing matrons and ADNPPS redeploy staff using the safe care tool. Working in partnership with NHS P to improve temporary staff recruitment to cover unavailability. Recruitment support is being given to clinical areas that require a workforce with a specific or extended clinical skill set	To apply the Safer Staffing SOP to ensure safecare is used to its potential to capture real time staffing and patients risks at the bedside. Review of the Extended care provision across the trust to support enhanced care and the unfilt HCW hours. Recruitment are working with clinical leads to support fragile services and areas where there are vacancies.
		Care Staff	Limited			
	Nights	RN / Midwives	Satisfactory			
		Care Staff	Limited			
HR Metrics		Sickness Rate	Limited	December 2025 has seen an increase in the departments absence rate rising from 9.1% to 9.4%. Staff turnover has also seen an increase inline with this increasing from 14.6 % in December 25 from 14.2% in October 25. Vacancy rate although green at -3.9% must be treated with caution due to the elevated turnover rate; meaning that the vacancy position for the department fluctuates frequently.	Our clinical leaders are following the trust wide **absence management policy** to both support staff returning to work. **Vacancy and turnover rate is monitored** by our senior leaders and reported on as part of our trust wide workforce (myhelp) governance process. To continue to report on clinical areas unavailabilities as part of our weekly senior leaders bank and agency meetings.	To **review sickness rate as part of the weekly bank and agency meeting**, including **review of the weekly head room report**. For Leaders to be robust in following HR policies. **Centralised recruitment events** to support filling NI vacancies across the trust.
		Turnover Rate	Limited			
		Vacancy Rate	Limited			
Temporary Staffing		Prop. Bank Hours	Limited	Use of temporary staffing within the department is red. In December 2025 saw the proportion of bank staff at 12.5% a decrease of 3.2% and agency use at 11.8% a decrease of 5.3% since November 25.This highlights the great work that the team are completing to support agency migration to bank and fcused efforts to plan ahead to fill vacancies.	Twice daily staffing meetings ensure all areas staffing levels are reviewed. To **manage risk where there are short fall in staffing matrons and ADNPPS redeploy staff using the safe care tool**. This also ensures that the **correct skill mix of staff** are being evenly distributed across the organisation. To work with **NHS P to prioritise bank workers over agency use**. **To prohibit use of off framework agencies**. Introduction of SOP for use of bank and agency shifts. Introduction of Assurance and mitigation form for use of overtime. To work with recruitment to reduce on boarding timeline	To **review proportion of bank and agency hours as part of the weekly bank and agency meeting**, including review of the weekly head room report. To **report as part of the workforce council to ensure governance and oversight**. To continue work as part of the **wider system** to manage agency spend, alongside other **workforce controls**. To review bank and agency spend at weekly senior nurse meetings. To share booking themes and trends shared with us by NHS P
		Prop. Bank Hours	Limited			
Accreditation			Satisfactory			
PATIENT SENSITIVE INDICATORS						
Number of Unplanned Reattendances						
Service Delivery Times		% Waiting > 4 Hrs	Satisfactory	4 hour waits have decreased in Deember 25 by 2.8% now residing at 42.4%. 12 hour waits have also decreased to 7.4% and average triage time has improved to 15 mins as opposed to 16 mins in October 25. Ambulance handover times has increased upon November 25 to 68.4% this is an increase of 5.2%.	THP 45 protocol now embedded to support this the Trust has a well practiced surge SOP. This support timely handover of patients , ensuring patients are off loaded from ambulances and care for in one of the Trusts escalated areas. Focused work is also underway looking at discharges and use of the discharge lounge to supportpatient flow.	To ensur robust use of the Surge SOP. To collect Trust data on discharge to understand blockers for discharges. To collect, reprt and review data trends for use of escalated areas.
		% Waiting > 12 Hrs	Satisfactory			
		Avg. Triage Time (mins)	Satisfactory			
		Ambulance Handovers < 30 mins	Limited			
Safety		All Red Flags	Satisfactory	Throught December 25 the Department has seen its safety metrics fluctuate. Great work has been completed and reflected in the reduction of G2 pressure ulcers resulting in 0 for December 25. There has been 4 moderate events, 6 falls resulting in harm and 2 medicine errors. The medicine errors triangulates with the risk of increased use of temporary workforce, raised turn over rate and absence rate. These safety metrics are a further reason to focus on ensuring the Department is fully recruited and able to support staff within the working environment to ensure a sustainable workforce. There has been excellent work	To ensure staff are raising ETDC red flag to highlight where shift are not being filled. To ensure areas are being using red flags to capture **real time risks for staff and patients**. Red flags are discussed as part of the twice daily staffing meetings. **Escalation to mitigate red flags can be seen in the Safer Staffing SOP.**	To launch and embed **OneDevon Safer Staffing SOP** and embed across the ED. For the **ETDC lead nurse** to work with senior leaders to ensure that ETDC red flags are being used to highlight risks across the organisation
		Mod. Harm Incs and Above	Limited		Review daily high risk areas at twice daily staffing meeting, ensuring that they have appropriate skill mix and substantive staff on shift	All incidents follow a robust process where **duty of candour** is completed. Learning is shared embedding a **'just culture'**. **Report of trends to indicate where patient demand is needed to reduce risks.**
		Medicine Errors	Limited		Review daily high risk areas at twice daily staffing meeting, redeploy staff in accordance to risk and patient dependency. To work with **clinical governance to ensure learning is shared** around incidents raised about pressure ulcers	For senior leaders to follow the escalation process within the One Devon safer staffing SOP. **Robust governance process and timely review of Datix and response**. Where harm has been caused **AARs are completed. Trends across the directorate are reported to the Quality and Safety group.**
		PUs G2+ Acquired in Our Care	Satisfactory			
	Falls	Falls - No Harm	Limited		**Review high risk areas** twice a day as part of the **staffing meeting, redeploy staff in accordance to risk and patient dependency.**	**Organisational falls to be reported on and shared at the Quality and Safety group with keys trends being shared. The Falls link nurse** to be an active presence in **staff training.** Falls lead to feed into **national work to ensure with are aligning with guidance.**
	Falls	Falls - Harm	Limited			

	Sepsis	% Overall Sepsis 6 Compliance	Satisfactory	completed despite these challenges with the Sepsis 6 protocols residing at 100% for all patients that meet the criteria for antimicrobial treatment.	To ensure where temporary staff are used they are supported by the ward manager in their supervisory role. To track complaints and datix reporting to improve learning on how staff can be supported. Appropriate staff skill mix is discussed at the daily staffing meeting and where appropriate redeployed to support risk across areas.	To review medicine error trends and themes as part of the trustwide safety and quality group. For skill mix to be discussed daily at staffing meetings. For skill mix to be reviewed at 1st and 2nd approval. To work with ward 8 to monitor complaints, themes and trends with temporary staffing.
		% Antibiotics within 1 Hour	Satisfactory		Data is reported monthly and sent to clinical leads for actions. Where compliance is below 85% this is managed within care divisionates by the ADNPPs.	Monthly compliance remit to be sent to ADNPP and trends to be escalated via care groups.
Feedback		Patient Complaints	Satisfactory	The Department has seen 3 complaints for December 25. This is a further improvement. 100% of patient feedback was also positive relfecting the kind, caring and compassionate workforce that we have working in the department.	Where harm is caused a **full investigation** is completed and reported on using the **Datix platform**. Timelines for complaint reponses are clear and where they can not be met this is escalated to the DCNO, PALS and patient, family member and or relative.	All complaints are reported on Datix. **Trends and themes are discussed are the trustwide safety and quality group.**
	FFT	% Positive Resp.	Satisfactory		QR codes have been developed for all clinical areas to ensure that accessibility of providing feedback has improved. Where the patient group are unable to use QR codes volunteers have been used to support patients in completing feedback questionnaires. There is a monthly trust wide report so our senior leader can track the number of responses and work within their care group to improve upon this.	Report monthly on patient reponses themes and trends. To ensure areas who are not yet collecting data are supported by their ADNPP to begin the data collection process.
		Number of Resp.	Satisfactory			

[1] *Definitions for the Assurance Summary categories are given in the 'Notes and Definitions' section of this document.*

Torbay and South Devon NHS Foundation Trust

Quality and Assurance People Committee

Combined Gender,Ethnicity, Disability Pay Gap Report

Date of meeting	Date report produced
27 January 2026	20 January 2026

Author(s)		Report approved by	
Name and title:	Sharifa Milford Al Hashemy, Interim Joint Head of Inclusion, Diversity and Equity and Monish Mohandas Meyana, Equality Diversity and Inclusion Officer	**Name and title:**	Jessica Piper, Acting Chief People Officer
		Date:	20 January 2026

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

Executive summary

This combined executive summary presents the Trust's Gender, Ethnicity and Disability Pay Gap outcomes for the 2026 reporting year.

The reports show that while the Trust demonstrates broadly equitable pay across the majority of staff, there remain gaps in senior and medical roles, particularly among consultants, leadership positions, disabled staff, and colleagues from global majority background.

Overall summary

- Median gender pay gap for Torbay trust is significantly lower than both the national and industry specific benchmarks.
- Women, disabled and colleagues from global majority background remain under-represented in higher-paid roles, especially consultant and senior AfC bands. This is a key driver across all pay gaps.
- Colleagues from a Global Majority background earn higher than White

colleagues on both mean and median measures, but representation is still much lower in higher-paid quartiles, showing progression barriers despite positive pay indicators.
- Disabled colleagues earn 10.94% less (mean) and 12.27% less (median) than non-disabled colleagues, with fewer disabled staff in higher bands.
- Consultant pay is the biggest structural driver influencing mean gaps across gender, ethnicity, and disability. When consultants are removed from the data, all pay gaps reduce significantly.

Action for improvement

The Trust has established Global Majority Staff Network, a Disability Staff Networks and Neurodiversity Staff Network, which provide structured and safe spaces for colleagues to share their lived experiences and raise awareness of barriers they may be facing within the organisation. These networks play a vital role in informing our understanding of the challenges experienced by under-represented groups and help guide our improvement plans. While staff networks alone will not close the disability or ethnicity pay gaps, they are a critical enabler of change, offering insight, support, and a platform for colleagues' voices to influence Trust policies, culture, and decision-making.

There must be a comprehensive review of our recruitment and attraction practice particularly looking at approaches that will ensure we increase recruitment to under-represented groups, specifically across senior leadership and medical roles. The review will be aligned with the Cultural Ambassador role programme, which has been recently implemented and will play a significant part in promoting equality, diversity and inclusion across our recruitment process and challenging conscious and unconscious bias.

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
Gender Pay Gap	Satisfactory	Satisfactory
Ethnicity Pay Gap	Satisfactory	Satisfactory
Disability Pay Gap	Satisfactory	Satisfactory

Appendices

Appendix 1 - Gender Pay Gap Report
Appendix 2 - Ethnicity Pay Gap Report
Appendix 3 - Disability Pay Gap Report

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

No previous discussions or approvals have taken place.

Key recommendations and actions requested
The Committee are asked to AGREE the overarching assurance rating and take SATISFACTORY assurance as to those matters reviewed.

How does this report further our Trust strategy?
This report supports the Trust's strategic objectives by promoting equity, inclusion, and workforce excellence. By providing transparent analysis of Gender, Disability, and Ethnicity pay gaps, the Trust can identify areas of inequality, implement targeted interventions, and monitor progress over time.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	By promoting equity, inclusion, and fair pay across Gender, Disability, and Ethnicity groups, the Trust supports a motivated and engaged workforce. A satisfied and supported workforce is better able to provide high-quality care, improving population health outcomes.
Quality of services provided	Addressing pay gaps and under-representation in senior roles ensures that leadership and decision-making reflect diverse perspectives. Inclusive workforce practices help maintain high standards of care, innovation, and patient safety across services.
Sustainable and efficient use of resources	Transparent pay gap reporting and targeted interventions allow the Trust to retain talent, reduce turnover, and optimise workforce planning. Efficient allocation of resources is supported by equitable reward systems and fair career progression opportunities, contributing to long-term organisational sustainability.

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

Finance	

Risk
N/A

Risks lodged on Datix:
N/A

External Standards affected by this report and associated risks
Equality Act 2010 Statutory Gender Pay Gap Reporting NHS Workforce Race Equality Standard (WRES) NHS Workforce Disability Equality Standard (WDES)

Pay Gap Reporting – Gender, Ethnicity and Disability

1. Introduction and background

At Torbay and South Devon NHS Foundation Trust we publish three annual pay gap reports comprising of a gender pay gap report, ethnicity pay gap report and disability pay gap report.

From 2017, any organisation that has 250 or more employees must publish and report specific figures about their gender pay gap. The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings.

The Trust must both:

- publish their gender pay gap data and a written statement on their public-facing website;
- report their data to the government online using the gender pay gap reporting service.

This report fulfils our legal obligation to produce and comment upon the following data with regards our gender pay gap:

- mean gender pay gap;
- median gender pay gap;
- mean bonus gender pay gap;

- median bonus gender pay gap;
- proportion of males and females receiving a bonus payment and proportion of males and females in each pay quartile.

Whilst submitting ethnicity or disability pay gap data or producing a report is not required reporting under the Equality Act (2010) in the same way as the gender pay gap reporting, there is an understanding that this may happen in the coming year or so. As part of our commitment to inclusion and understanding the intersectional experience of our staff we have been producing the ethnicity pay gap and disability pay gap for the last two years for our own assurance and action planning.

2. Purpose of report

These reports form part of our annual pay gap reporting, whilst the Gender Pay Gap report is legally mandated, the Disability Pay Gap and Ethnicity Pay Gap reports are not and they form part of our commitment to widen our approach to inclusion. It is expected that the Disability Pay Gap and Ethnicity Pay Gap reporting will become legally mandated in the coming years.

3. Analysis and Key Conclusions

It is worth noting that the pay gap is different from equal pay. Equal pay is covered by the Equality Act 2010 and requires all employers to pay the same for work of equal value. Pay gap reporting uses the median as the most reliable and widely used measure of pay equity as the mean allows the outliers to distort the measure. It is also worth noting that pay gaps are difficult to influence directly, the challenge is in how we create a culture which is inclusive and treats everyone equally well, ensuring we action plan to support this piece. It is clear from all three reports that the gap in Torbay trust exists at senior leadership roles (8a+), meaning that we have proportionately less people identifying as female, disabled or from a Global Majority in senior leadership role in our Trust. Where we have seen improvements has been as a result of our wider inclusion and cultural work which has supported the development and progression of underrepresented groups, allowing them to better progress in our Trust.

The data in these reports is based on snapshots taken on 31st March 2025. Throughout the reports, when data is labelled “2026” this refers to the year of publishing our pay gap reports (so the data is from 2025).

The value of these reports is, in making year-on-year comparisons and benchmarking nationally. We can compare our performance with our own results submitted previously and we have used data from other organisations who have submitted their data, to widen our benchmarking.

It is also of note that reporting disability and ethnicity on ESR is not mandated, as such we have a number of incomplete records. The pay gap reports provide us with an indication of the work we need to do, and we use them alongside our Workforce Disability Equality Standard and Workforce Ethnicity Equality Standard reporting to better understand and plan our activity for the coming year. As such these reports are not treated by the Trust as standalone mechanisms in understanding inequity, but rather as part of a suite of data which we use to design our cultural plan and work.

4. Key Risks, issues and action

We continue to see benefit in our pay gap reporting with notable improvements in our Gender Pay gap, but there remains inequity in particular at accessing senior leadership roles for women, people from a Global Majority and disabled staff. Our reports suggest a number of actions associated with supporting us to move towards a more equitable position for all.

It is proposed that we take two approaches for our assurance, one is around our overall recruitment processes to posts at Band 8a and above due to the under representation of all groups at a senior level which are part of the pay gap. Secondly, we need to review our AACE interviews to understand the process and likely successful candidates. Assurance over our practices will enable us to understand if the bonus pay concern is a local one or related to the national AACEA scheme.

It is worth noting for the Ethnicity Pay Gap Report that whilst the mean and media tell us that people from a Global Majority background earn more than their white counterparts, the reality is that the middle bandings *Band 5 and Band6) give false assurance due to the comparative over representation of people from a Global Majority background at other bandings. To ensure we understand the reality behind the initial data we carry out further analysis at banding levels as includes in the report.

The Cultural Ambassador role and programme will also ensure the Trust is promoting equality, diversity and inclusion through our recruitment and other HR practices. Through a comprehensive review the Trust must consider how it will completely modernise its recruitment process including how it attracts candidates from under-represented groups and assesses skills and capability.

5. Assurance recommendations and summary

The Committee are asked to note the findings from the Trusts Gender, Ethnicity and Disability Pay Gap Reports and actions for improvement.

It is recommended that, the Committee AGREE the overarching assurance rating and take SATISFACTORY assurance as to those matters reviewed.

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Gender Pay Gap	Satisfactory	Satisfactory
Ethnicity Pay Gap	Satisfactory	Satisfactory
Disability Pay Gap	Satisfactory	Satisfactory

Torbay and South Devon NHS Foundation Trust

Gender Pay Gap Report (March 2026)

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Torbay and South Devon NHS Foundation Trust

Introduction

From 2017, any organisation that has 250 or more employees must publish and report specific figures about their gender pay gap. The gender pay gap is the difference between the average earnings of men and women in an organisation, expressed relative to men's earnings. The gender pay gap is different from equal pay. Equal pay is covered by the Equality Act 2010, and requires employers to pay men and women the same for work of equal value

The Trust must both:

- publish their gender pay gap data and a written statement on their public-facing website;
- report their data to the government online using the gender pay gap reporting service.

This report fulfils our legal obligation to produce and comment upon the following data with regards our gender pay gap:

- mean gender pay gap;
- median gender pay gap;
- mean bonus gender pay gap;
- median bonus gender pay gap;
- proportion of males and females receiving a bonus payment and proportion of males and females in each pay quartile.

It should be noted that no bonuses are paid within the Trust as part of pay packages; however, for the purposes of the Gender Pay Gap report, ACCIA[1] payments, part of a national scheme are classified as a bonus.

Other than for medical and dental staff (doctors and dentists), Apprentices, Non-Executive Directors and Very Senior Managers, all other jobs are evaluated using the national Agenda for Change (AfC) job evaluation scheme. This process evaluates the job and not the post holder and makes no reference to gender or any other personal characteristics of existing or potential job holders. VSM's include Executive Directors and a small number of other senior posts.

The data in this report is based on a snapshot taken on 31st March 2025.

Throughout this report, when data is labelled "2026" this refers to the year of publishing our gender pay gap report (data from 2025). Similarly, references to "2025" refer to this report, published in 2025, but using data from 2024.

The value of this report is, in making year-on-year comparisons and benchmarking nationally. We can compare our performance with our own results submitted in March 2025 and we have used data from other organisations who have submitted their data based on the March 2025 snapshot, to widen our benchmarking.

Executive summary

The report outlines Torbay and South Devon NHS Foundations Trust's gender pay gap data for 2026, comparing performance with national and sector benchmarks and to last year. The report also highlights areas of progress and ongoing challenges in achieving pay equity.

[1] Advisory Committee on Clinical Impact Awards - GOV.UK

Torbay and South Devon NHS Foundation Trust

Some of the key findings include:

- **Overall Gender Pay Gap:** Women's mean hourly pay remains lower than men's, increasing slightly from 18.56% to 19.23%; the median gap decreased from 5.49% to 3.13%, showing relative balance for most staff.
- **Pay Quartiles:** The workforce is predominantly female across all quartiles, with minor shifts in representation; top quartile male representation increased slightly.
- **Bonus Pay:** Median bonus gap reduced from 90.18% to 74.15% due to higher female bonus receipt, although the mean bonus gap remains high at 67.57% because of larger male bonuses in senior roles.
- **National Benchmarking:** The Trust's median pay gap is significantly lower than national and industry benchmarks, indicating that most staff pay is relatively balanced.
- **Critical Staff Groups:** Although the number of female consultants grew slightly, their share of total consultants decreased, increasing male representation in senior roles.
- **Workforce Context:** The overall workforce remains predominantly female, but higher-paid roles continue to have higher male representation.
- **Data Correction:** 2025 figures have been corrected, ensuring accurate comparison and percentage change reporting.

Reportable data

The data shown below is that which has been uploaded to the Gender Pay Gap Reporting Service website. There is no opportunity to add explanatory text on the website but this report will be uploaded to the Trust website as part of the reporting requirements.

Women's hourly rate is	
19.23% LOWER (mean)	**3.13%** LOWER (median)
Pay quartiles	
How many men and women are in each quarter of the employer's payroll.	
Top quartile	
31.61% MEN	**68.39%** WOMEN
Upper middle quartile	
18.28% MEN	**81.72%** WOMEN
Lower middle quartile	
20.55% MEN	**79.45%** WOMEN
Lower quartile	
21.48% MEN	**78.52%** WOMEN
Women's bonus pay is	
67.57% LOWER (mean)	**74.15%** LOWER (median)
Who received bonus pay	
14.29% OF MEN	**10.88%** OF WOMEN

National benchmarking

The table below shows our performance against the most recent official headline pay gap benchmarking, for all employers, from ONS[2]:

[2] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/annualsurveyofhoursandearningsashegenderpaygaptables

Torbay and South Devon NHS Foundation Trust

	Pay gap based on mean average	Pay gap based on median average
National benchmark	13.4%	12.8%
Human Health Activities	22.1%	14.4%
Hospital Activities	23.1%	13.6%
Torbay and South Devon Trust	19.23%	3.13%

Commentary

The pay gap based on the median average is the most reliable and widely used measure of gender pay equality. When the pay gap is measured using the mean average, this allows outliers at either end to distort the measure.

The figures above indicate that the median gender pay gap for Torbay and South Devon trust is significantly lower than both the national and industry specific benchmarks.

Comparison with previous year

Mean average for hourly rate of pay

	2025	2026	% change
Male	£23.32	£25.01	7.25%
Female	£18.99	£20.20	6.37%
% difference	18.56%	19.23%	0.67%

Median average for hourly rate of pay

	2025	2026	% change
Male	£17.68	£19.09	7.91%
Female	£16.71	£18.49	4.58%
% difference	5.53%	3.13%	2.40%

Quartiles

Quartile	2025		2026		% change	
	Male	Female	Male	Female	Male	Female
Top	31.38%	68.62%	31.61%	68.39%	0.23%	-0.23%
Upper middle	19.29%	80.71%	18.28%	81.72%	-1.01%	1.01%
Lower middle	22.20%	77.80%	20.55%	79.45%	-1.65%	1.65%
Lower	23.37%	76.63%	21.48%	78.52%	-1.89%	1.89%

Bonus pay % receiving bonus pay

	2025	2026	% change
Male	14.98%	14.29%	-0.69%
Female	8.57%	10.88%	2.31%

Torbay and South Devon NHS Foundation Trust

Bonus pay mean average

	2025	2026	% change
Male	£14,316.63	£10,728.95	-25.06%
Female	£5,044.06	£3,479.19	-31.02%
% difference	64.77%	67.57%	4.32%

Bonus pay median average

	2025	2026	% change
Male	£8,144.98	£5,312.76	-34.77%
Female	£800.00	£1,373.23	71.65%
% difference	90.18%	74.15%	-16.03%

Commentary

Between 2025 and 2026, average hourly pay increased for both male and female employees, with male pay rising slightly faster. As a result, the mean gender pay gap increased from 18.56% to 19.23%, while the median gap reduced from 5.49% to 3.13%, reflecting changes in pay distribution rather than unequal pay for the same roles.

The Trust's workforce remains predominantly female across all pay quartiles, with only modest shifts year on year. Small increases in female representation in middle and lower quartiles and minor changes in the top quartile were observed. In terms of bonus pay, a higher proportion of females received bonuses in 2026, while male bonus values decreased overall. This led to a reduction in the median bonus gap from 90.18% to 74.15%, although the mean bonus gap remained high at 67.57%.

Note: There was an error in the 2025 mean and median data which has now been corrected. The figures presented here reflect the corrected values.

Torbay and South Devon NHS Foundation Trust Workforce Context

The current gender split for the overall workforce is 77.03% (5369) female and 22.97% (1601) male.

Our data analysis shows that our pay gaps were largely being driven by the bonus pay (ACCEA) given to consultants.

The table below shows the impact of excluding consultants from our mean and median average gender pay gap indicator.

	All Staff			Excluding Consultants		
	Male Hourly Rate	Female Hourly Rate	Gap	Male Hourly Rate	Female Hourly Rate	Gap
Mean average	£25.00	£20.20	19.2%	£20.62	£19.23	6.74%
Median average	£19.09	£18.50	3.13%	£18.43	£18.00	2.33%

Progress within critical staff groups

The previous section has confirmed that the consultant body remain our critical staff group, for addressing our gender pay gap.

Between 2025 and 2026, the Trust's consultant workforce grew from 269 to 289. While the number of female consultants increased slightly, their share of the total fell to 42.6%, reflecting a rise in male representation at senior medical roles.

This shift contributes to the widening mean gender pay gap, as higher-paid roles have a greater impact on average pay, even though median pay remains relatively balanced for the majority of staff.

Consultants	Male	Female	Total	% Female
2025	151	118	269	43.87%
2026	166	123	289	42.56%

Closing the Gender Pay Gap and Action Planning

We are pleased to note our gender pay gap in TSDFT remains significantly below the national average and industry standards. We continue to action plan to work towards eliminating any existing inequalities. It is suggested that action planning must include a review of applicants for consultants' posts and recommended that we review our current practices to ensure they are equitable.

As a Trust, we welcome the introduction of gender pay gap reporting and are fully supportive of equality of opportunity within our workforce. We recognise that this data tells us that there is further work to be undertaken to achieve that equality of opportunity. However, we acknowledge that there could be greater representation in the senior clinical roles which drives the greatest variances in this report.

We also have family-friendly policies with a range of agile working patterns including support for women returning to work and a champion of Flexible Training for resident doctors. We continue to look for areas of improvement and development as a Trust, we are working hard to ensure we reduce and minimise any gender pay gaps.

We aim to foster a culture of accountability and awareness regarding gender equity by training on unconscious bias and compassionate leadership for our leaders.

Whilst we continue our own cultural development work in Torbay trust we will continue to consult and consider national reviews and changes, including Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England[3].

[3] https://assets.publishing.service.gov.uk/media/5fd893a7e90e076631fb2286/Gender_pay_gap_in_medicine_review.pdf

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Ethnicity Pay Gap Report (March 2026)

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Torbay and South Devon NHS Foundation Trust

Introduction

Submitting Ethnicity Pay Gap data or producing a report is not a statutory requirement in the same way as the Gender Gap reporting.

As part of the Trust's ongoing commitment to inclusion we have created this report to ascertain if there is a difference between the average pay for our colleague's dependant on ethnicity for the second year.

The data in this report is based on a snapshot taken on 31st March 2025. Throughout this report, when data is labelled "2026" this refers to the year of publishing our pay gap report (so the data is from 2025).

The pay gap is different from equal pay. Equal pay is covered by the Equality Act 2010, and requires all employers to pay the same for work of equal value

Executive summary

Due to the recording of ethnicity status not being mandated on ESR, there will be colleagues missing from the data due to the Trust having 2.08% of staff not having an ethnicity recorded on ESR[1], Our Workforce Race Equality Standard (WRES) report details at which bandings and staff groups this unknown data is more prevalent. We are pleased that our data is better than the national benchmarking (4.3% unknown as of 2025 reporting[2]) which allows us clarity over existing pay gaps and actions to eliminate them

This Ethnicity Pay Gap Report contains a number of elements:

- Mean ethnicity pay gap
- Median ethnicity pay gap
- Quartile distribution
- Bonus pay gap
- Comparison to previous year
- Source of pay gap

The pay gap based on the median average is the most reliable and widely used measure of pay equity. When the pay gap is measured using the mean average, this allows "outliers" at either end to distort the measure.

https://www.torbayandsouthdevon.nhs.uk/uploads/wres-annual-report-2025.pdf

[2] [1] https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2024-data-analysis-report-for-nhs-trusts/

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Hourly rate pay gap

The below is expressed relative to the earnings of White staff members

BME hourly rate is	
13.86% HIGHER (mean)	**9.15%** HIGHER (median)
Unknown ethnicity hourly rate is	
1.84% LOWER (mean)	**2.69%** HIGHER (median)

The above data shows that both the mean and median hourly rate is higher for BME staff when compared to White staff. Staff whose ethnicity is recorded as 'Not Known' have a slightly lower mean hourly rate but a slightly higher median hourly rate compared to White staff.

Ethnicity groupings

The below pay gaps are expressed relative to the earnings of White British staff members, a negative number means that the average earnings of that ethnic grouping are higher than White British staff

Ethnic origin grouping summary	Mean Hourly Rate	Median Hourly Rate	Median Pay Gap %
White	£21.13	£18.18	
BME	£24.06	£19.84	**-9.15%**
Unknown	£20.74	£18.67	**-2.69%**

Ethnic origin grouping	Mean Hourly Rate	Median Hourly Rate	Median Pay Gap %
White British	£20.89	£17.79	
White Other	£23.45	£19.09	**-7.36%**
Asian or Asian British	£24.24	£19.87	**-11.74%**
Black or Black British	£22.06	£20.40	**-14.68%**
Mixed or Multiple ethnic groups	£24.07	£18.66	**-4.91%**
Other ethnic group	£26.29	£19.33	**-8.67%**
Unknown	£20.74	£18.67	**-4.96%**

The table above shows the average and median hourly pay by ethnic origin groups. Median pay is highest for Black or Black British staff (£20.40) and lowest for White British staff (£17.79)

Quartiles

Pay quartiles		
How many ethnicities are in each quarter of the employer's payroll.		
Top quartile		
84.06% White	**16.23%** BME	**2.29%** Unknown
Upper middle quartile		
83.06% White	**17.55%** BME	**2.36%** Unknown
Lower middle quartile		
85.48% White	**14.04%** BME	**2.52%** Unknown
Lower quartile		

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92.71% White	**5.17%** BME	**2.13%** Unknown

Bonus Pay

BME bonus pay is		
18.20% HIGHER (mean)	**31.75%** HIGHER (median)	
Unknown ethnicity bonus pay is		
14.37% LOWER (mean)	**43.50%** HIGHER (median)	
Who receives bonus pay		
10.94% of White staff	**16.78%** of BME staff	**9.69%** of unknown staff

Please note that due to the small numbers of unknown staff receiving bonus pay, these figures should be interpreted with caution.

Comparison with previous year

The ethnicity pay gap figures for 2025 have been revised following the identification of inaccuracies in the underlying data. Updated calculations have been applied to ensure consistency and accuracy in the 2026 analysis.

Mean average for hourly rate of pay

	2025	2026	% change
BME	£22.06	£24.06	9.07%
White	£19.73	£21.13	7.10%
Unknown	£18.27	£20.74	13.52%

Median average for hourly rate of pay

	2025	2026	% change
BME	£18.57	£19.84	6.84%
White	£16.30	£18.18	11.53%
Unknown	£16.14	£18.67	15.68%

Between 2025 and 2026, mean and median hourly pay increased across all ethnic groups. While mean pay growth was higher for BME staff (9.07%) compared to White staff (7.10%), median pay growth was higher for White staff (11.53%) than for BME staff (6.84%)

Quartiles

Quartile	% change from 2025		
	White	BME	Unknown
Top	-1.43%	1.64%	-0.53%
Upper middle	2.83%	-1.39%	-1.41%
Lower middle	0.40%	1.96%	-1.56%
Lower	0.48%	0.20%	-0.71%

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Pay gap differences - mean

	2025	2026	% change
BME	-11.80%	-13.86%	-2.06%
Unknown	7.39%	1.84%	-5.55

Pay gap differences - median

	2025	2026	% change
BME	-13.87%	-9.15%	4.72
Unknown	1.02%	-2.69%	-3.71

The data shows that BME staff earn more on average and at the median than White staff in both 2025 and 2026. The mean gap widened slightly in 2026 while median gap narrowed. For staff with The 'Unknown' ethnicity category shows notable year-on-year movement in both mean and median pay gaps. This volatility reflects changes in data completeness and workforce composition rather than pay outcomes. Due to the unstable nature of this category, it is not used to draw conclusions about pay inequality.

Source of pay gap
Excluding consultants

As we know from our Gender Pay Gap reporting, pay gaps are largely driven by consultant pay, below is a comparison of the pay gap when we remove consultants from the analysis

TSDFT Excluding consultants				
	Hourly rate average		Mean pay gap %	
	Mean average	Median average	Mean pay gap %	Median pay gap %
White	£19.34	£17.37		
BME	£21.21	£19.34	-9.67%	-11.34%
Unknown	£19.30	£18.46	0.21%	-6.28%

When consultant roles are excluded, the ethnicity pay gap narrows, particularly at the mean level, confirming that senior medical roles significantly influence the figures.

AfC banding

As with previous years reporting we have examined the pay gap by AfC banding, due to some of the small numbers of staff in each banding, particularly at both ends of the spectrum, please see below staff numbers for context:

	White	%	BME	%	Unknown	%	Total
Band 1	5	100.00%	0	0.00%	0	0.00%	5
Band 2	956	93.27%	62	6.05%	7	0.68%	1025
Band 3	1312	88.95%	111	7.53%	52	3.53%	1475
Band 4	540	94.90%	13	2.28%	16	2.81%	569

Band 5	903	71.05%	329	25.89%	39	3.07%	1271
Band 6	1154	90.58%	98	7.69%	22	1.73%	1274
Band 7	618	94.35%	30	4.58%	7	1.07%	655
Band 8a	171	94.48%	7	3.87%	3	1.66%	181
Band 8b	73	97.33%	1	1.33%	1	1.33%	75
Band 8c	40	97.56%	0	0.00%	1	2.44%	41
Band 8d	13	92.86%	1	7.14%	0	0.00%	14
Band 9	15	100.00%	0	0.00%	0	0.00%	15
Total	**5800**	**87.88%**	**652**	**9.88%**	**148**	**2.24%**	**6600**

Closing the Ethnicity pay gap and Action Planning

Ethnicity Pay Gap reporting remains more complex in nature than Gender Pay Gap reporting for a number of reasons. Gender is mandated on ESR, which means we have overall data which reflects the workforce, whereas we have a much lower sharing rate on ethnicity on ESR which makes the data less reliable. Overall, we can see some positive trends in our data, but there remains a concern around representation at senior management and leadership roles.

The reporting is also complex as the median pay gap does not reflect the full story, it is clear from looking at data from a banding level that you can begin to see where the issue around lack of representation lies. Band 4 is a supervisor level role, Band 7 is a first step management role and Band 8a and above are leadership positions. Viewing the data from the perspective of leadership and management at banding levels allows us to action plan more effectively. Currently at Band 8a and above there are only 9 individuals who identified as being from a BME background across the organisation, representing a much smaller percentage of our overall workforce numbers for people from similar backgrounds.

It is proposed that our action planning must include leadership opportunities and support for people from a BME background at leadership levels and an understanding of barriers which are getting in the way of progress.

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Disability Pay Gap Report (March 2026)

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Introduction

Submitting Disability Pay Gap data or producing a report is not a statutory requirement in the same way as the Gender Gap reporting.

As part of the Trusts ongoing commitment to inclusion we have created this report to ascertain if there is a difference between the average pay for our colleague's dependant on disability status for the first time.

The data in this report is based on a snapshot taken on 31st March 2025. Throughout this report, when data is labelled "2026" this refers to the year of publishing our pay gap report (so the data is from 2025).

The pay gap is different from equal pay. Equal pay is covered by the Equality Act 2010, and requires all employers to pay the same for work of equal value

Executive summary

Due to the recording of disability status not being mandated on ESR, there will be colleagues missing from the data due to the Trust having 5.22% of staff not having a disability status recorded on ESR[1]. Our organisational data is favourable in comparison to the national benchmarking which is positive and allows us to have better clarity around action planning (14.3% unknown as of 2024 reporting).

This Disability Pay Gap Report contains a number of elements:

- Mean disability pay gap
- Median disability pay gap
- Quartile distribution
- Bonus pay
- Source of pay gap
- Comparison to previous year

The pay gap based on the median average is the most reliable and widely used measure of pay equity. When the pay gap is measured using the mean average, this allows "outliers" at either end to distort the measure.

[1] https://www.torbayandsouthdevon.nhs.uk/uploads/wdes-annual-report-2025.pdf?last-updated=20260120

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Average hourly rates

The below is expressed relative to the earnings of non-disabled staff members

Disabled staff hourly rate is	
10.94% LOWER (mean)	**12.27%** LOWER (median)
Not Declared hourly rate is	
15.36% HIGHER (mean)	**16.87%** HIGHER (median)
Prefer not to answer hourly rate is	
2.52% LOWER (mean)	**1.12%** LOWER (median)
Unspecified hourly rate is	
10.02% LOWER (mean)	**8.39%** LOWER (median)

Pay quartiles		
Proportion in each quarter of the employer's payroll.		
Top quartile		
91.34% Non-disabled	**4.30%** Disabled	**4.36%** Unknown
Upper middle quartile		
88.91% Non-disabled	**7.71%** Disabled	**3.38%** Unknown
Lower middle quartile		
89.99% Non-disabled	**6.50%** Disabled	**3.51%** Unknown
Lower quartile		
88.05% Non-disabled	**8.50%** Disabled	**3.45%** Unknown

The above data shows that Disabled staff earn 10.94% less on average and 12.27% less at the median than non-disabled staff. The mean and median average of an unknown disability status is higher than for non-disabled staff. We can also see that disabled staff are over-represented in the lower quartile, lower middle and upper quartile, whilst remaining under-represented in the top quartile. The data in comparison to last year shows a decrease in pay gap where last year the median was reported to be 14.81% lower and the mean was reported to be 11.13% lower.

Bonus Pay

Disabled bonus pay is	
9.66% LOWER (mean)	**3.99%** LOWER (median)
Unknown disability bonus pay is	
6.69% HIGHER (mean)	**3.99%** LOWER (median)

Who receives bonus pay		
11.94% of non-disabled staff	**7.40%** of disabled staff	**11.57%** of unknown staff

We can see that non-disabled staff recieve a higher proportion of bonus pay across both the mean and median pay, although due to the small numbers of disabled and unknown staff receiving bonus pay, these figures should be interpreted with caution.

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Comparison with previous year

Mean average for hourly rate of pay

	2025	2026	% change
Disabled	£17.64	£19.16	8.62%
Non-disabled	£19.85	£21.51	8.36%

Median average for hourly rate of pay

	2025	2026	% change
Disabled	£15.07	£19.14	27.00%
Non-disabled	£17.68	£21.82	23.42%

Quartiles

Quartile	% change from 2025		
	Non-disabled	Disabled	Unknown
Top	1.17%	0.60%	-1.78%
Upper middle	-0.14%	1.64%	-1.50%
Lower middle	-0.40%	0.76%	-0.36%
Lower	0.94%	0.79%	-1.73%

Pay gap differences

	2025	2026	% change
Disabled (mean)	11.13%	10.94%	-0.19%
Disabled (median)	14.81%	12.27%	-2.54%

The pay gap has reduced between 2025 and 2026. The mean pay gap has only reduced marginally, we see an overall positive percentage change for disabled staff, whilst accepting that a pay gap remains.

Source of pay gap

As we know from our Gender Pay Gap reporting, pay gaps are largely driven by medical and dental pay, below is the difference in pay gaps when we exclude our consultants from the analysis.

TSDFT Excluding consultants				
	Hourly rate average		Mean pay gap %	
	Mean average	Median average	Mean pay gap %	Median pay gap %
Non-disabled	£19.62	£18.27		
Disabled	£18.57	£16.53	**5.35%**	**9.52%**

Unknown	£20.42	£18.66	**-4.08%**	**-2.13%**

We can see that excluding consultants from the analysis shows that a disability pay gap remains within the Trust. Disabled staff earn 5.35% less than non-disabled staff on a mean hourly basis and 9.52% less at the median. In contrast, staff with an unknown disability status have higher mean and median hourly rates than non-disabled staff.

Action planning

This is our second year of reporting on the Disability pay gap and we have undertaken a year-on-year comparison.

As a Trust, we welcome the introduction of Disability pay gap reporting and are fully supportive of equality of opportunity within our workforce. We recognise that this data tells us that there is further work to be undertaken to achieve that equality of opportunity. The top quartile of our workforce remains the least representative overall both in terms of pay for staff who have a disability, as well as people who have not shared their disability status on ESR.

We recognise that supporting our disabled colleagues to thrive and progress at work, along with creating a more inclusive recruitment process will be central to reducing the Disability Pay Gap.

The Trust has established staff networks, including a Disability Staff Network and a Neurodiversity Staff Network, which aim to provide a structured and safe forum for disabled and/or Neurodivergent colleagues to share lived experience and highlight barriers they face within the organisation. While the existence of staff networks alone will not close the disability pay gap, they are a critical enabler of change.

Torbay and South Devon NHS Foundation Trust

Quality People Committee

The improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Survey programme for 2025

Date of meeting	Date report produced
24th February 2026	11th February 2026

Author(s)		Report approved by	
Name and title:	Joanna Bassett Director of Midwifery and Gynaecology Mair Davies Maternity Matron Inpatient Services Lisa Statham Transformation Midwife	**Name and title:**	Nicola McMinn CNO
		Date:	18th February 2026

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

Executive summary

This report provides assurance to the Quality and People Committee regarding the Trust's response to the 2025 Care Quality Commission (CQC) National Maternity Survey. It outlines areas of high performance, identifies domains requiring targeted improvement, and describes the governance mechanisms in place to oversee delivery of the associated improvement plan.
The Trust continues to perform **"**Better than expected**"** or **"**Somewhat better than expected**"** in three quarters of survey domains, with demonstrable year-on-year

improvement across labour and birth, postnatal care, complaints and overall experience.

The improvement plan has been:

- Co-produced with the Devon Maternity and Neonatal Voices Partnership (MNVP)
- Embedded within the overarching Maternity and Neonatal Improvement Plan
- Allocated to named executive and operational leads
- Subject to structured oversight via the Feedback and Engagement Group
- Escalated through divisional governance to the Quality and People Committee

Governance arrangements ensure triangulation of patient experience data with safety metrics, complaints, FFT data, Birth Afterthoughts feedback and workforce intelligence to provide a robust, system-wide view of maternity quality and culture.

The overall assurance rating remains **Significant**, reflecting:

- Strong delivery of core metrics
- Effective control systems operating consistently
- Risk levels below appetite in most domains
- Clear mitigation plans where improvement is required

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
3.0 Antenatal Care	Significant	No change
4.0 Care in labour and birth	Significant	Improvement from 2024 report.
5.0 Care in the ward after birth	Satisfactory	New metric
6.0 Postnatal care	Significant	Improvement from 2024 report.
7.0 Triage	Significant	New metric
8.0 Complaints	Significant	Improvement from 2024 report.
9.0 Improvement Plan	Significant	Improvement from 2024 report.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Feedback and Engagement Group Jan 2026.

Appendices
Appendix 1 – NHS Maternity Survey 2025 Benchmark Report - *included in the Quality and People Committee Information Pack*

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

Key recommendations and actions requested
The Committee is asked to support the following recommendations: • To support the development of the improvement plan aligned to the Maternity Survey 2025 and the areas for focused improvement. • To support the recommendation that the Feedback and Engagement Group will oversee and monitor the progress of both plans.

How does this report further our Trust Strategy?
This report details service user feedback and the action plan demonstrate the commitment of maternity services to listening and acting. Co-production of services including the voice of users is vital to enable the provision of safe care within maternity to support the people of Torbay and South Devon to live well

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	This report supports the aims described by demonstrating best practice guidance in the delivery of care to promote the health and wellbeing of pregnant women and babies
Quality of services provided	

Impact on BAF Objectives	
BAF Objective	**Impact**

Quality, Safety and Patient Experience	This report supports the BAF objective of Quality and Patient Experience: Personalised Care by demonstrating how women's experiences directly inform service improvement and strategic oversight. Strong survey performance in areas such as informed choice, communication, relational continuity and postnatal support evidences delivery of personalised, woman-centred care
People and Culture	This report supports the BAF objective of People by highlighting the positive impact of workforce culture, teamwork and compassionate leadership on patient experience. Improvements in labour and birth, triage and postnatal domains reflect effective multidisciplinary working and staff commitment to safe, respectful care

Risk

N/A

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risks

NHS England licence and regulations
National policy, guidance
Care Quality Commission
NHS Provider Licence and national maternity policy, including *Better Births*, the *Three-Year Delivery Plan for Maternity and Neonatal Services*, and the *Maternity Incentive Scheme*.

Associated Risks

- Reputational risk should patient experience deteriorate or improvement actions not be delivered.
- Regulatory risk if themes identified are not demonstrably addressed through robust governance and quality improvement.
- Compliance risk in relation to CQC Fundamental Standards, particularly Regulation 9 (Person-centred care) and Regulation 17 (Good governance).

The improvement plans developed in response to the results of the Care Quality Commission (CQC) NHS Patient Experience Survey programme for 2025.

1. Overview of Findings

The 2025 survey demonstrates that women's experiences of maternity care within the Trust remain consistently positive across antenatal, labour and birth, postnatal care and triage services. Improvements in labour and birth and postnatal care reflect sustained work on relational continuity, teamwork and information sharing.

The results reinforce the strength of the Trust's model of care, which prioritises personalised care, informed choice and collaborative multidisciplinary working.

Women reported high levels of confidence in staff, clarity of communication and feeling involved in decisions about their care. The improvement seen in questions relating to mental health information postnatally demonstrates responsiveness to national priorities and local quality improvement initiatives.

The separation of triage into a dedicated section within the survey has further highlighted the effectiveness of this service. The Trust's performance in this domain suggests that recent service developments are translating into positive experience for women at the point of urgent assessment.

The complaints question, introduced in 2023, continues to demonstrate improvement, with the Trust performing better than expected nationally. This is a meaningful indicator of relational culture, responsiveness and openness.

2. Areas for Development: Care in the Ward After Birth

The only domain requiring targeted improvement relates to care on the postnatal ward. While most questions were aligned with the national average, one question scored below the national benchmark and several were only marginally above.

Themes identified include:

- Partner support overnight
- Discharge delays
- Pain management following birth

The issue of partner overnight stay has been a recurring theme over recent years and reflects the inherent tension between service user expectations, estate configuration, privacy and safety considerations.

This matter has been subject to structured review through the Devon MNVP, the Local Maternity and Neonatal System Board and the Trust's Health and Safety Team. The decision to allow 24-hour partner presence in side rooms represent a balanced and risk-assessed position, although limitations within multi-bedded bays remain.

This issue is not one of absence of control, but rather one of estate constraint. The residual risk is recognised and monitored within divisional governance processes, with oversight through the divisional risk register. Further work will continue in collaboration with service users to explore safe and proportionate solutions.

Discharge delays are being addressed through a Devon-wide quality improvement initiative, ensuring a system-level response rather than a siloed organisational approach.

Pain management standards remain subject to routine audit, including review of self-administration of analgesia. These controls are embedded and operating effectively.

For these reasons, assurance for this domain is rated Satisfactory — controls are in place and functioning, but further improvement is required to optimise experience.

3. Governance, Oversight and Assurance Arrangements

The Trust has applied a structured governance framework to the survey findings and subsequent improvement plan.

The detailed benchmarking analysis was reviewed by the Patient Feedback and Engagement Group in January 2026. The improvement plan has been co-produced with MNVP representatives, ensuring that actions are grounded in lived experience and partnership working.

Oversight operates at multiple levels:

- Monthly review through the Maternity Senior Leadership Team
- Triangulation with complaints, PALS, FFT and Birth Afterthoughts feedback
- Integration within the overarching Maternity and Neonatal Improvement Plan
- Reporting through divisional governance structures
- Formal assurance reporting to the Quality and People Committee

This layered approach ensures that improvement actions are not standalone tasks but are embedded within routine governance and quality surveillance processes.

Performance data is triangulated with workforce insight, safety metrics and cultural indicators, providing a comprehensive picture of maternity quality. Where risks are identified, they are assessed against the Trust's risk appetite and escalated appropriately.

At present, no maternity experience risks exceed the agreed risk appetite, and there are no indicators of systemic control failure.

4. Measuring and Sustaining Improvement

Improvement will be monitored through:

- Trend analysis of Friends and Family Test results
- Complaints and concern themes
- MNVP feedback questionnaires
- Birth Afterthoughts thematic review
- Senior leadership walkabouts and real-time engagement
- Audit data relating to discharge and pain management

Progress will be reviewed monthly, with formal updates through governance channels. This ensures continuous visibility and accountability.

The improvement plan is dynamic and will evolve as further feedback and intelligence emerge.

5. Conclusion and Overall Assurance

The 2025 CQC Maternity Survey demonstrates sustained high-quality maternity care within the Trust, with notable improvement in key domains and strong national and regional benchmarking.

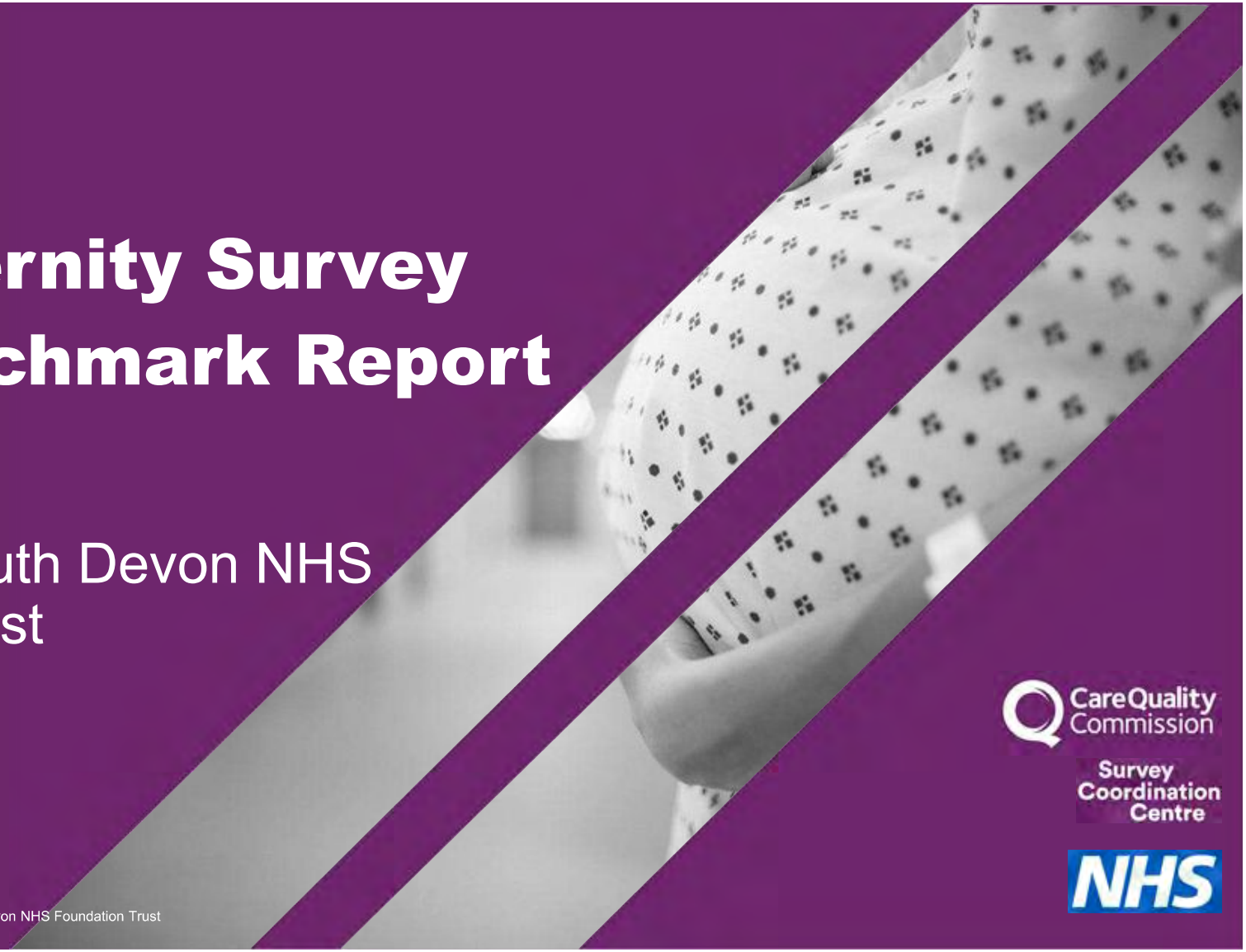
The Trust has responded proactively and transparently to areas requiring development. Governance arrangements are robust, multi-layered and integrated into existing quality and safety frameworks. Controls are well designed and consistently applied.

The Committee is therefore asked to:

- Note the positive comparative performance.
- Recognise the targeted improvement work underway.
- Take Significant Assurance overall regarding governance, oversight and delivery of the improvement plan.

NHS Maternity Survey 2025 Benchmark Report

Torbay and South Devon NHS Foundation Trust



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- **Section 6: Complaints**

6. Comparison to other trusts
- Comparison to other trusts

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

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Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the 2025 Maternity Survey
- a description of key terms used in this report
- navigating the report

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Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey was first carried out in 2007. The 2025 Maternity Survey will be the twelfth carried out to date. CQC use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The 2025 Maternity Survey

The survey was administered by the Survey Coordination Centre (SCC) at Picker.

A total of 43,955 maternity service users were invited to participate in the survey across 119 NHS trusts.

Completed responses were received from 16,755 maternity service users; a 38.53% adjusted response rate, where undelivered questionnaires were removed from the response rate calculation.

Service users were eligible to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2025. If there were fewer than 300 people within an NHS trust who gave birth in February 2025, then births from January were included. Full sampling criteria can be found in the Sampling Instructions.

Fieldwork (the time during which questionnaires were sent out and returned) took place between April and July 2025.

Trend data

In 2021, the Maternity Survey transitioned from a solely paper-based methodology to both paper and online.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2013 survey and subsequent years are comparable, unless a question has changed or there are other reasons for lack of comparability such as changes in organisational structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included.

Further information about the survey

- For published results and for more information on the Maternity Survey, please visit the Maternity Survey page on the NHS Surveys website.
- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Background and methodology (continued)

Antenatal and Postnatal data

The Maternity Survey is split into seven sections that ask questions about:

1) Antenatal Care
2) Labour and Birth
3) Care in the ward after birth
4) Postnatal Care
5) Triage: Assessment and Evaluation
6) Complaints

It is possible that some maternity service users may have experienced their antenatal care, postnatal care, and triage in different trusts. This may be for many reasons such as moving house, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth, and care in the ward after birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth, and care in the ward after birth across all 119 NHS trusts that took part in the survey.

When answering survey questions about antenatal care, postnatal care and triage we cannot determine from the survey responses alone whether the care was received within the trust from which the respondent was sampled. Trusts were asked to carry out an “attribution exercise”, where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2025, all of the 119 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

Scores for sites

Scores for sites within your trust have been provided for the first time in this report. However, scores for sites are only available for ‘Section 2: Labour and birth and ‘Section 3: Care in the ward after birth’ due to attribution data completed by trusts currently at trust-level only.

Limitations of this approach

Data is provided voluntarily. In 2025, all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against all trusts that provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the ‘How to interpret benchmarking in this report’ section.

Standardisation

Demographic characteristics, such as age, can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual service user responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by parity (whether or not a service user has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile of maternity users and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing.

Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example A2), and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C23). These questions are not scored.

Please refer to the Scored questionnaire for further details. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied. More information can be found in the ‘How questions are scored’ slide.

National average

The ‘national average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the Survey technical document which is in the 'Analysis and Reporting' section of the 2025 Maternity Survey webpage on the NHS Surveys Website.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology –** provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results –** includes key trust-level findings relating to the maternity service users who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Scoring and benchmarking –** shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Trusts that provide data on antenatal and/or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.
- **Trust and site results –** includes the score for your trust and breakdown of scores across sites within your trust (scores for sites are available for the 'Labour and birth' and 'Care in the ward after birth' sections only). Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.
- **Change over time –** includes your trust's mean score for each evaluative question in the survey shown in a significance test table, comparing it to your 2024 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.
- **Comparison to other trusts –** includes where your trust has performed better or worse in comparison to other trusts.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the 'How to interpret benchmarking in this report' slides.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results and technical document.
- National and trust-level data for all trusts who took part in the 2025 Maternity Survey.
- Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys Website.
- Information on the NHS Patient Survey Programme, including results from other surveys.
- Information about how CQC monitors hospitals.

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

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Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

269 invited to take part

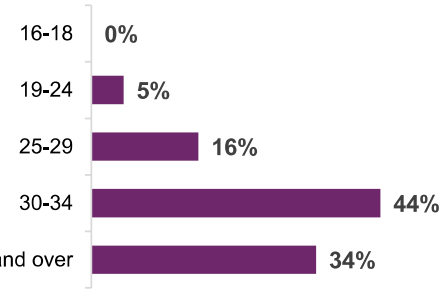
122 completed

46% response rate

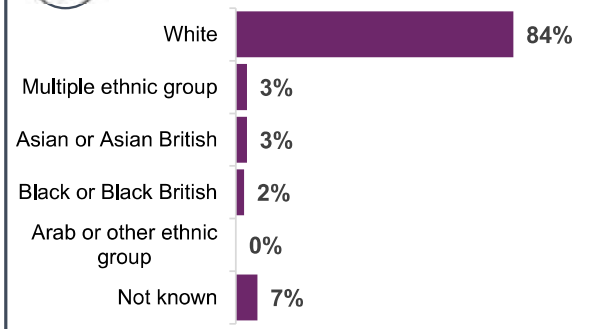
39% average response rate for all trusts

45% response rate for your trust in 2024

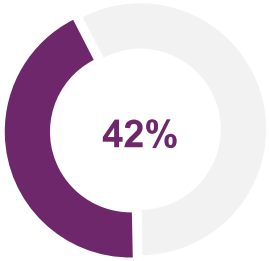
Age



Ethnicity



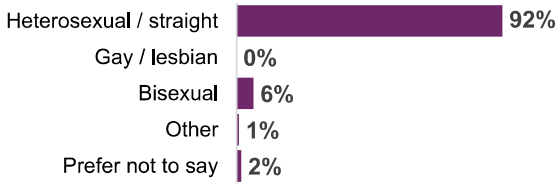
Parity



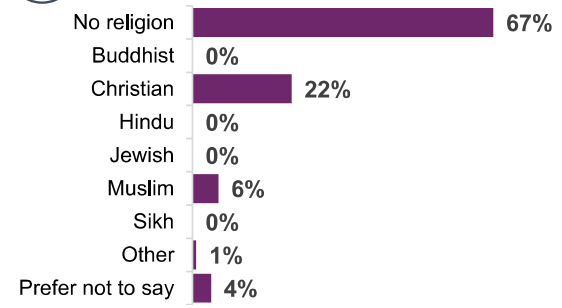
of respondents gave birth to **their first baby**.

Sexuality

Which of the following best describes your sexual orientation?



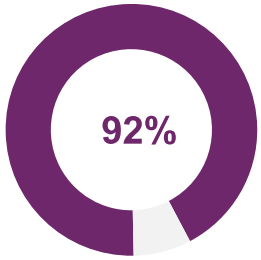
Religion



Who took part in the survey? (continued)

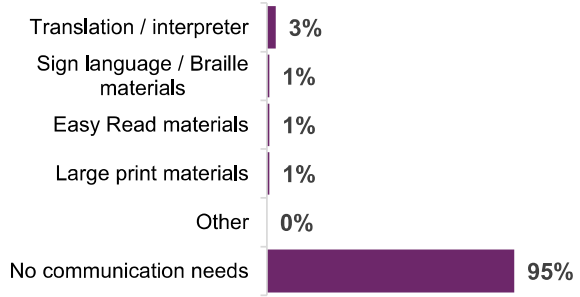
This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

English as main language

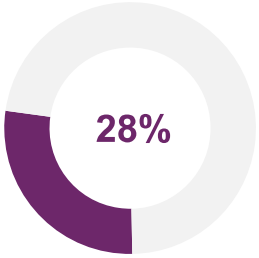


of maternity service users have **English as their main language.**

Types of communication needs

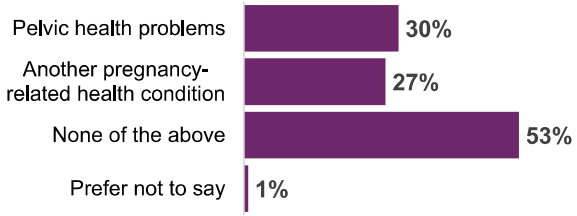


Long-term conditions

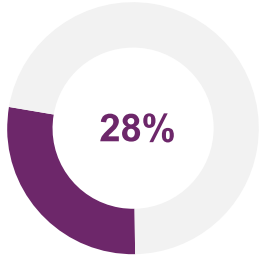


of maternity service users have a **physical or mental health condition or illness** that has lasted or is expected to last for 12 months or more.

Pregnancy-related health conditions



Baby received neonatal care

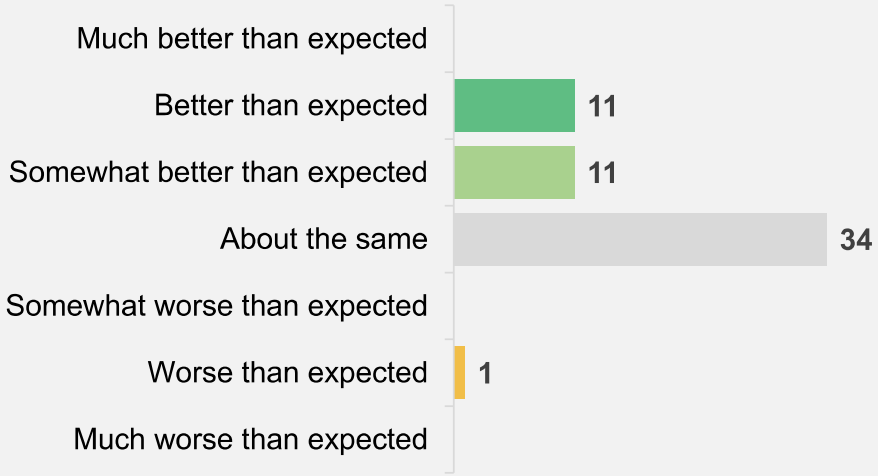


of respondents reported that their baby received **neonatal care**.

Summary of findings for your trust

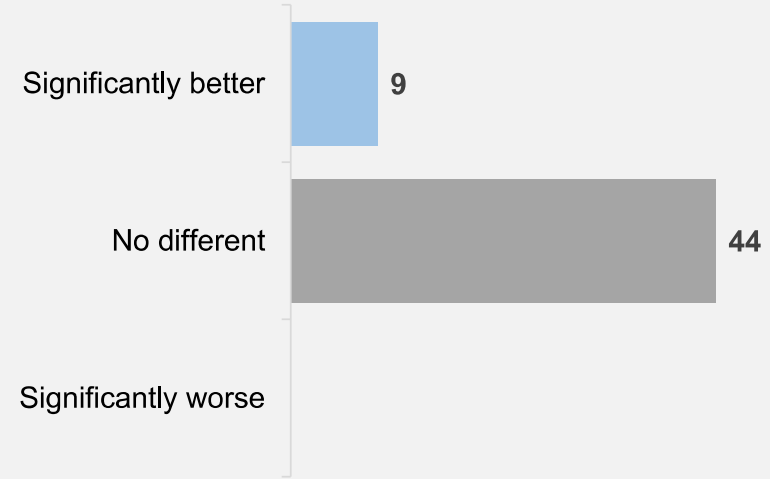
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2025 vs 2024.



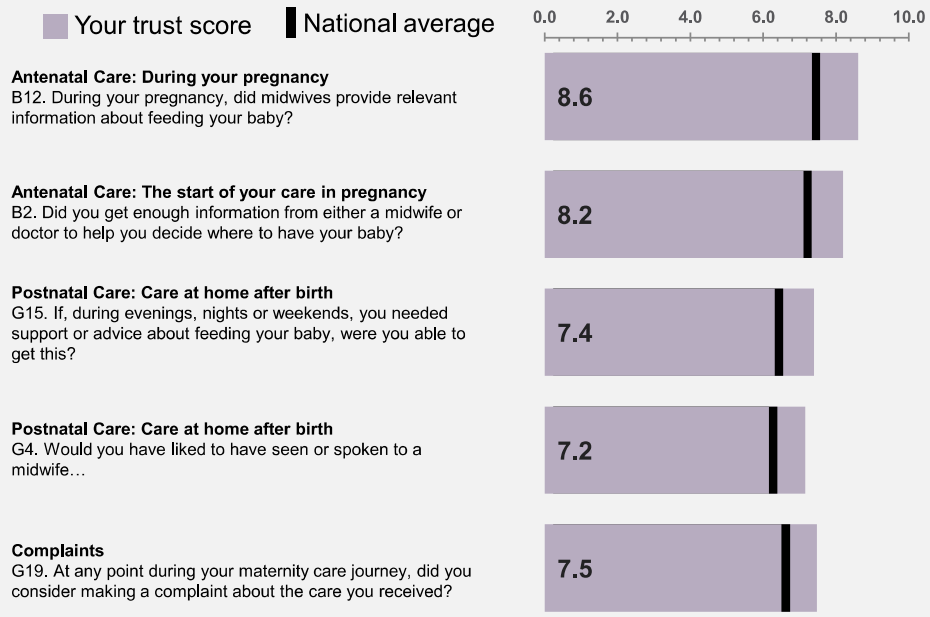
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the section "Comparison to other Trusts".

Best and worst performance relative to the national average

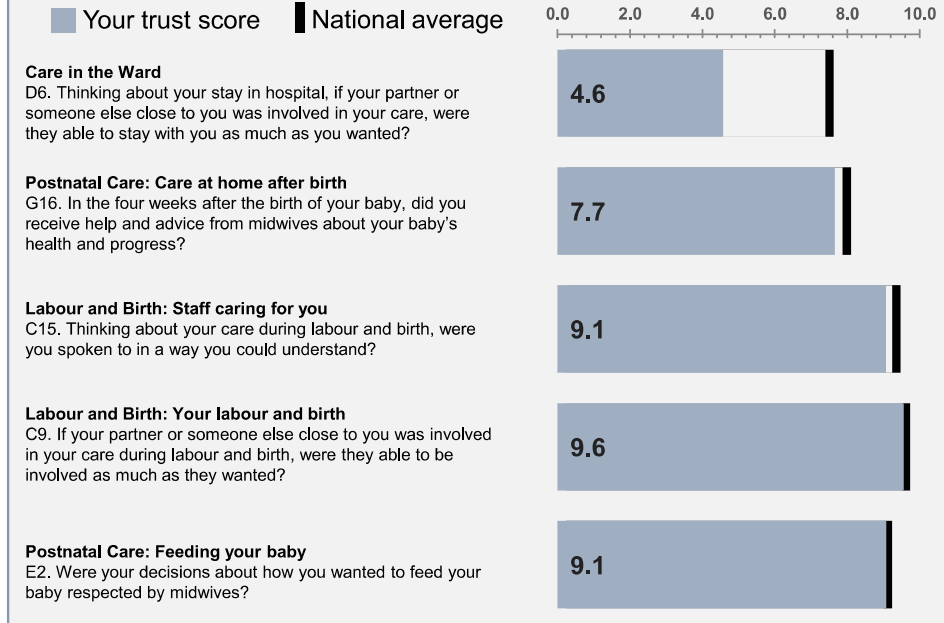
These five questions are calculated by comparing your trust's results to the average trust score across England.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)



Bottom five scores (compared with national average)



2025 Maternity Survey

Results for Torbay and South Devon NHS Foundation Trust

Where service user experience is best

- ✓ **Antenatal care: During your pregnancy:** Relevant information provided from midwives about feeding their baby
- ✓ **Antenatal care: Start of your pregnancy:** Information from midwife or doctor to help decide where to have their baby
- ✓ **Postnatal Care: Care at home after birth:** Being able to get support or advice about feeding baby during evenings, nights or weekends
- ✓ **Postnatal Care: Care at home after birth:** Frequency of seeing or speaking to a midwife
- ✓ **Complaints:** Considering making a complaint about the care they received during their maternity journey

Where service user experience could improve

- ○ **Care in the Ward:** Partner or someone else close to them being able to stay as much as they wanted
- ○ **Postnatal Care: Care at home after birth:** Receiving help and advice from a midwife about baby's health and progress in the 4 weeks after birth
- ○ **Labour and Birth: Staff caring for you:** Being spoken to in a way they could understand
- ○ **Labour and Birth: Your labour and birth:** Partner or someone else close to them was able to be involved as much as they wanted
- ○ **Postnatal Care: Feeding your baby:** Decisions about how to feed their baby respected

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

This survey looked at the experiences of service users who gave birth at the trust in January and/or February 2025. Between April and July 2025, a questionnaire was sent to 269 recent service users who gave birth at Torbay and South Devon NHS Foundation Trust. Responses were received from 122 service users at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Scoring and benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts

Please note: If data is missing, this is due to a low number of responses.

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How questions are scored

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the maternity service user's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive maternity service user experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of maternity service user experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B9 "During your pregnancy, if you contacted a midwifery team, were you given the help you needed?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive maternity service user experience possible.
- The answer code "Yes, sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer codes "No" and "No, as I was not able to contact a midwifery team" would be given a score of 0, as these responses reflect considerable scope for improvement.
- The answer code "I did not contact a midwifery team" would not be scored, as they do not have a clear bearing on the trust's performance in terms of maternity service user experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the Survey technical document.

Calculating the section score

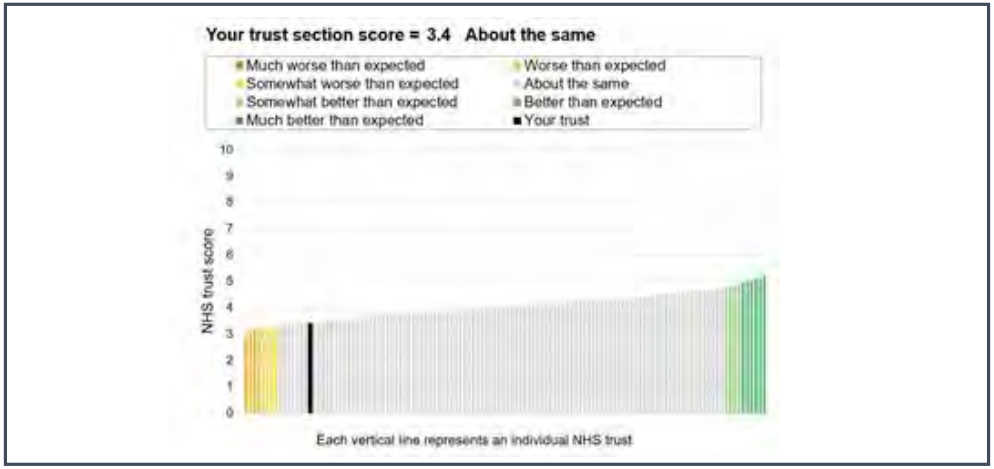
An arithmetic mean of each trust's question scores is taken to provide a score for each section.

How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange section** of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange section** of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.



How to interpret benchmarking in this report (continued)

The ‘much better than expected’, ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’, and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases, this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low number of responses.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

Scoring and benchmarking

Section 1: Antenatal Care

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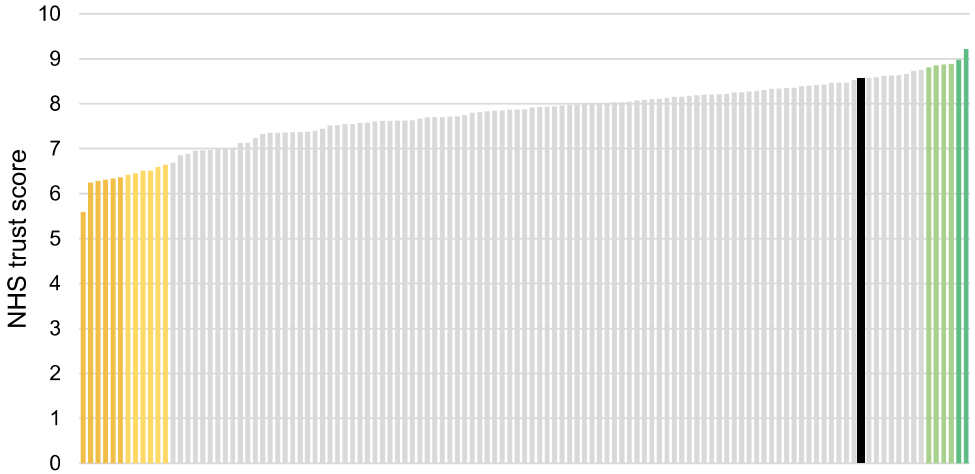
The start of your care in pregnancy

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care in pregnancy' is calculated from questions B1 and B2. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

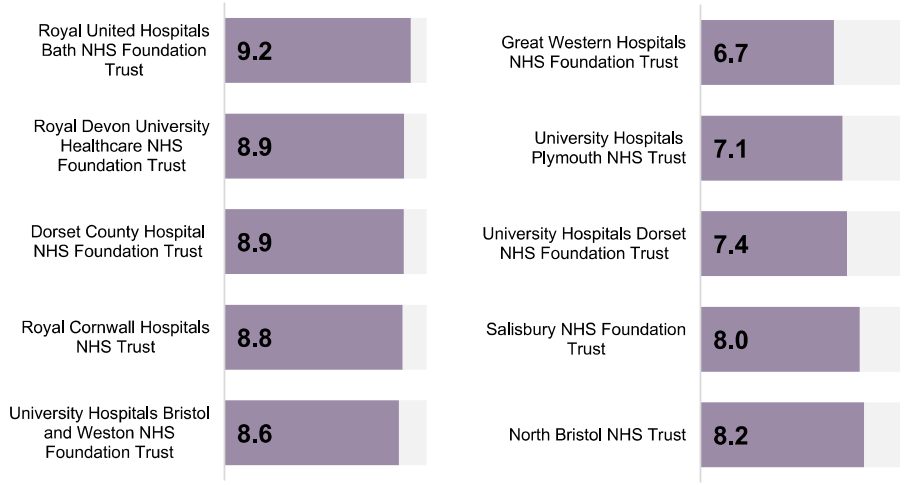
Your trust section score = 8.6 **About the same**

- Much worse than expected
- Somewhat worse than expected
- Somewhat better than expected
- Much better than expected
- Worse than expected
- About the same
- Better than expected
- Your trust



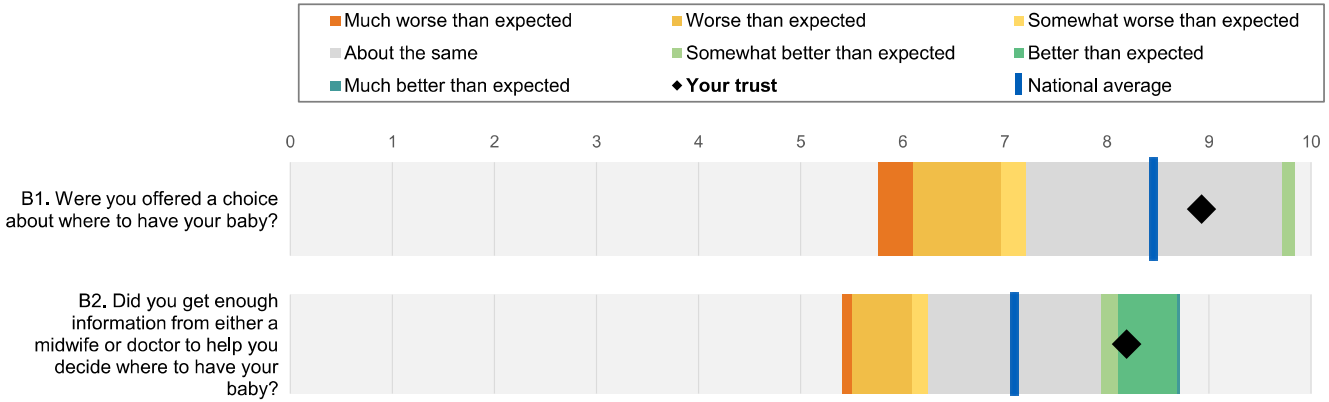
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: The start of your care in pregnancy

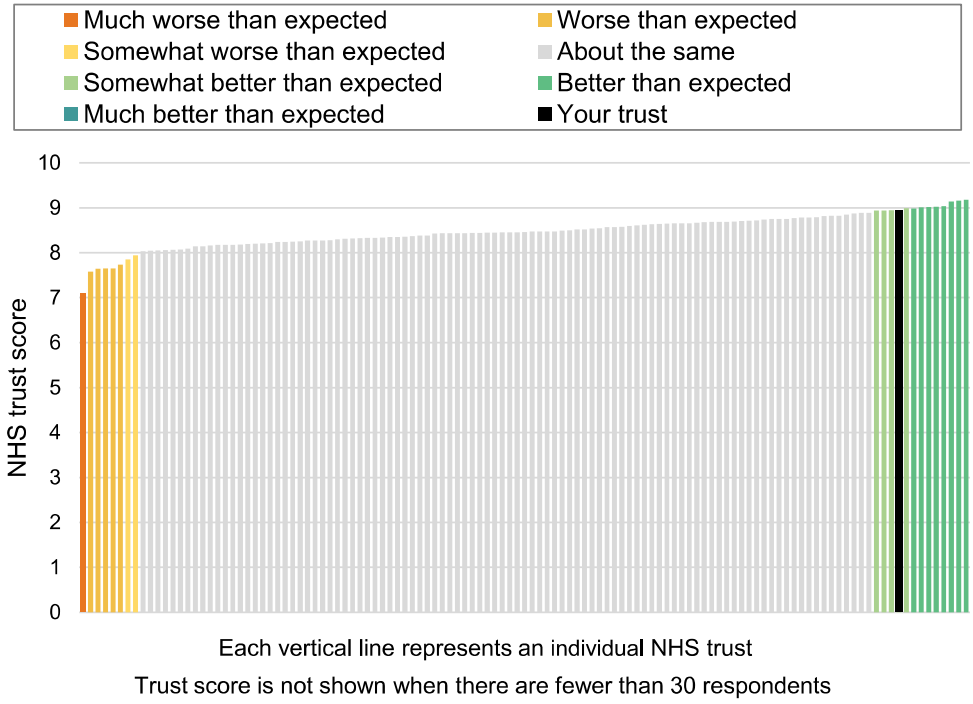


			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	100	8.9	8.5	5.8	9.8
Better than expected	112	8.2	7.1	5.4	8.7

Antenatal check-ups

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B4 to B7. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

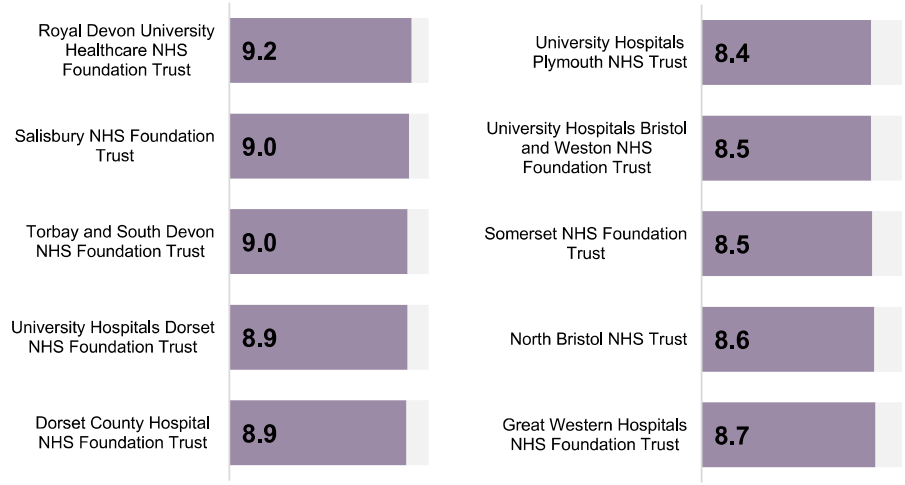
Your trust section score = 9.0 **Somewhat better than expected**



Each vertical line represents an individual NHS trust

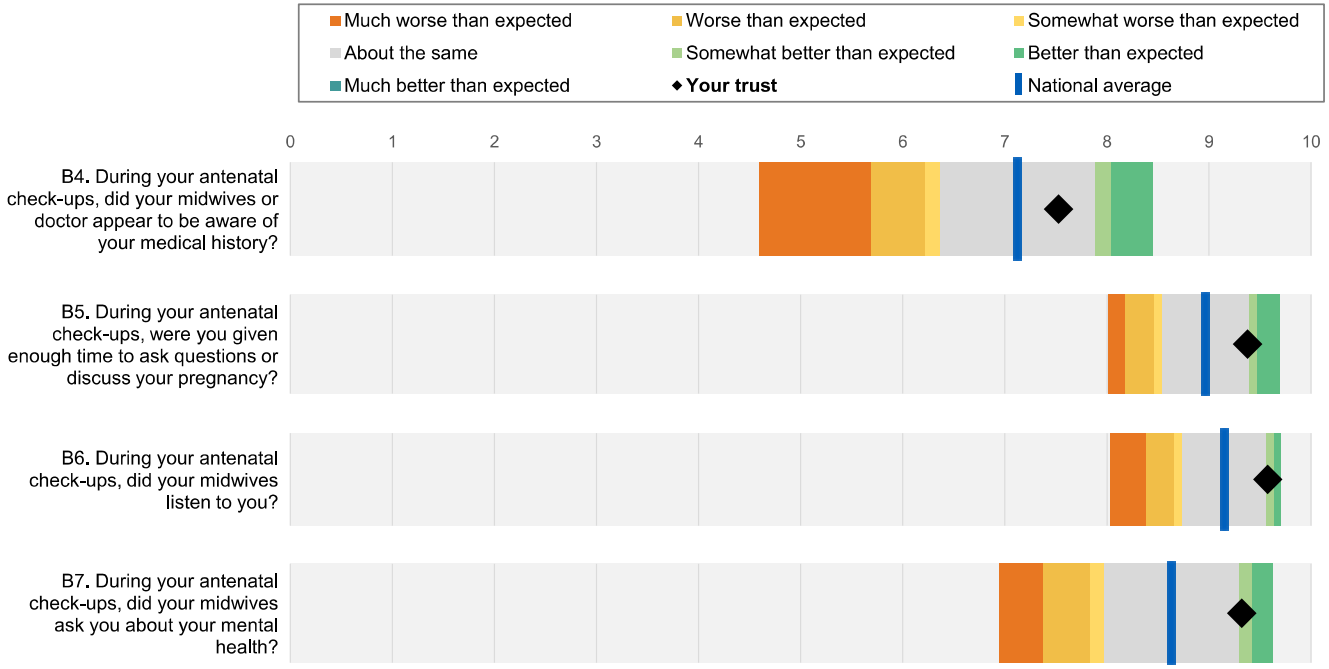
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: Antenatal check-ups

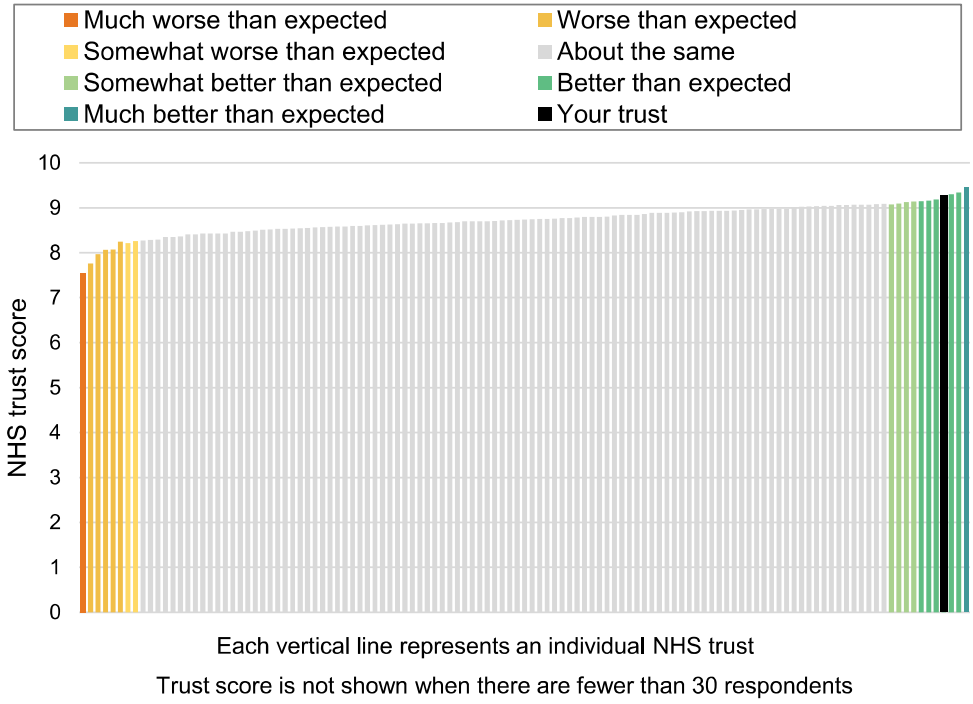


			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	115	7.5	7.1	4.6	8.4
About the same	116	9.4	9.0	8.0	9.7
Somewhat better than expected	115	9.6	9.2	8.0	9.7
Somewhat better than expected	116	9.3	8.6	6.9	9.6

During your pregnancy

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B8 to B16. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'better than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

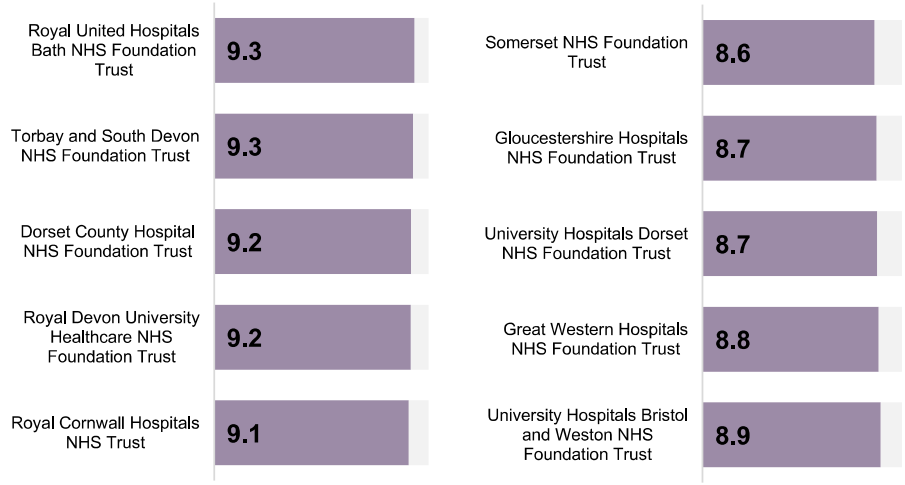
Your trust section score = 9.3 **Better than expected**



Each vertical line represents an individual NHS trust

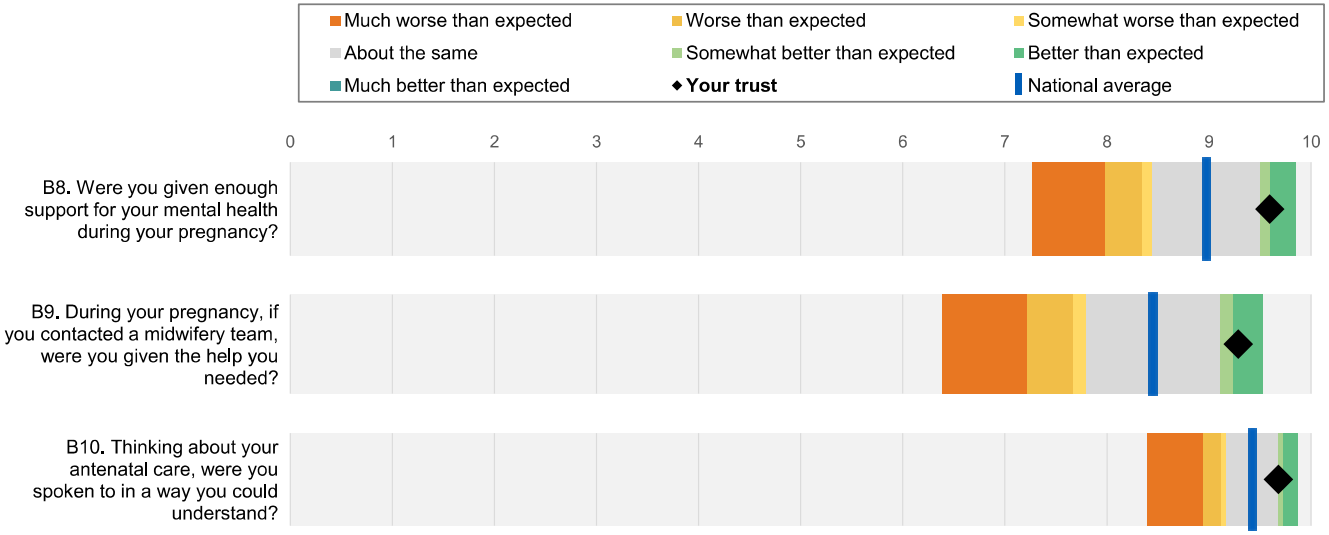
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 1. Antenatal Care

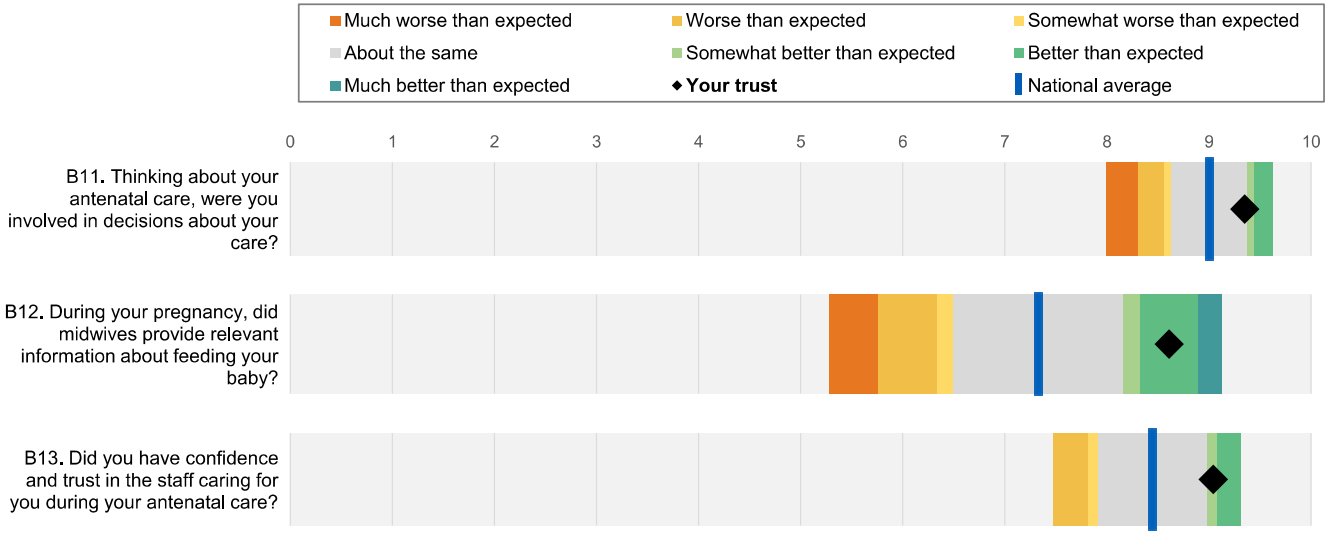
Question scores: During your pregnancy



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
Somewhat better than expected	76	9.6	9.0	7.3	9.8
Better than expected	111	9.3	8.5	6.4	9.5
About the same	115	9.7	9.4	8.4	9.9

Section 1. Antenatal Care (continued)

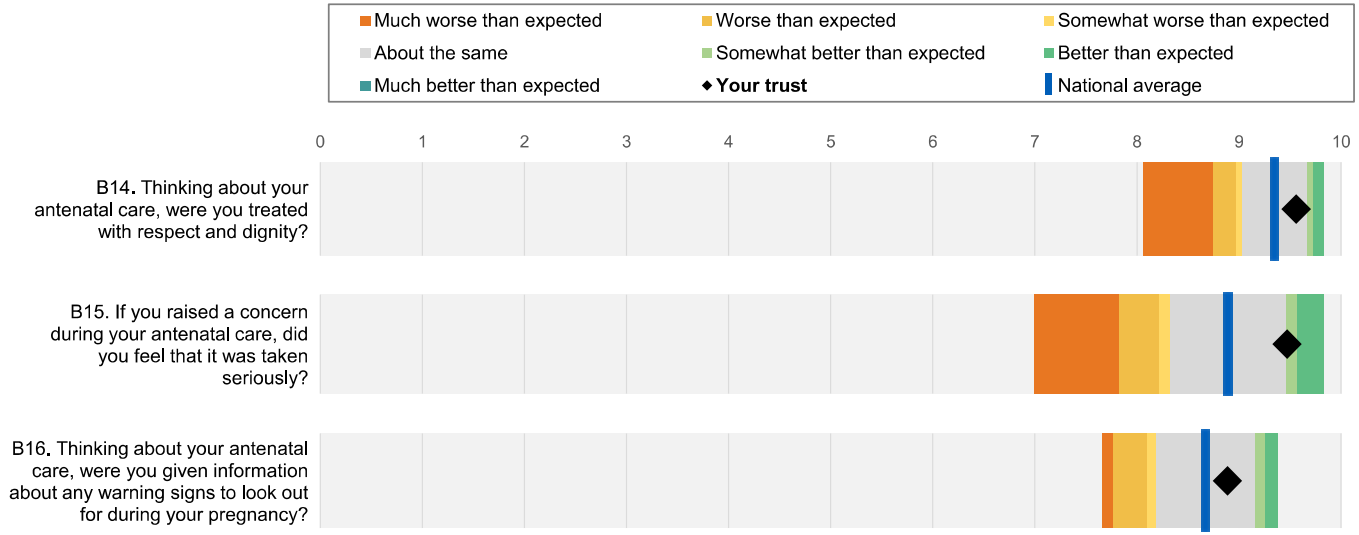
Question scores: During your pregnancy



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	114	9.4	9.0	8.0	9.6
Better than expected	115	8.6	7.3	5.3	9.1
Somewhat better than expected	117	9.0	8.4	7.5	9.3

Section 1. Antenatal Care (continued)

Question scores: During your pregnancy



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	117	9.6	9.3	8.1	9.8
Somewhat better than expected	94	9.5	8.9	7.0	9.8
About the same	116	8.9	8.7	7.7	9.4

Scoring and benchmarking

Section 2: Labour and Birth

CareQuality Commission

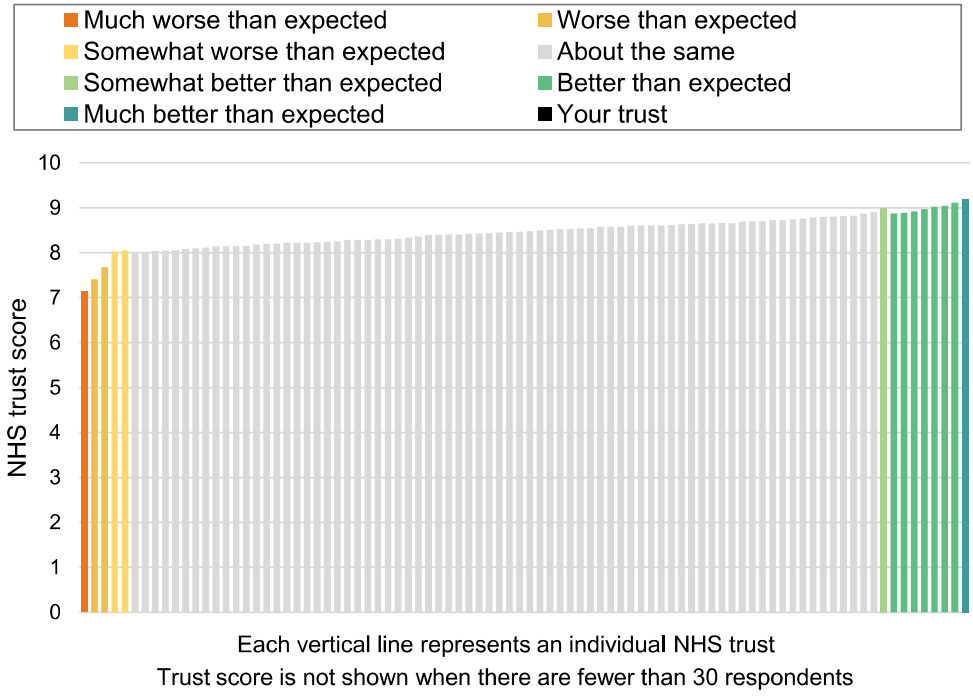
Survey Coordination Centre

NHS

Your labour and birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 and C6 to C9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

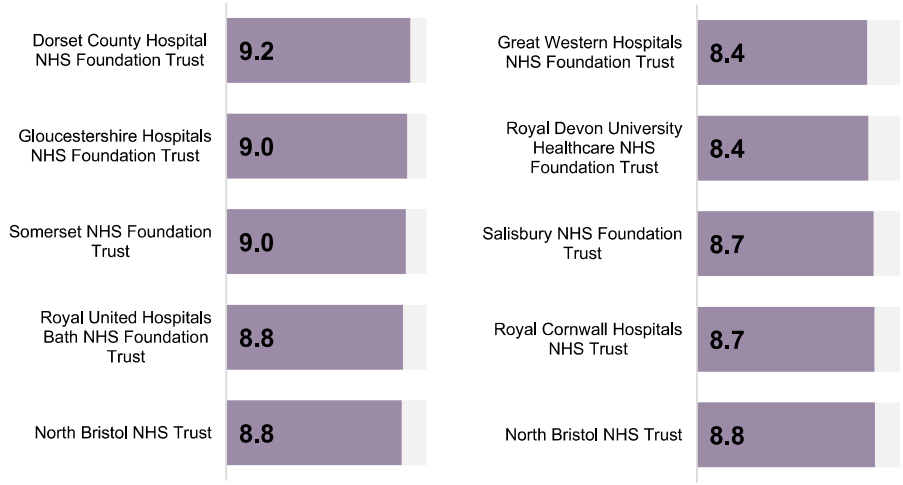
Your trust section score = - **No section score due to low number of responses**



Each vertical line represents an individual NHS trust

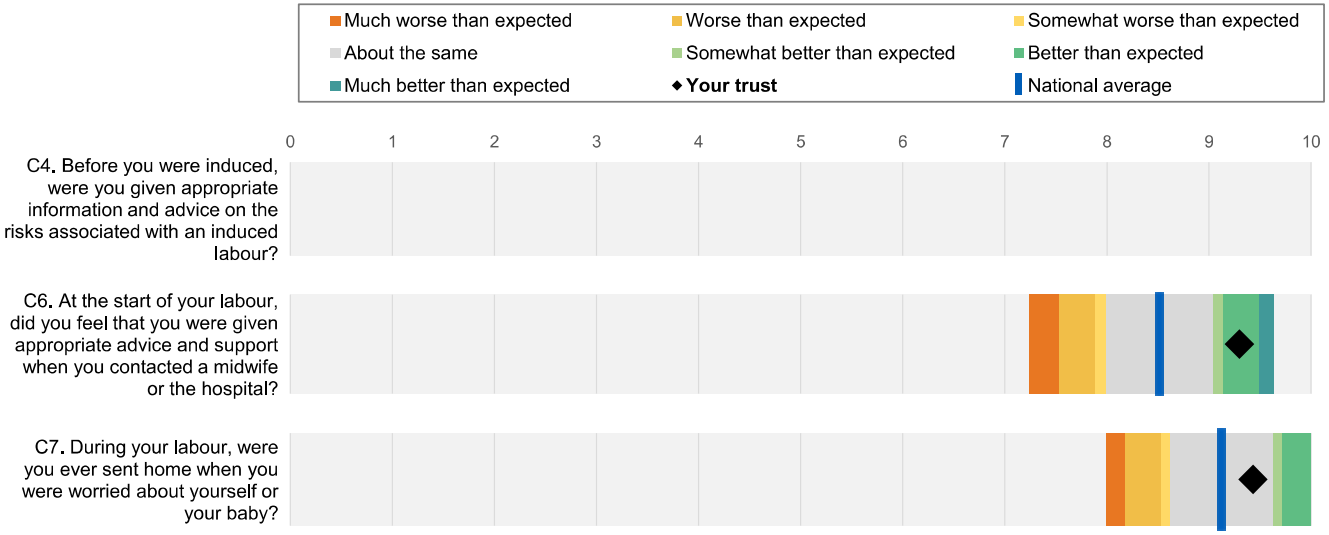
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 2. Labour and Birth

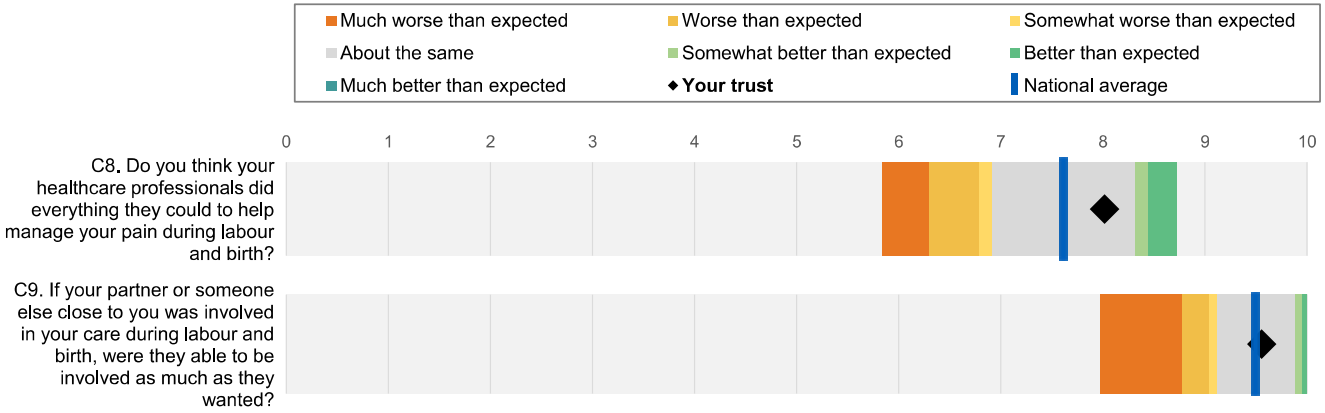
Question scores: Your labour and birth



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
-	-	-	7.6	4.9	9.0
Better than expected	74	9.3	8.5	7.2	9.6
About the same	77	9.4	9.1	8.0	10.0

Section 2. Labour and Birth (continued)

Question scores: Your labour and birth

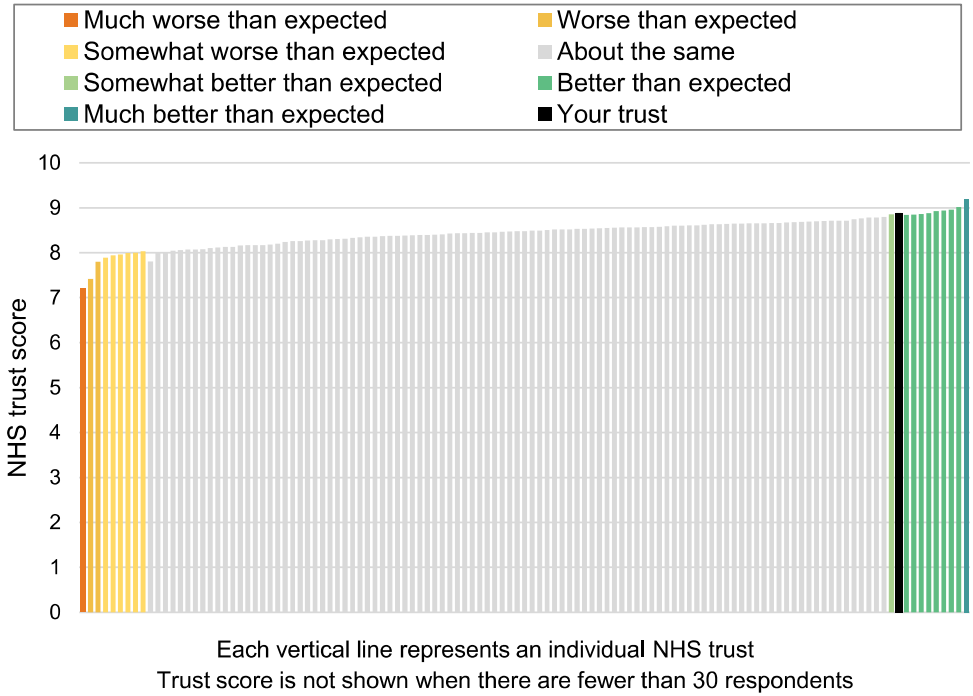


			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	74	8.0	7.6	5.8	8.7
About the same	115	9.6	9.5	8.0	10.0

Staff caring for you

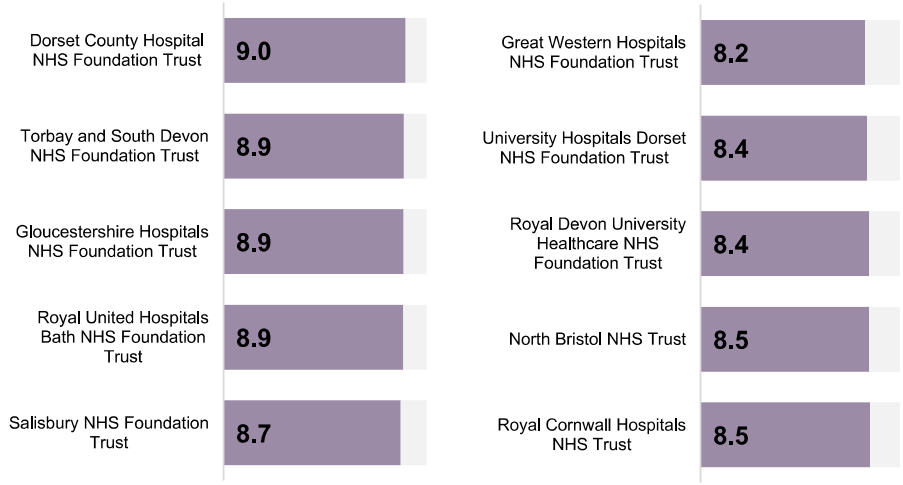
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.9 **Somewhat better than expected**



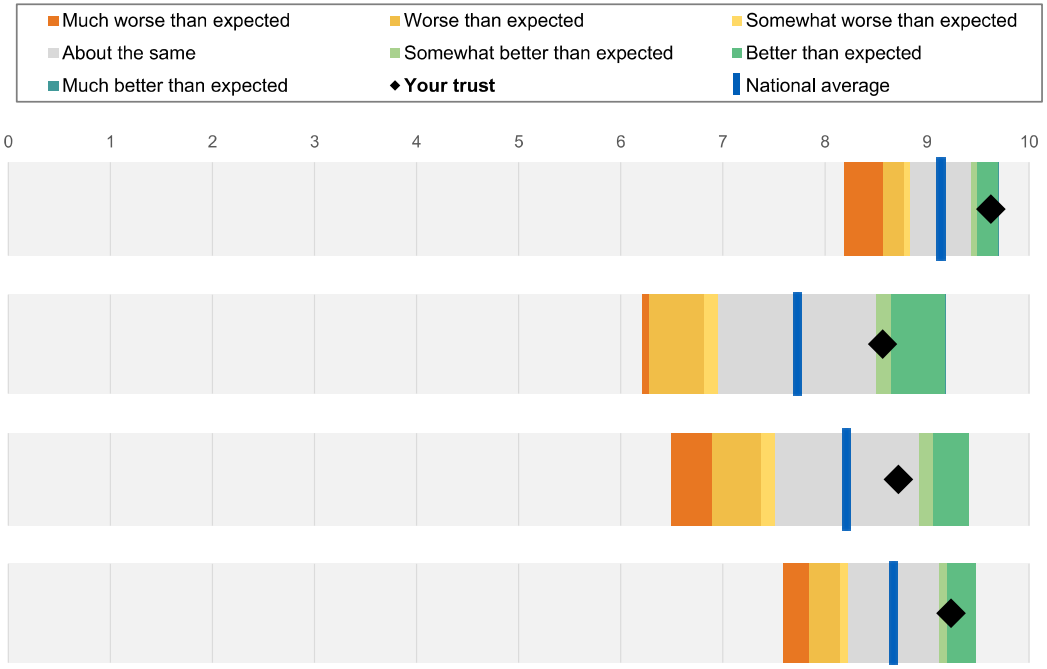
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 2. Labour and Birth

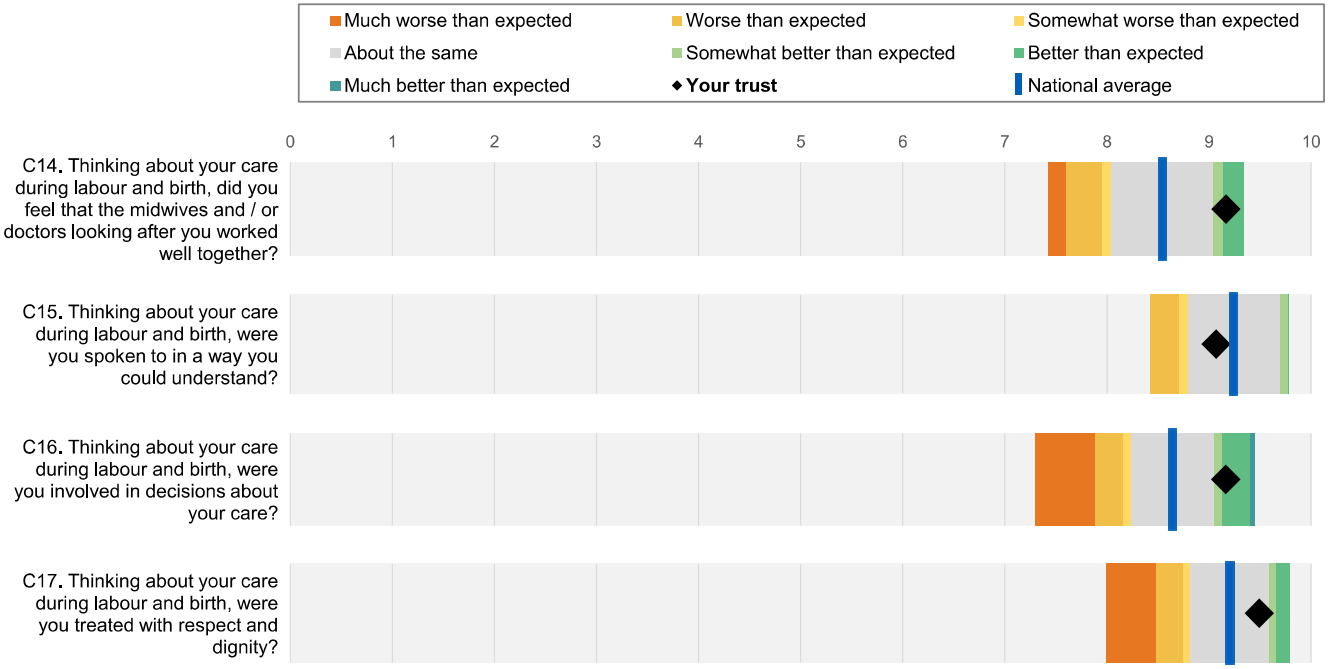
Question scores: Staff caring for you



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
Better than expected	112	9.6	9.1	8.2	9.7
Somewhat better than expected	117	8.6	7.7	6.2	9.2
About the same	78	8.7	8.2	6.5	9.4
Better than expected	113	9.2	8.7	7.6	9.5

Section 2. Labour and Birth (continued)

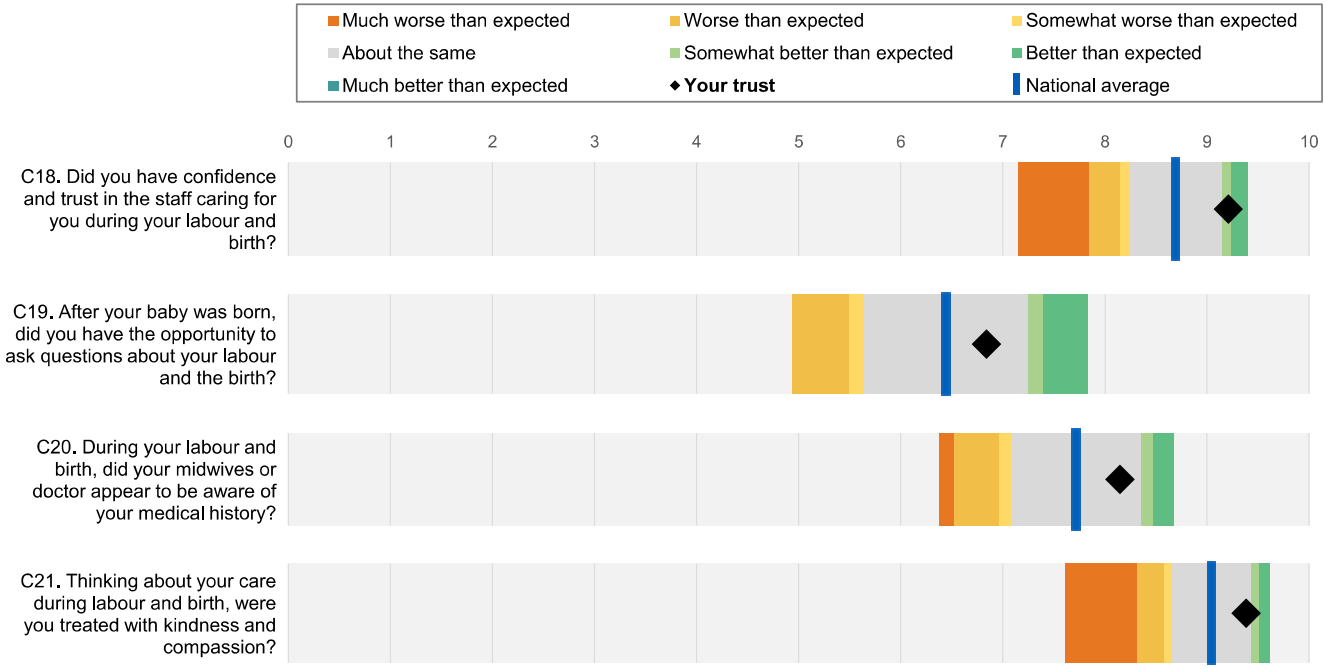
Question scores: Staff caring for you



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
Better than expected	114	9.2	8.5	7.4	9.3
About the same	115	9.1	9.2	8.4	9.8
Better than expected	113	9.2	8.6	7.3	9.4
About the same	116	9.5	9.2	8.0	9.8

Section 2. Labour and Birth (continued)

Question scores: Staff caring for you



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
Somewhat better than expected	116	9.2	8.7	7.2	9.4
About the same	105	6.8	6.4	4.9	7.8
About the same	102	8.1	7.7	6.4	8.7
About the same	117	9.4	9.0	7.6	9.6

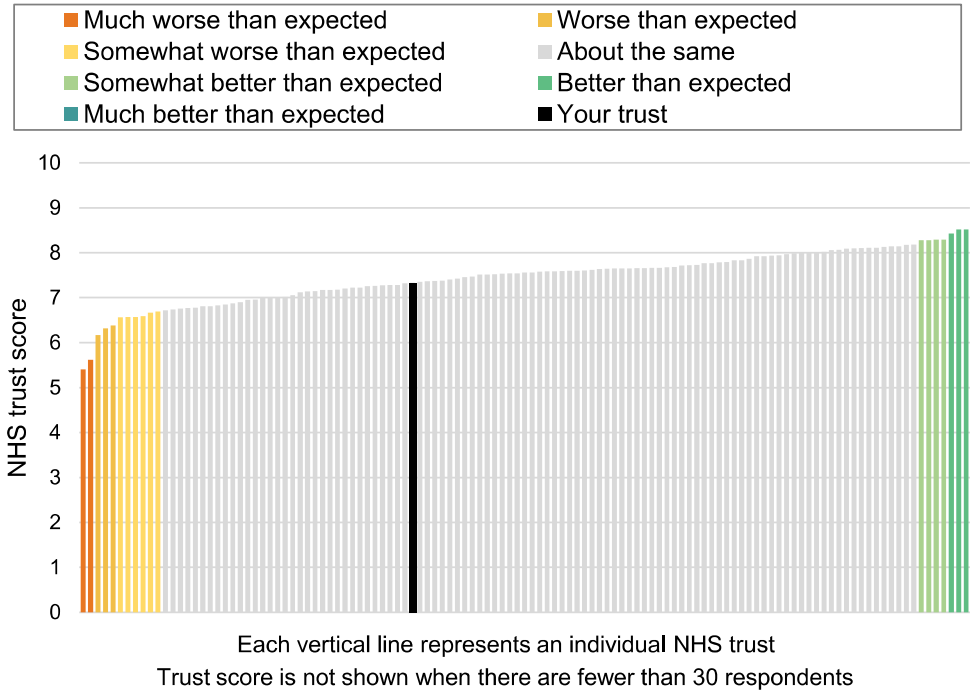
Scoring and benchmarking

Section 3: Care in the ward after birth

Care in the ward after birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D7. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

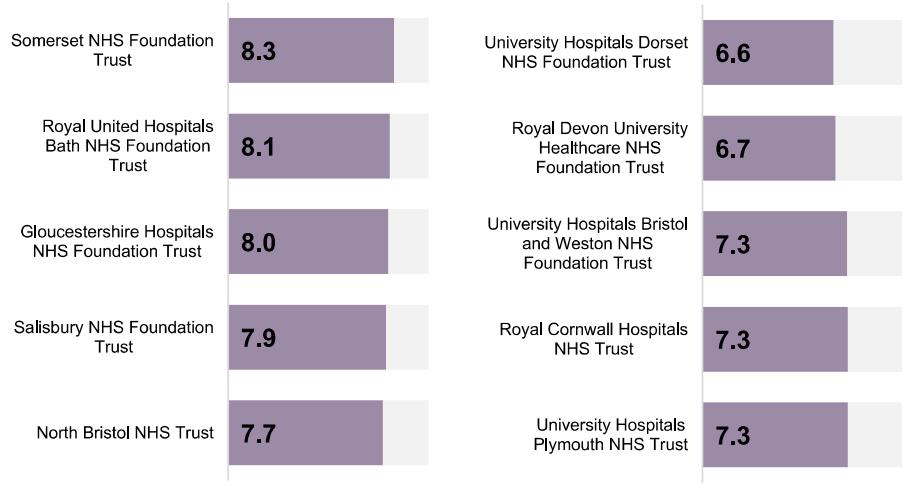
Your trust section score = 7.3 **About the same**



Each vertical line represents an individual NHS trust

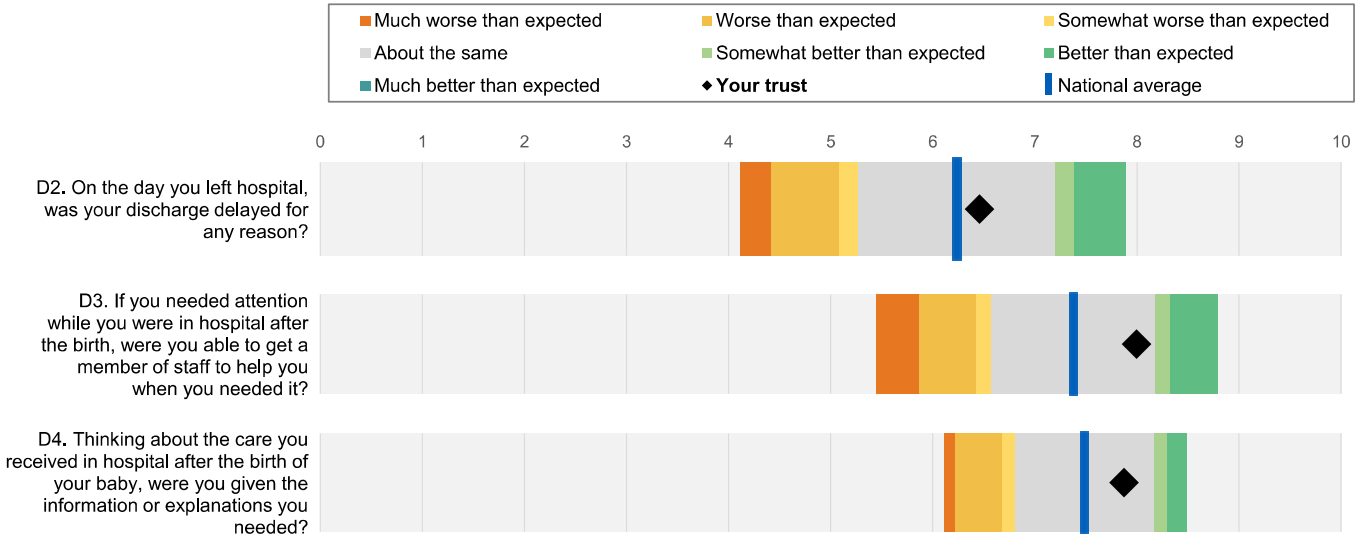
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 3. Care in the ward after birth

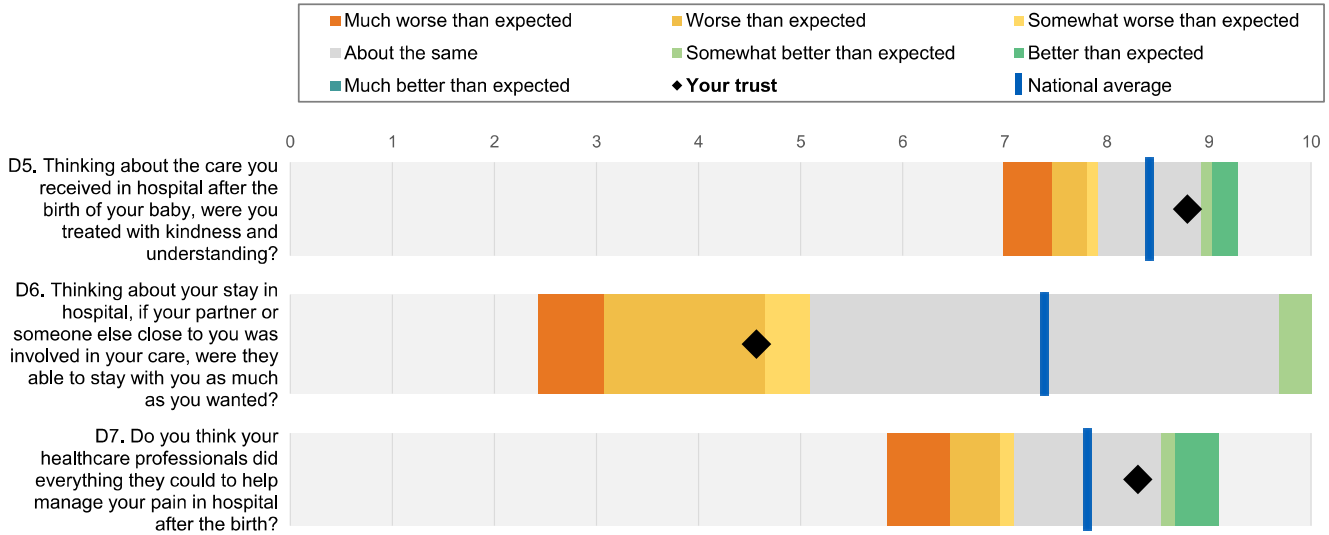
Question scores



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	116	6.5	6.2	4.1	7.9
About the same	108	8.0	7.4	5.5	8.8
About the same	113	7.9	7.5	6.1	8.5

Section 3. Care in the ward after birth (continued)

Question scores



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	116	8.8	8.4	7.0	9.3
Worse than expected	110	4.6	7.4	2.4	10.0
About the same	104	8.3	7.8	5.9	9.1

Scoring and benchmarking

Section 4: Postnatal Care

CareQuality Commission

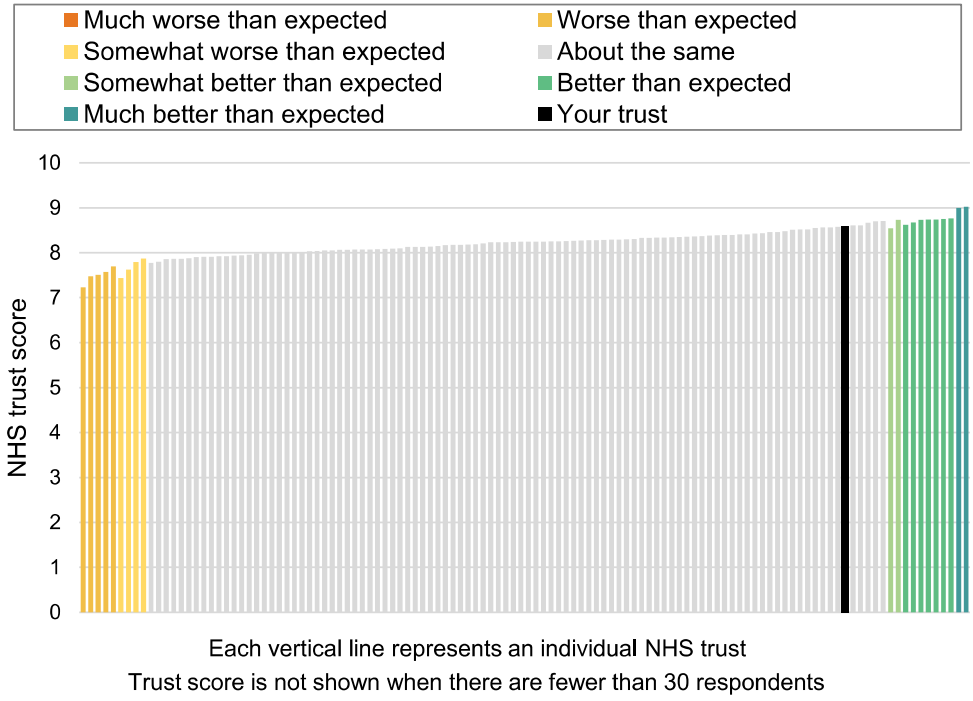
Survey Coordination Centre

NHS

Feeding your baby

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

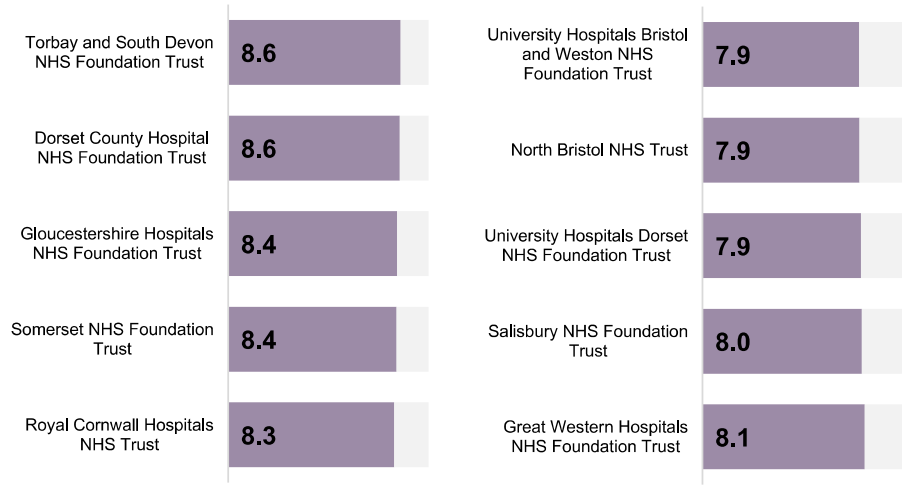
Your trust section score = 8.6 **About the same**



Each vertical line represents an individual NHS trust

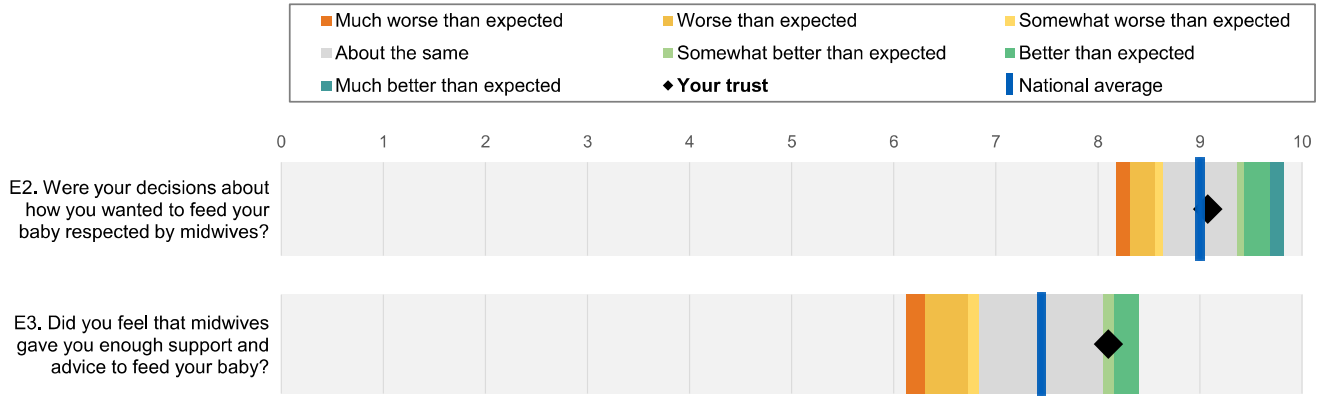
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 4. Postnatal Care

Question scores: Feeding your baby

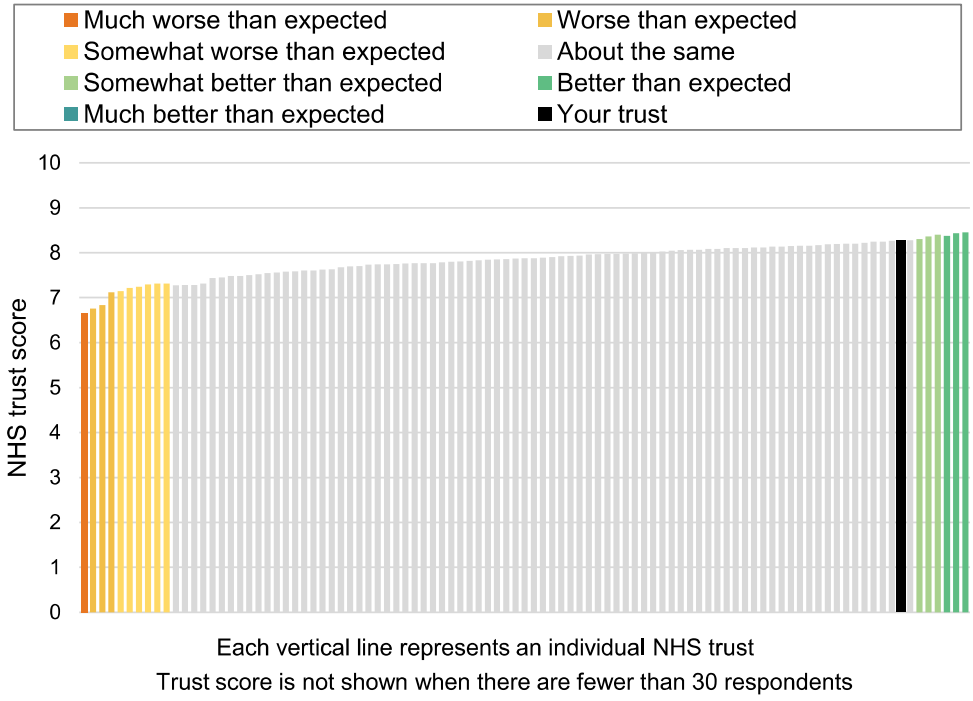


			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	117	9.1	9.0	8.2	9.8
Somewhat better than expected	114	8.1	7.4	6.1	8.4

Care at home after birth

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions G1 and G2, G4 to G8, and G10 to G16. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

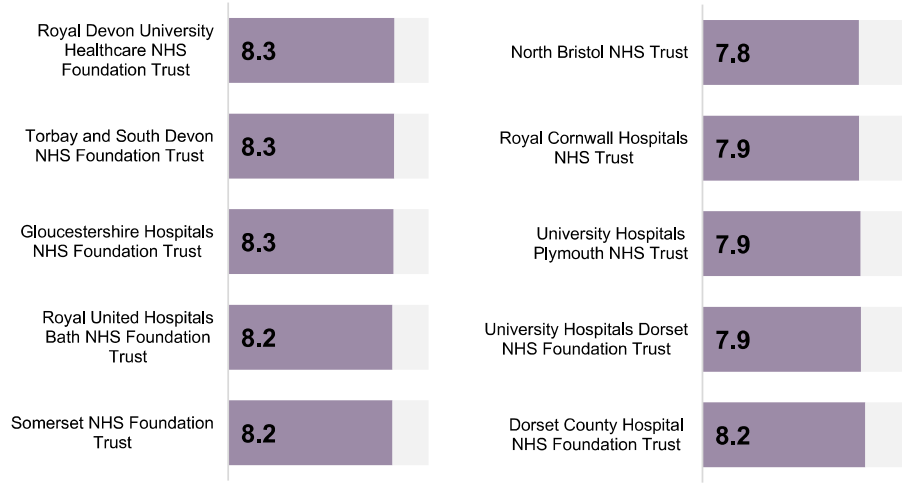
Your trust section score = 8.3 **About the same**



Each vertical line represents an individual NHS trust

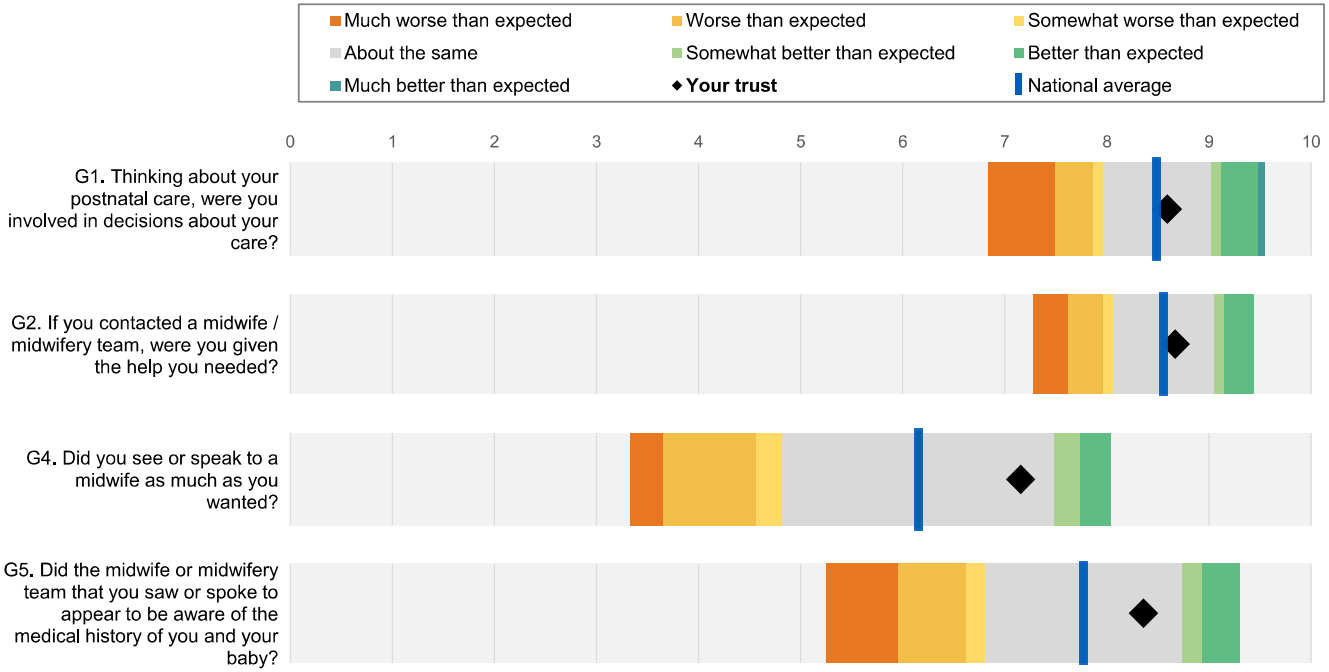
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 4. Postnatal Care

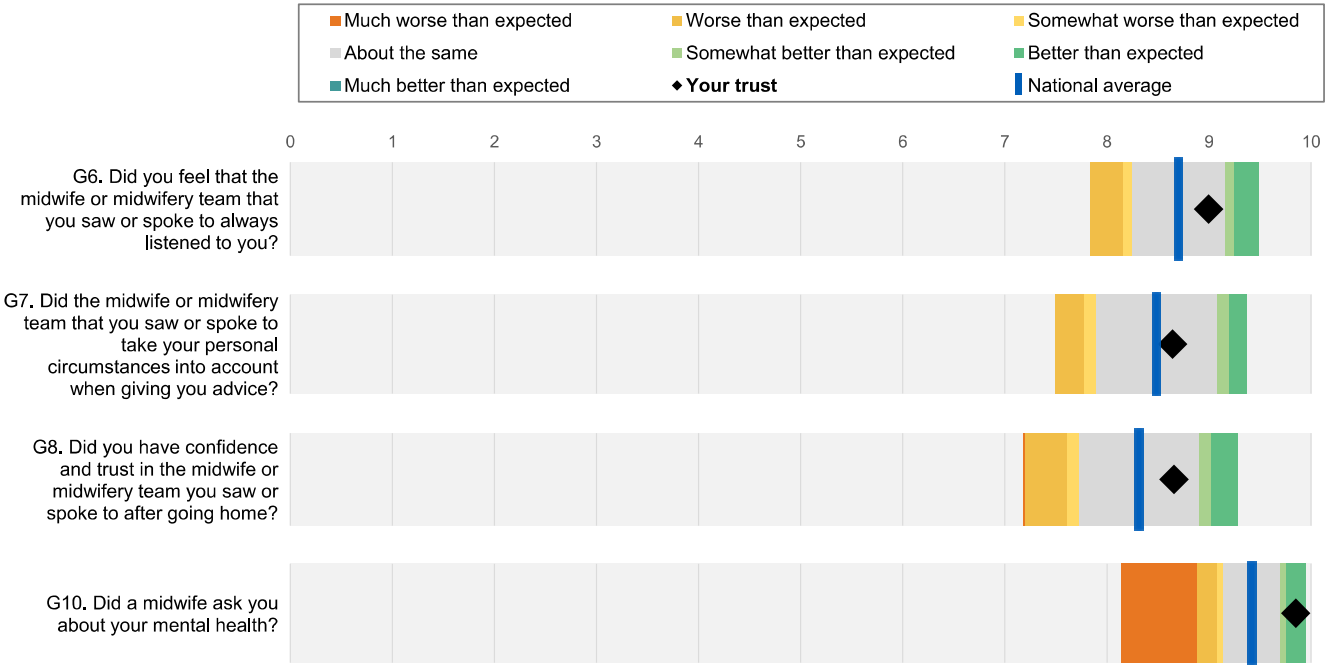
Question scores: Care at home after birth



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	113	8.6	8.5	6.8	9.5
About the same	105	8.7	8.6	7.3	9.4
About the same	117	7.2	6.2	3.3	8.0
About the same	109	8.4	7.8	5.2	9.3

Section 4. Postnatal Care (continued)

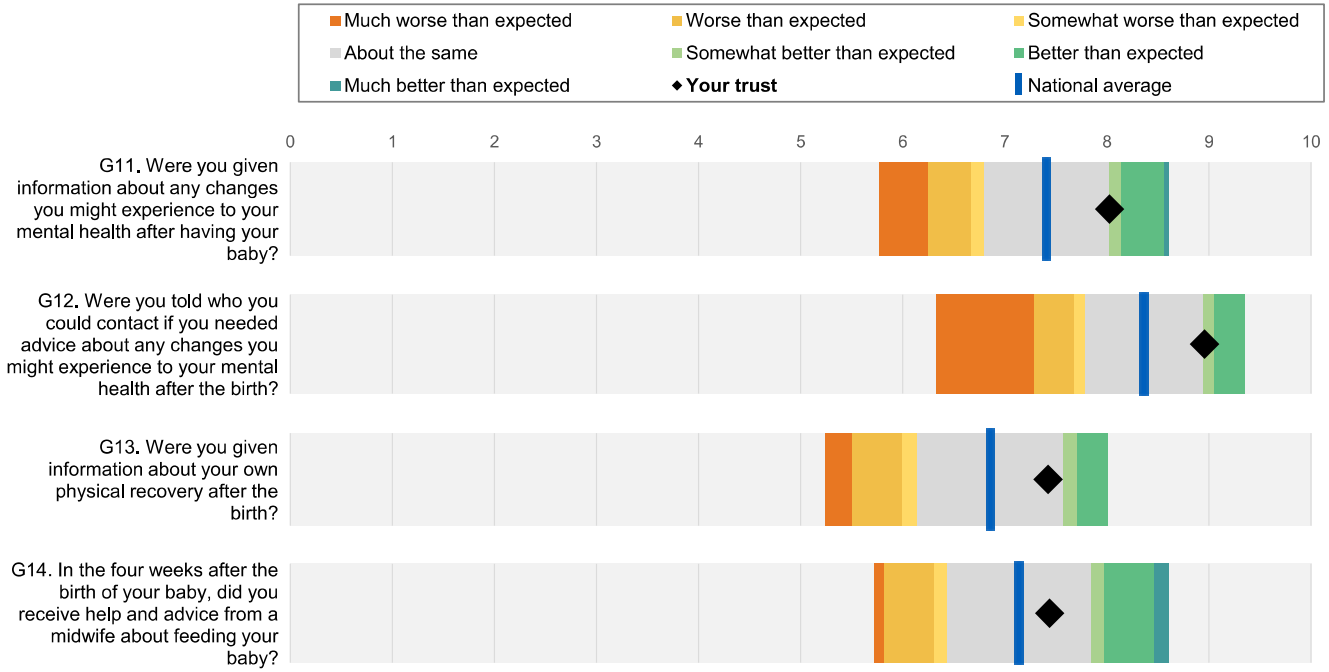
Question scores: Care at home after birth



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
About the same	117	9.0	8.7	7.8	9.5
About the same	112	8.6	8.5	7.5	9.4
About the same	117	8.7	8.3	7.2	9.3
Better than expected	115	9.8	9.4	8.1	9.9

Section 4. Postnatal Care (continued)

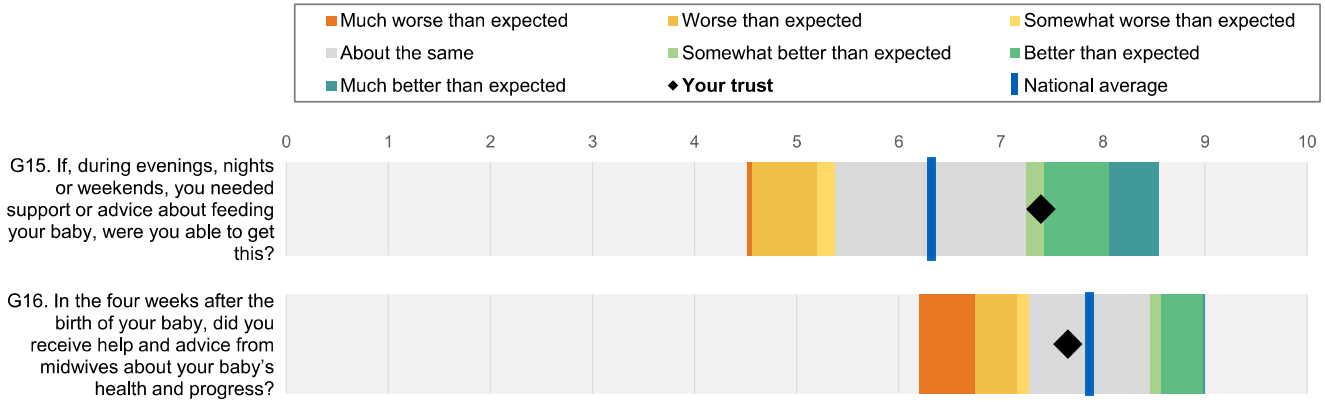
Question scores: Care at home after birth



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
Somewhat better than expected	113	8.0	7.4	5.8	8.6
Somewhat better than expected	110	9.0	8.4	6.3	9.3
About the same	110	7.4	6.9	5.2	8.0
About the same	101	7.4	7.1	5.7	8.6

Section 4. Postnatal Care (continued)

Question scores: Care at home after birth



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
Somewhat better than expected	51	7.4	6.3	4.5	8.6
About the same	103	7.7	7.9	6.2	9.0

Scoring and benchmarking

Section 5: Triage: Assessment and Evaluation

CareQuality Commission

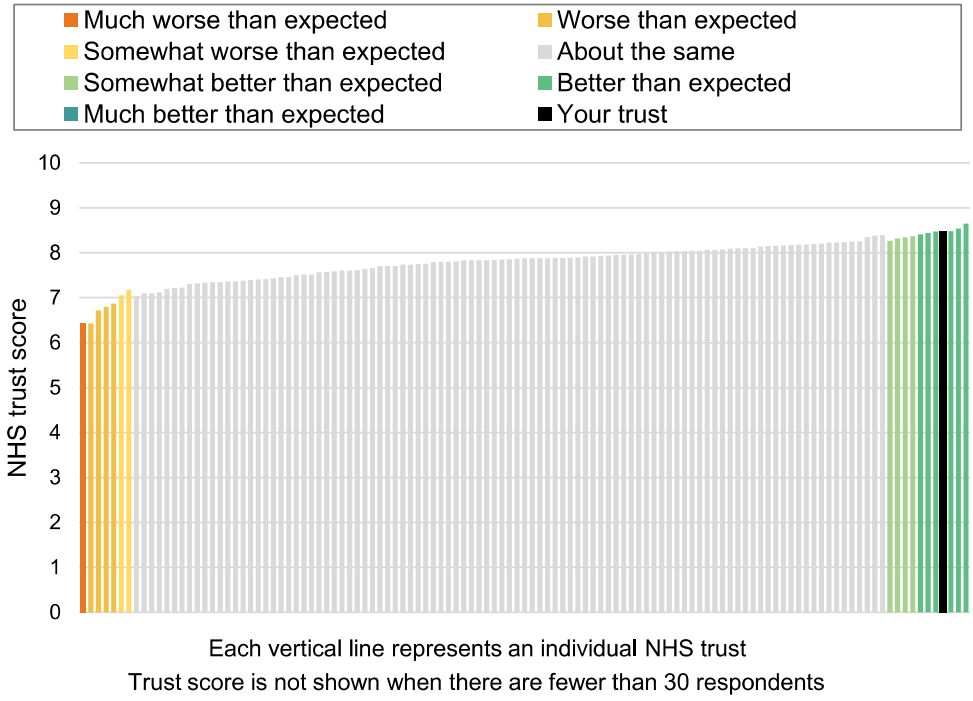
Survey Coordination Centre

NHS

Triage: Assessment and Evaluation

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'triage: assessment and evaluation' is calculated from questions F2-F4. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

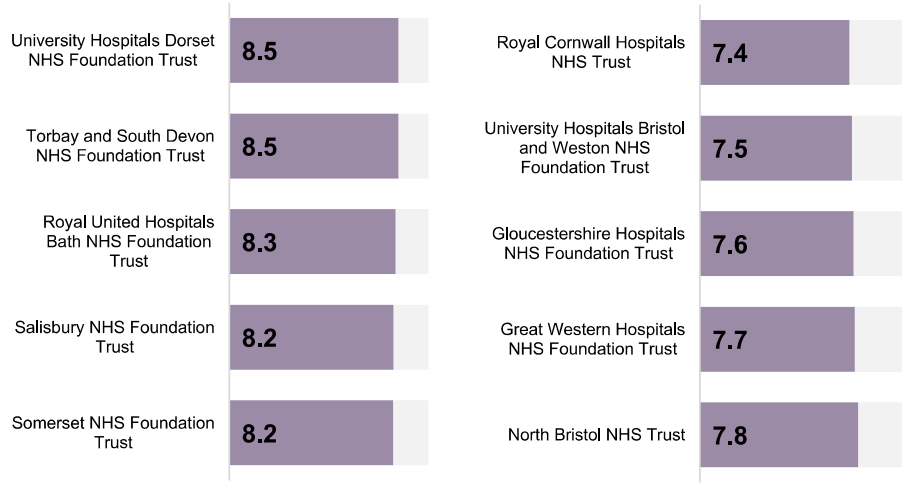
Your trust section score = 8.5 **Better than expected**



Each vertical line represents an individual NHS trust

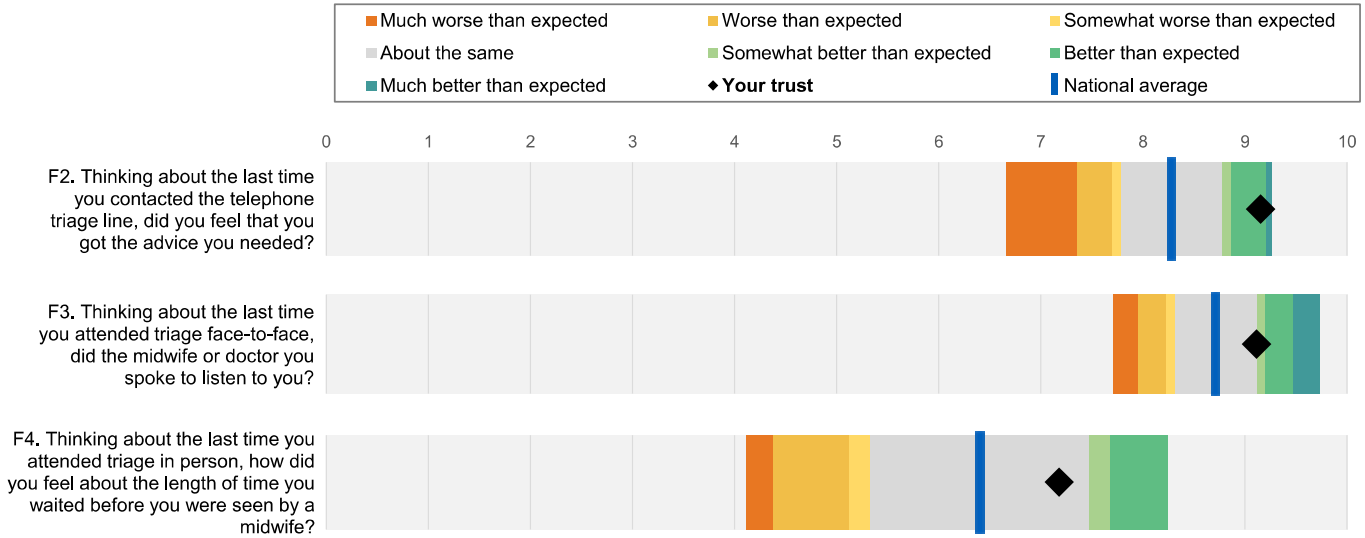
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 5. Triage: Assessment and Evaluation

Question scores



			All trusts in England		
	Number of respondents	Your trust score	National average	Lowest score	Highest score
Better than expected	83	9.2	8.3	6.7	9.3
About the same	78	9.1	8.7	7.7	9.7
About the same	75	7.2	6.4	4.1	8.2

Scoring and benchmarking

Section 6: Complaints

Care Quality Commission

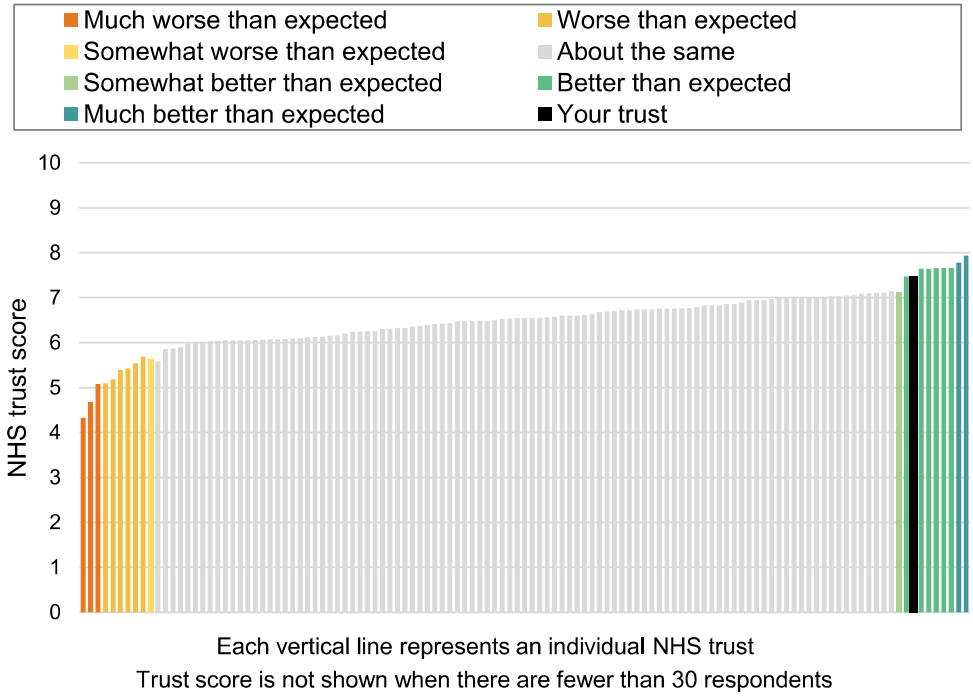
Survey Coordination Centre

NHS

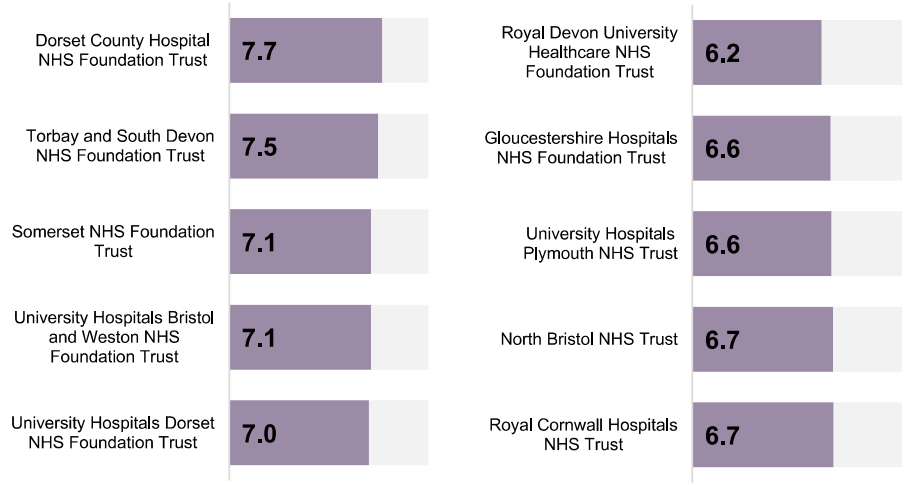
Complaints

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'complaints' is calculated from question G19. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.5 **Better than expected**

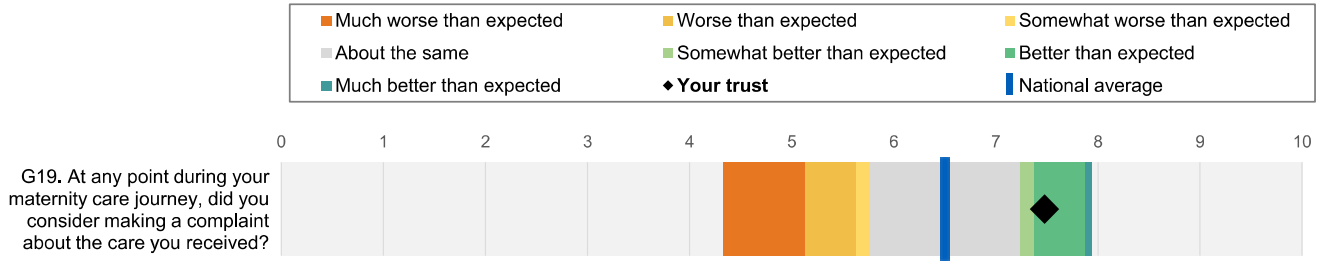


Comparison with other trusts within your region



Section 6. Complaints

Question scores



Better than expected

		All trusts in England		
Number of respondents	Your trust score	National average	Lowest score	Highest score
115	7.5	6.5	4.3	7.9

Trust and site results

This section includes:

- an overview of results for your trust for each question, including:
  - the score for your trust
  - a breakdown of scores across sites within your trust
- if fewer than 30 responses were received from maternity service users at a site, no scores will be displayed for that site
- in some cases where there is only one site within a trust, the trust score and banding may differ from the site score and banding. This is because benchmarking is calculated separately at trust and site levels

Please note: If data is missing, this is due to a low number of responses.

CareQuality Commission

Survey Coordination Centre

NHS

Trust and site results

Section 1: Antenatal Care

CareQuality Commission

Survey Coordination Centre

NHS

Section 1: Antenatal Care

Please note, results about antenatal care are not attributed at site level. Only results that are about hospital care are attributed at site level.

Trust and site results

Section 2: Labour and Birth

CareQuality Commission

Survey Coordination Centre

NHS

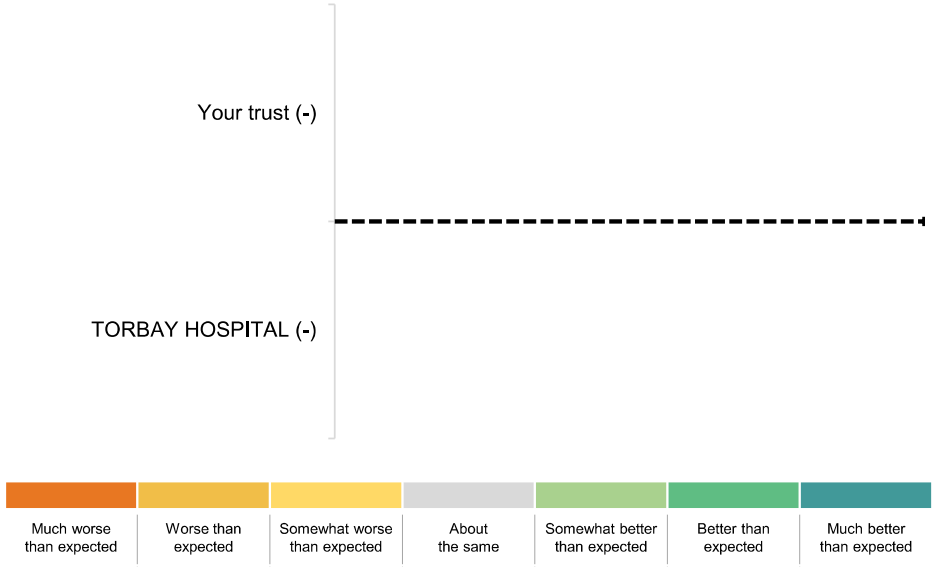
Section 2. Labour and Birth

Your labour and birth

C4. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

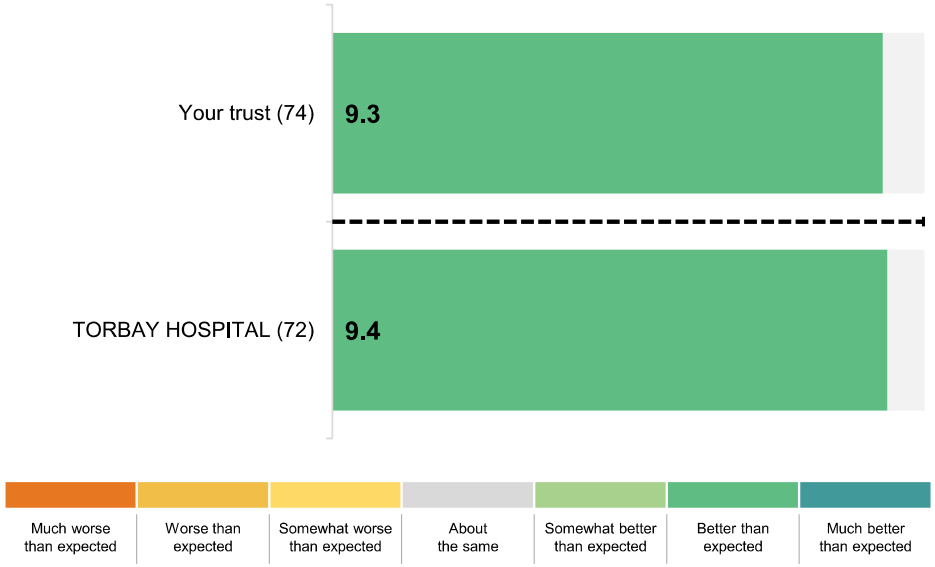
Section 2. Labour and Birth

Your labour and birth

C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

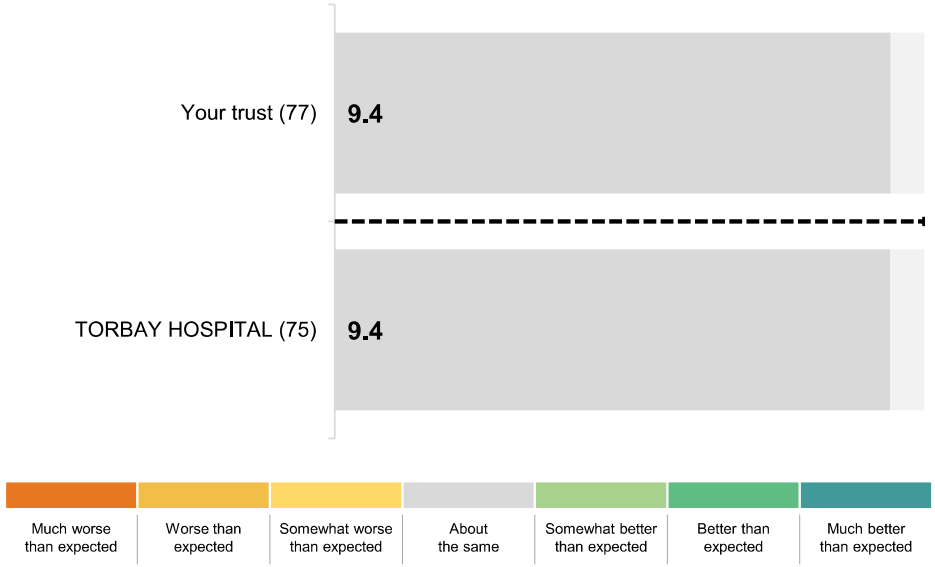
Section 2. Labour and Birth

Your labour and birth

C7. During your labour, were you ever sent home when you were worried about yourself or your baby?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

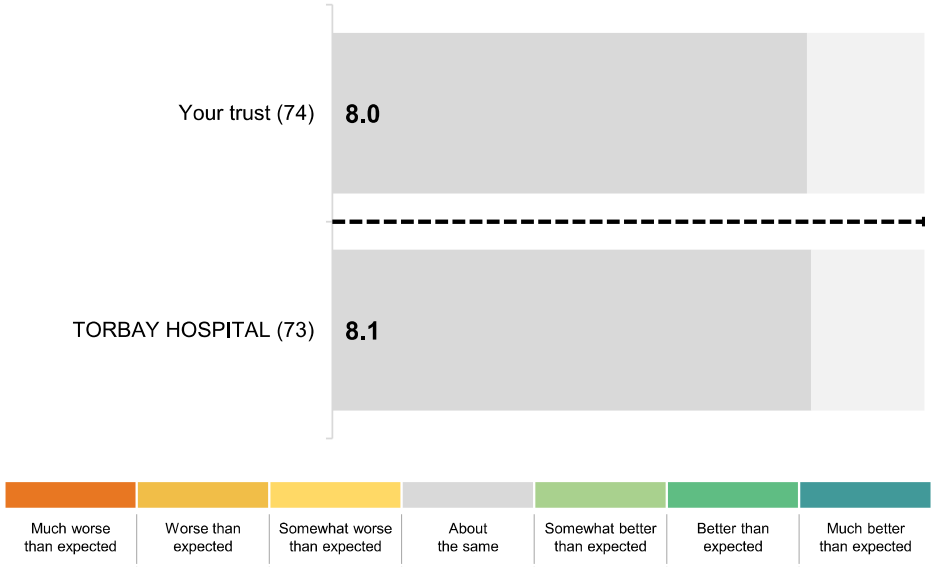
Section 2. Labour and Birth

Your labour and birth

C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

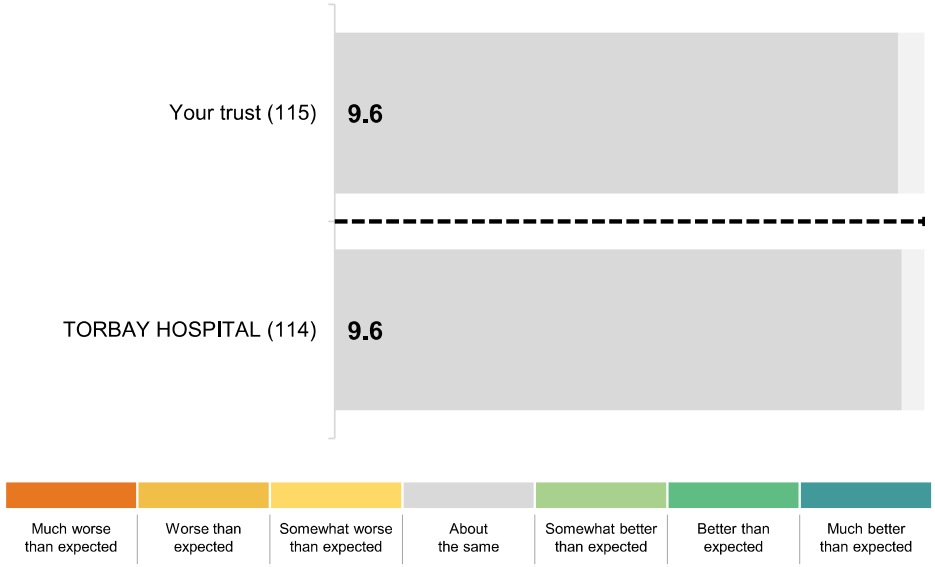
Section 2. Labour and Birth

Your labour and birth

C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

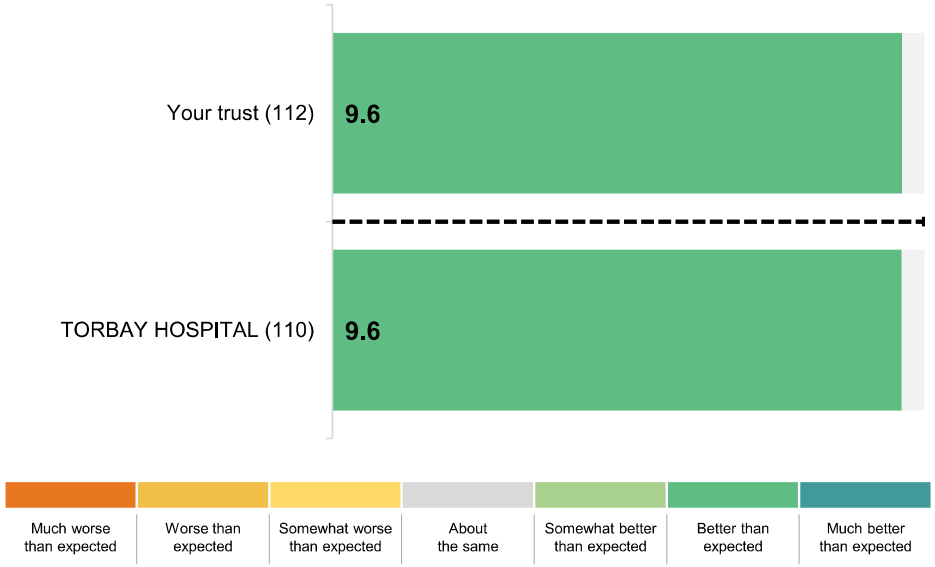
Section 2. Labour and Birth

Staff caring for you

C10. Did the staff treating and examining you introduce themselves?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

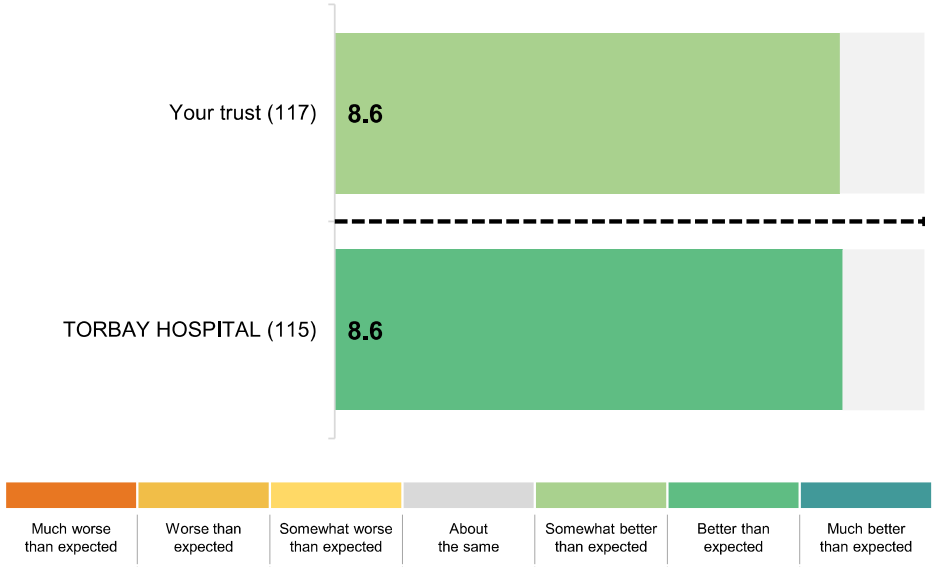
Section 2. Labour and Birth

Staff caring for you

C11. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

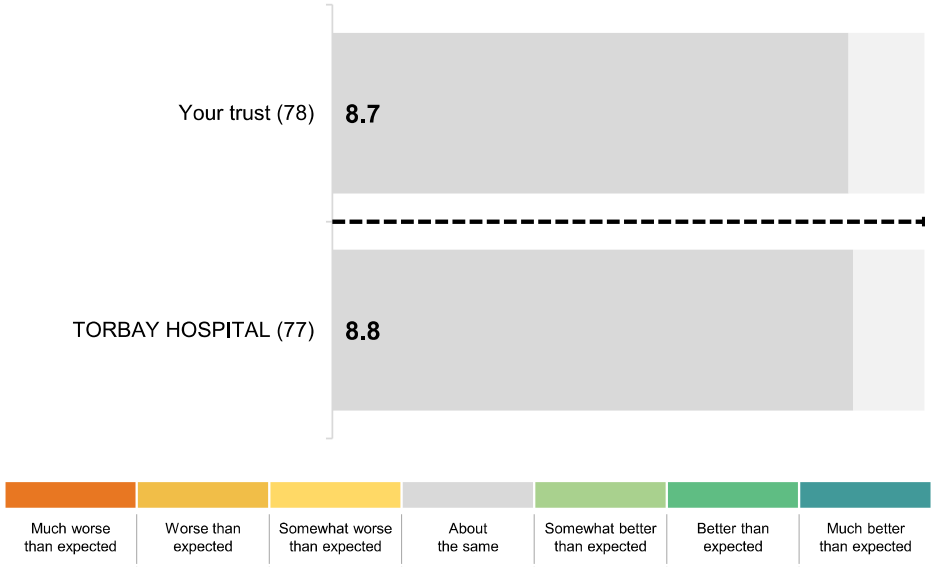
Section 2. Labour and Birth

Staff caring for you

C12. If you raised a concern during labour and birth, did you feel that it was taken seriously?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

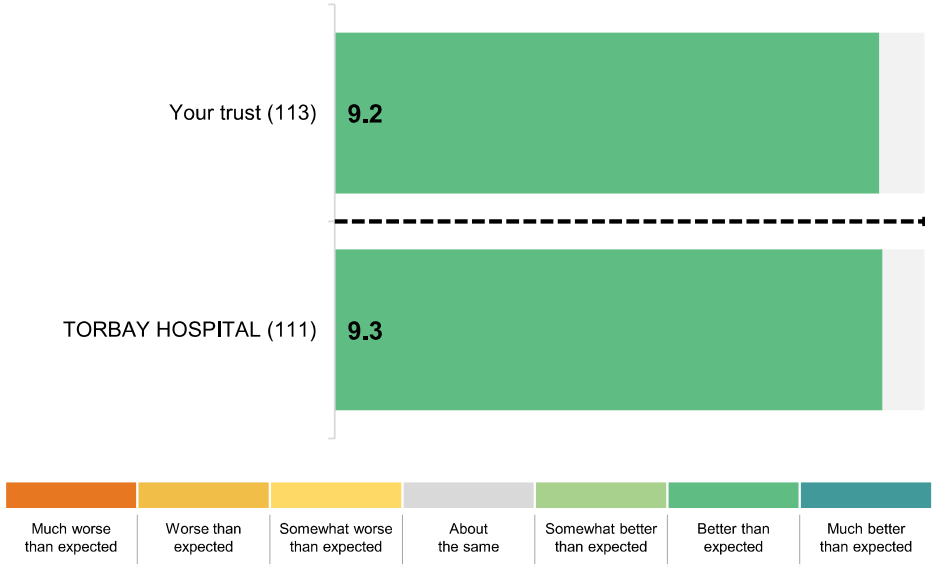
Section 2. Labour and Birth

Staff caring for you

C13. During labour and birth, were you able to get a member of staff to help you when you needed it?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

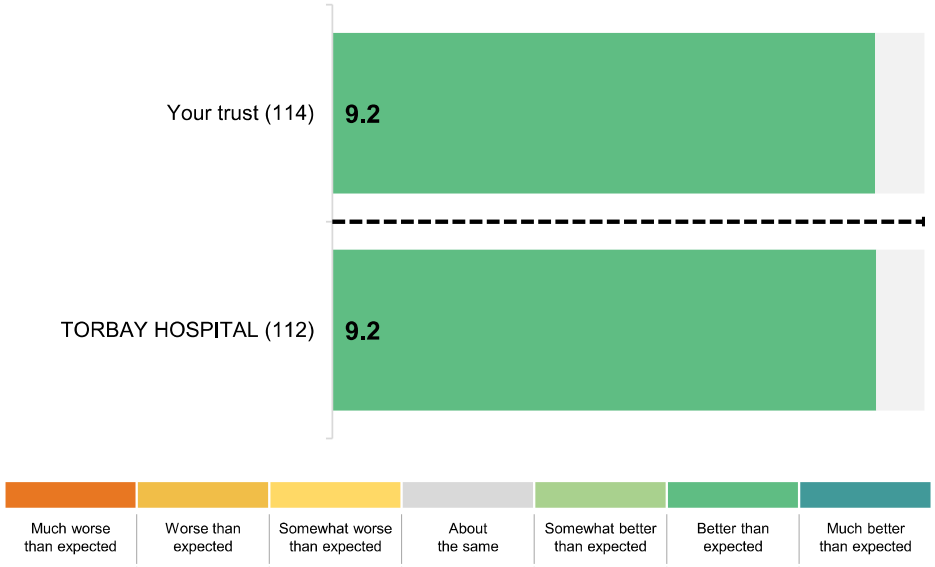
Section 2. Labour and Birth

Staff caring for you

C14. Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

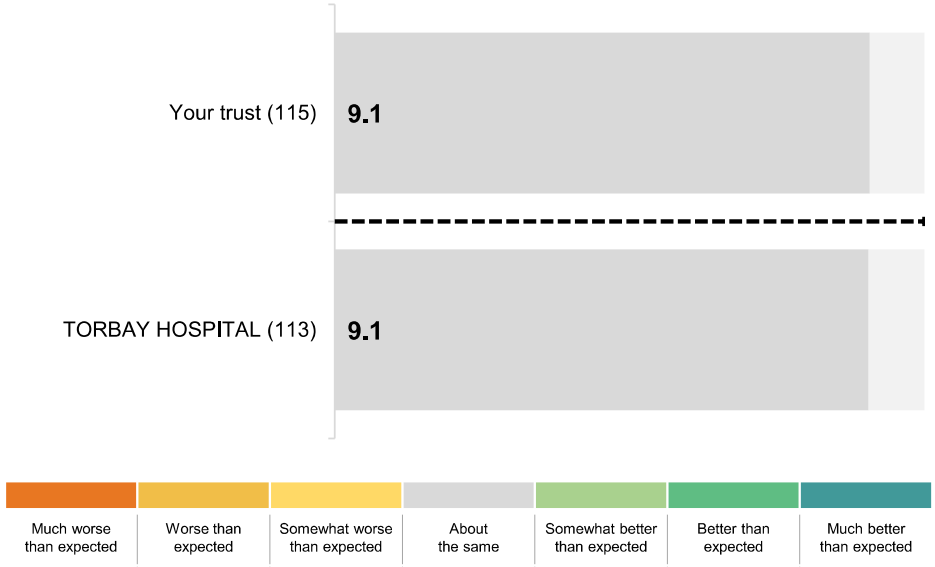
Section 2. Labour and Birth

Staff caring for you

C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

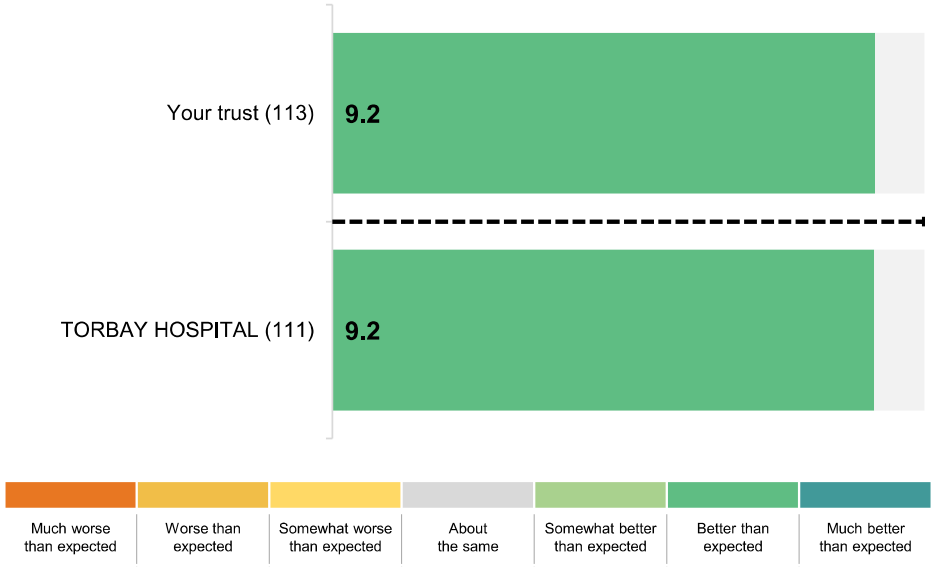
Section 2. Labour and Birth

Staff caring for you

C16. Thinking about your care during labour and birth, were you involved in decisions about your care?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

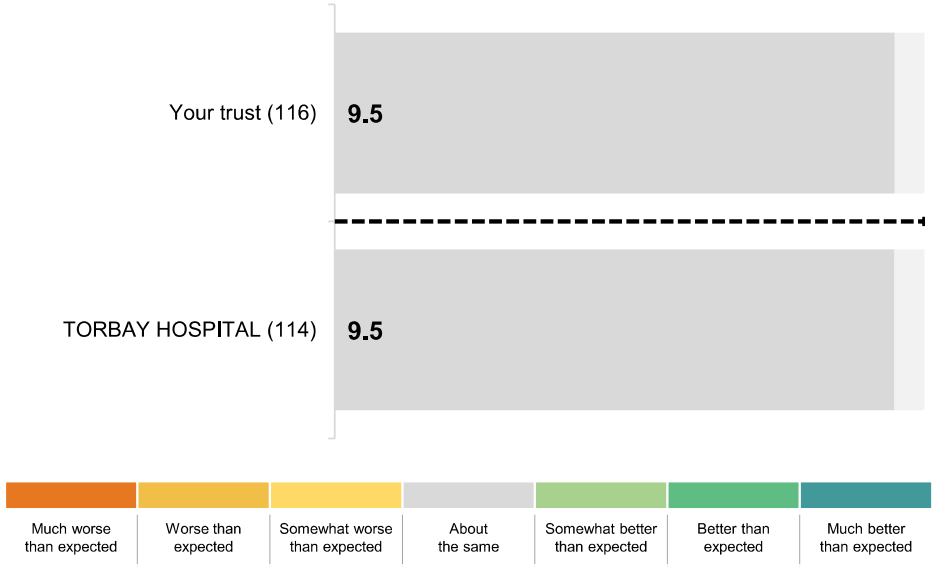
Section 2. Labour and Birth

Staff caring for you

C17. Thinking about your care during labour and birth, were you treated with respect and dignity?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

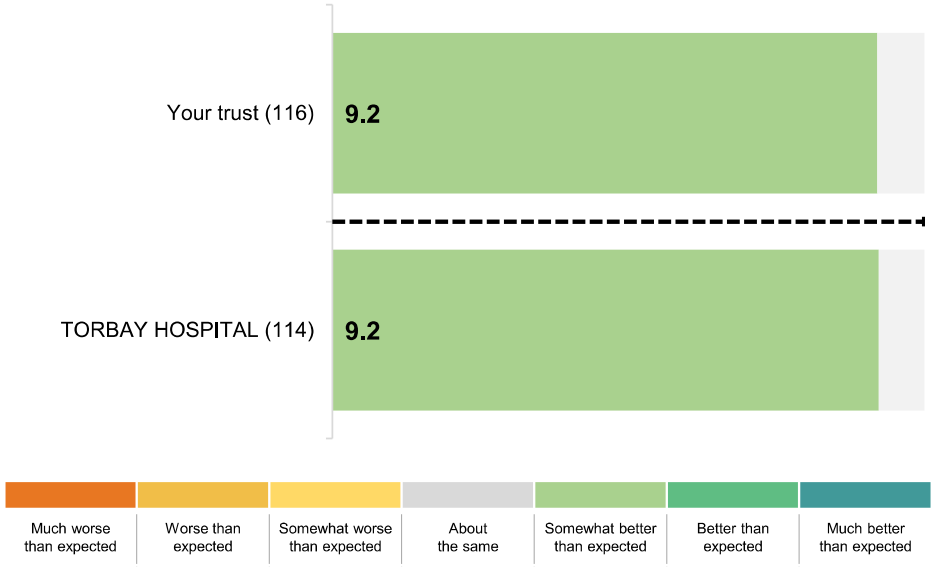
Section 2. Labour and Birth

Staff caring for you

C18. Did you have confidence and trust in the staff caring for you during your labour and birth?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

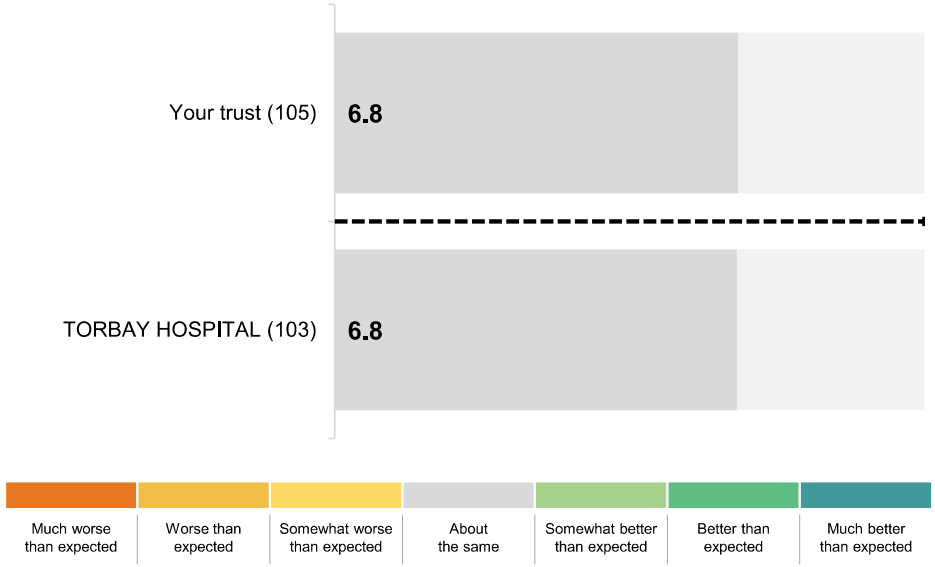
Section 2. Labour and Birth

Staff caring for you

C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

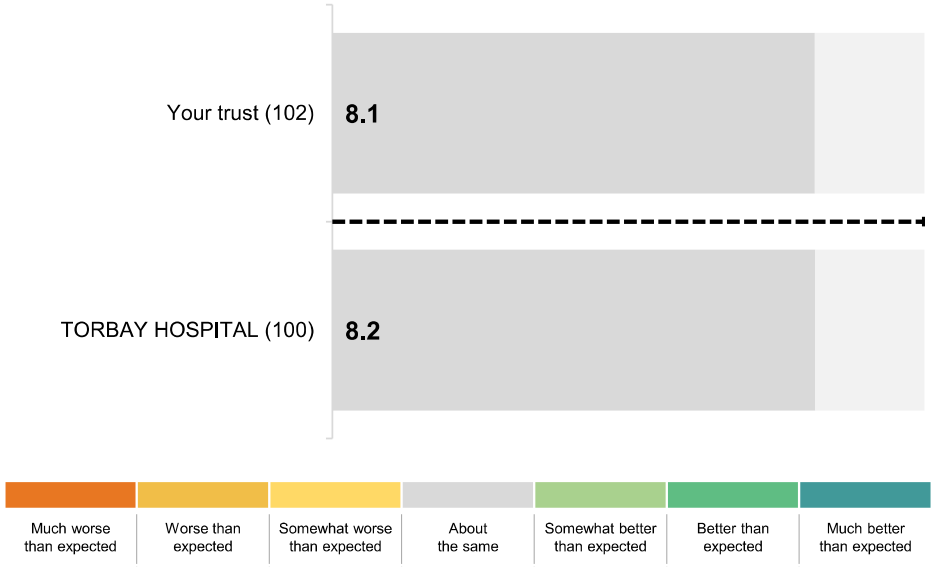
Section 2. Labour and Birth

Staff caring for you

C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

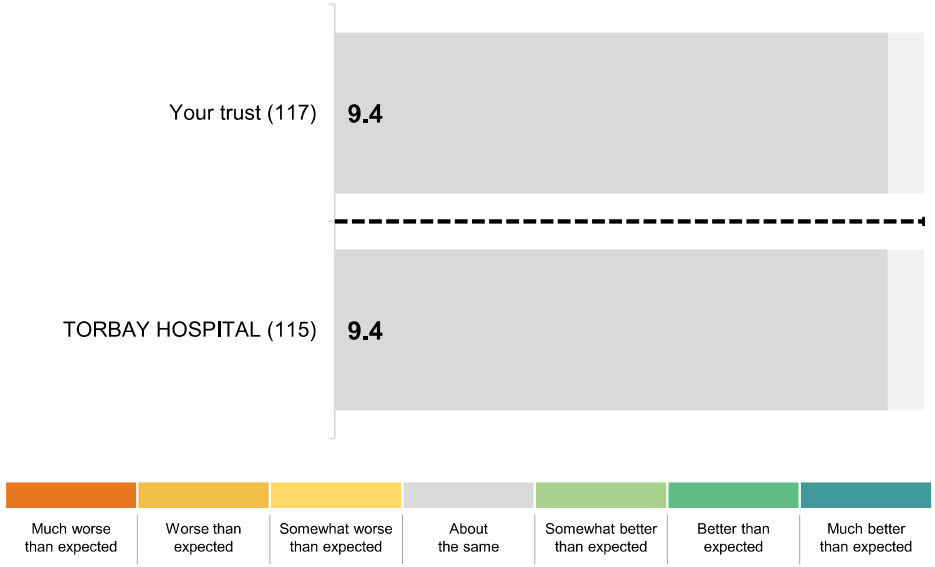
Section 2. Labour and Birth

Staff caring for you

C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

Trust and site results

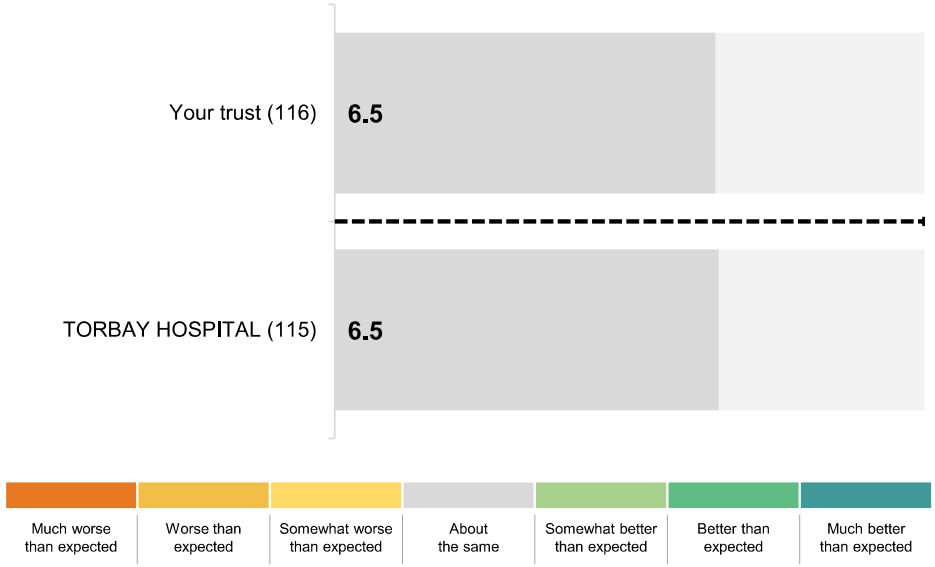
Section 3: Care in the ward after birth

Section 3. Care in the ward after birth

D2. On the day you left hospital, was your discharge delayed for any reason?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



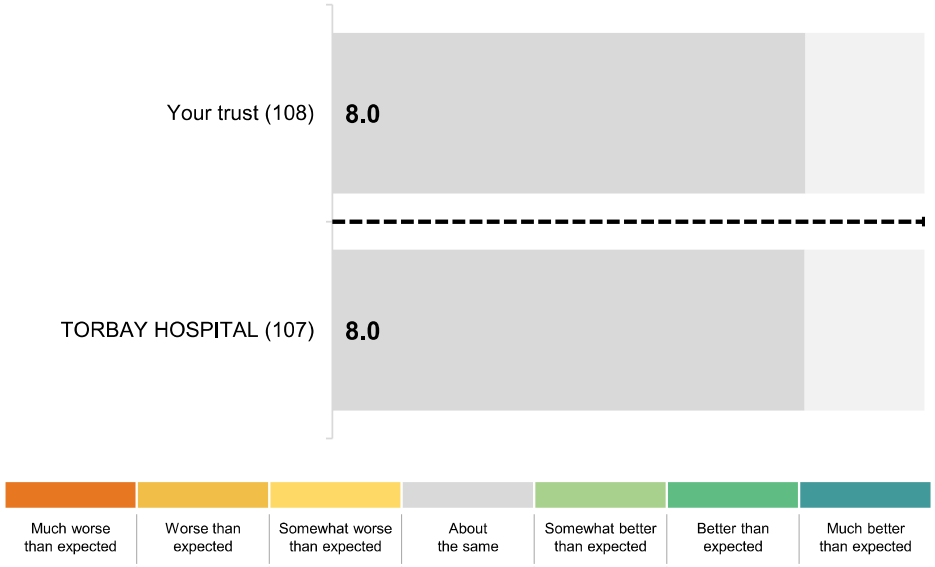
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Care in the ward after birth

D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



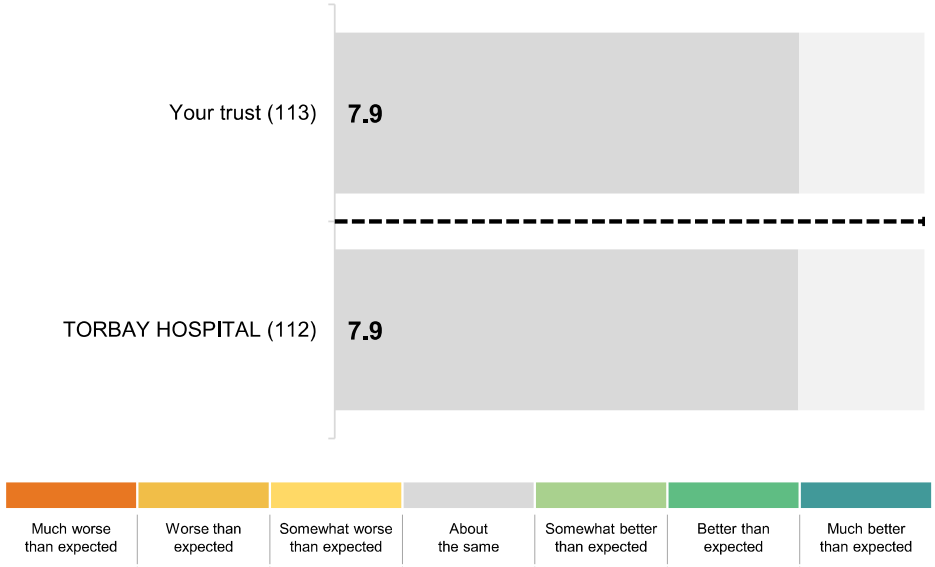
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Care in the ward after birth

D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



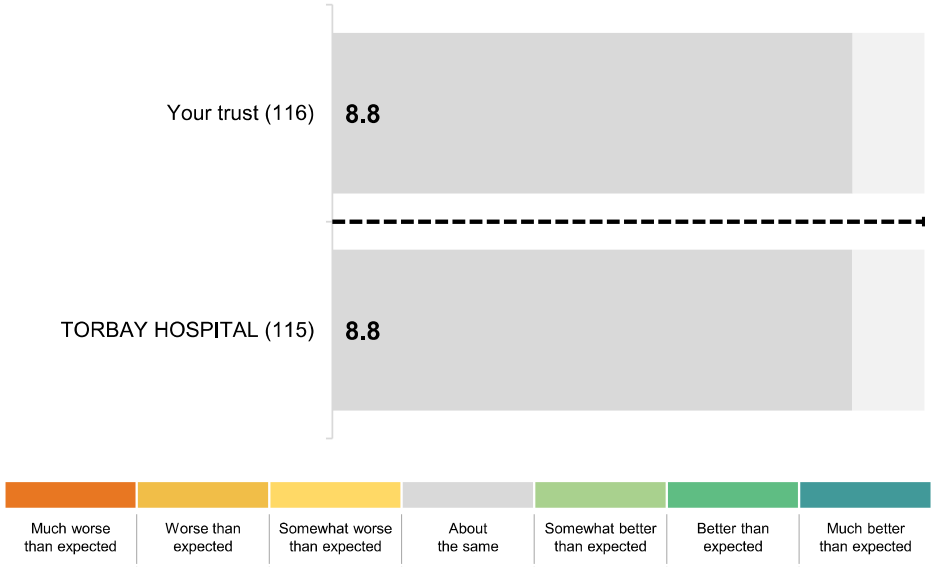
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Care in the ward after birth

D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



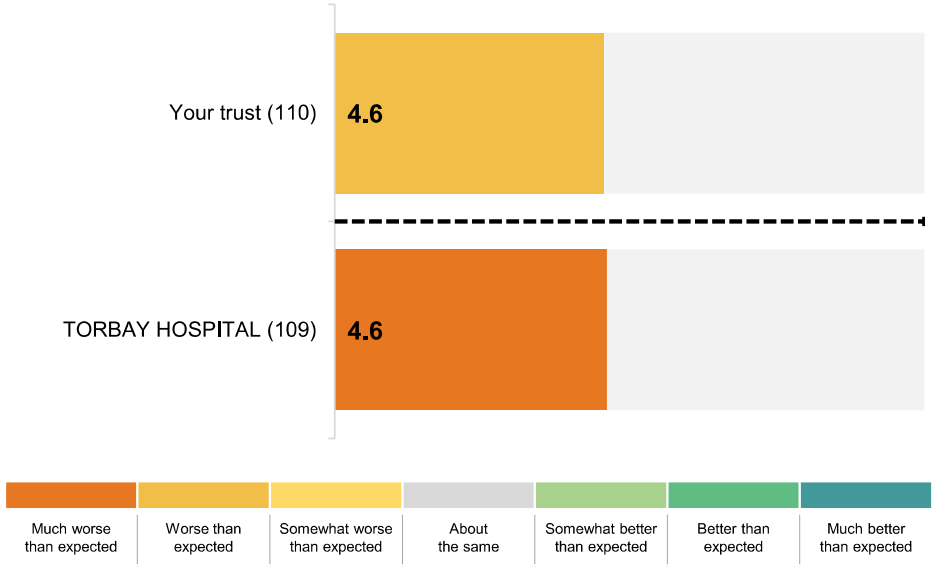
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Care in the ward after birth

D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



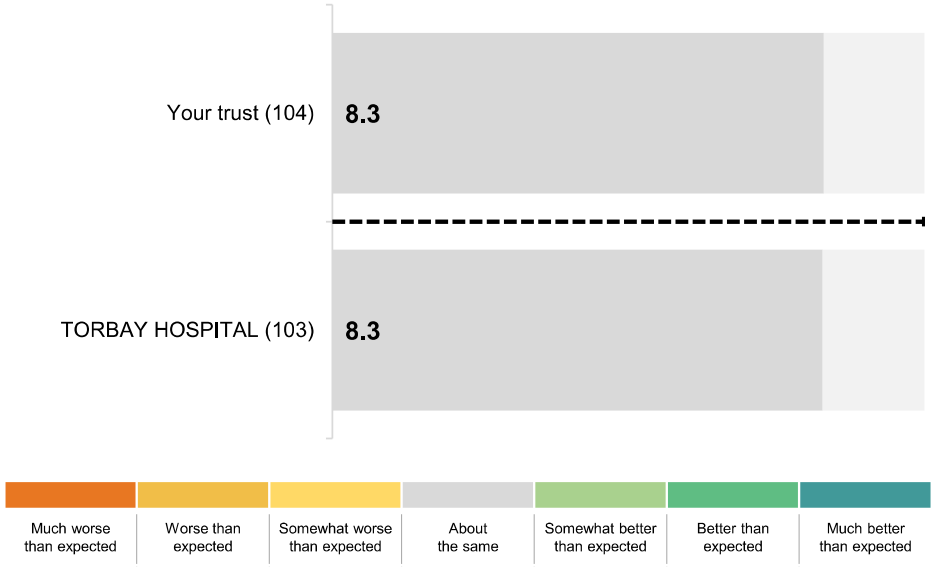
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Care in the ward after birth

D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

Trust and site results

Section 4: Postnatal Care

CareQuality Commission

Survey Coordination Centre

NHS

Section 4: Postnatal Care

Please note, results about postnatal care are not attributed at site level. Only results that are about hospital care are attributed at site level.

Trust and site results

Section 5: Triage: Assessment and Evaluation

CareQuality Commission

Survey Coordination Centre

NHS

Section 5: Triage: Assessment and Evaluation

Please note, results about triage are not attributed at site level. Only results that are about hospital care are attributed at site level.

Trust and site results

Section 6: Complaints

Care Quality Commission

Survey Coordination Centre

NHS

Section 6: Complaints

Please note, results about complaints are not attributed at site level. Only results that are about hospital care are attributed at site level.

Change over time

This section includes:

- your mean trust score for each evaluative question in the survey
- where comparable data is available, statistical significance testing using a two-sample t-test has been carried out against the 2024 and 2025 survey results for each relevant question. Where a change in results is shown as 'significant', this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust

CareQuality Commission

Survey Coordination Centre

NHS

Please note:

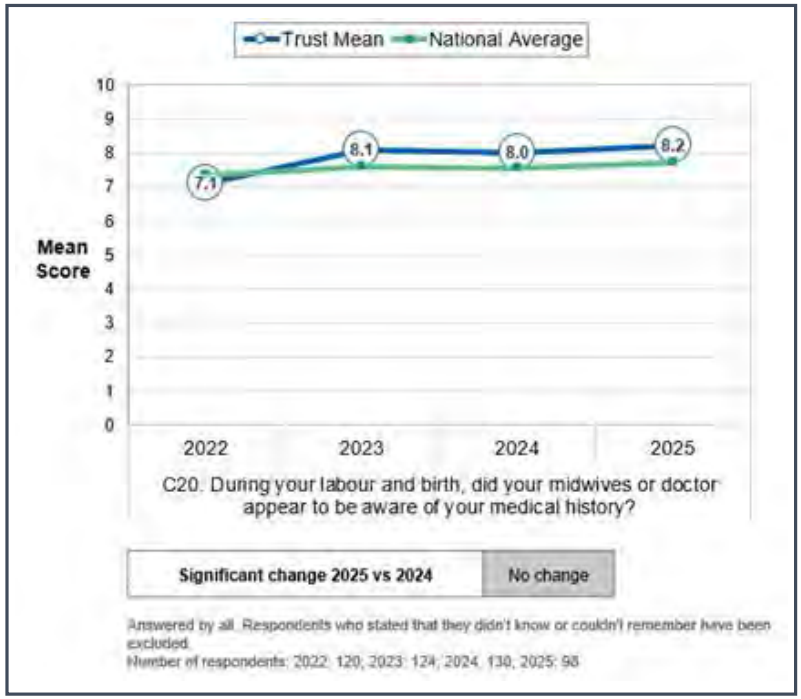
- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.
- The following questions were new or changed for 2025 and therefore are not included in this section: B1, C5, F2, F3 & F4.

How to interpret change over time in this report

The charts in the 'change over time' section show how your trust scored in each Maternity survey iteration. Where available, trend data from 2013 to 2025 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years; this is the average score for that question across all NHS trusts with a maternity department in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this may be due to either a low number of responses or because the trust was not included in the survey that year due to sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2025) and the previous year (2024). Z-tests set to 95% significance were used to compare data between the two years (2025 vs 2024). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.

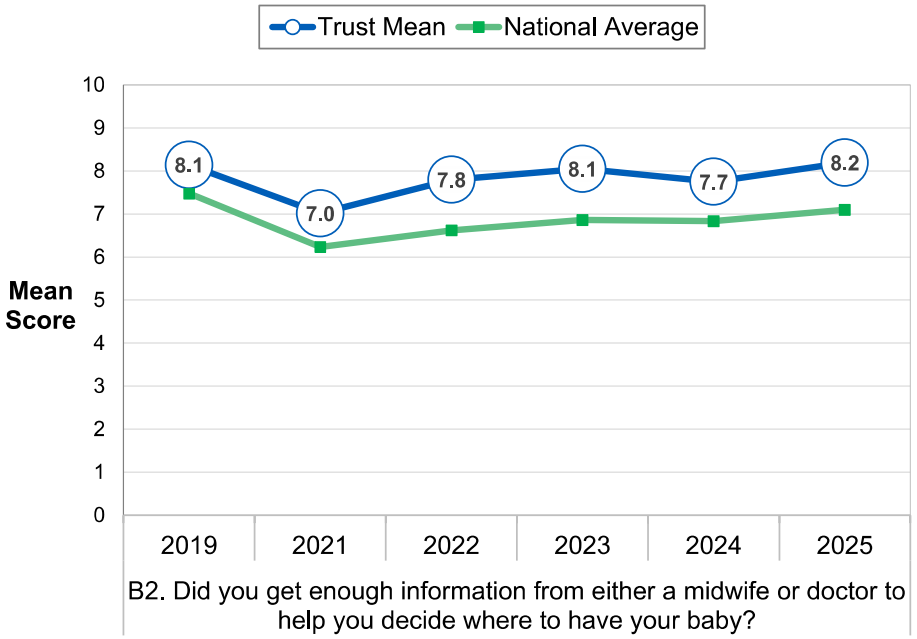


Change over time

Section 1: Antenatal Care

Section 1. Antenatal Care

The start of your care in pregnancy

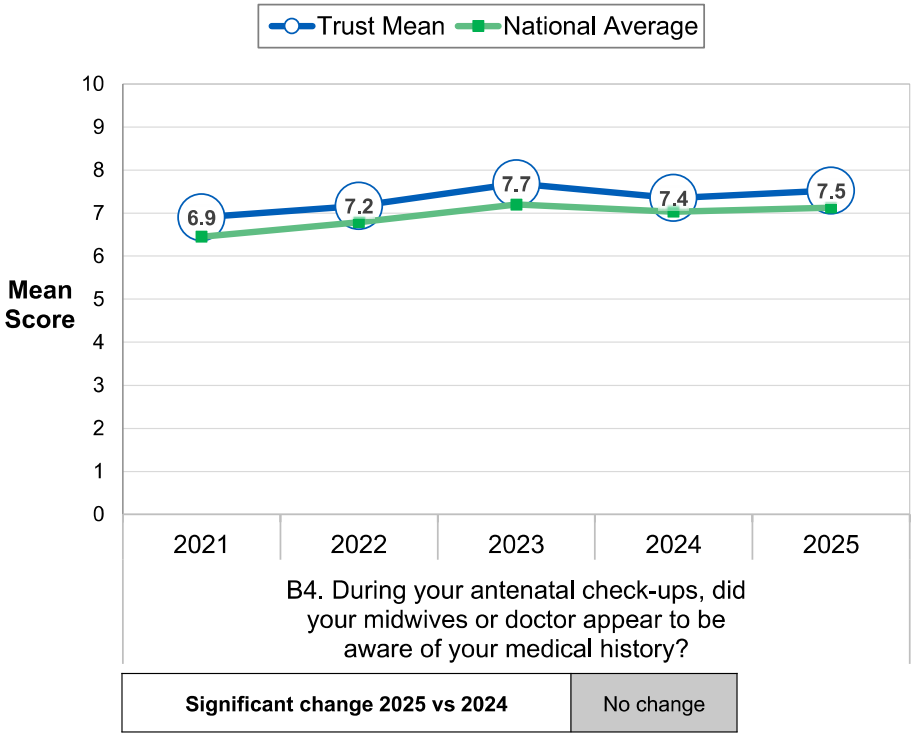


Significant change 2025 vs 2024	No change

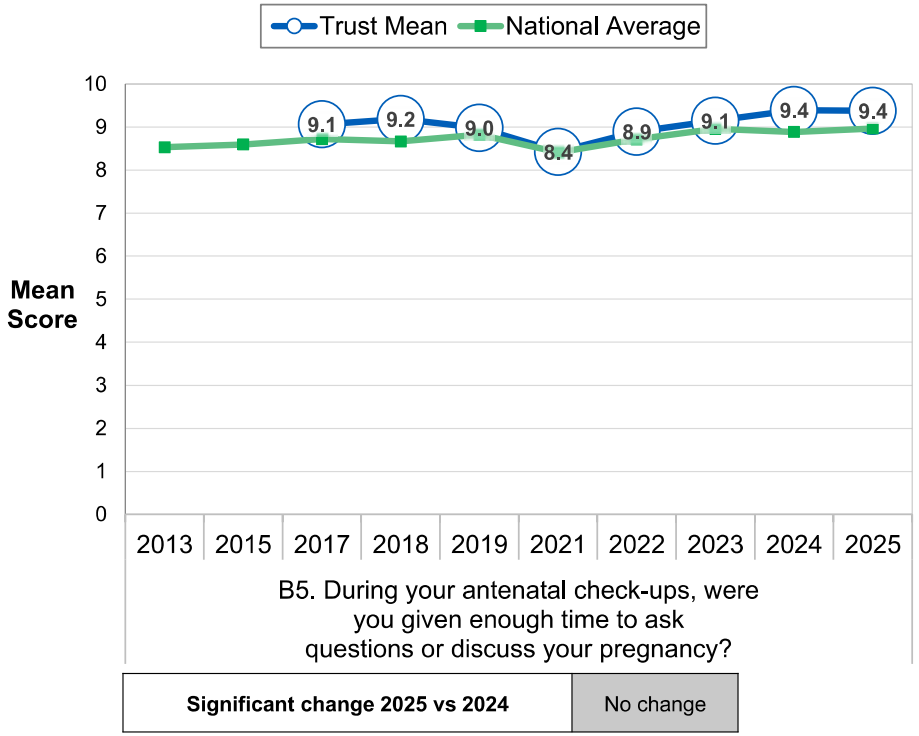
Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 116; 2021: 171; 2022: 132; 2023: 125; 2024: 125; 2025: 112

Section 1. Antenatal Care

Antenatal check ups



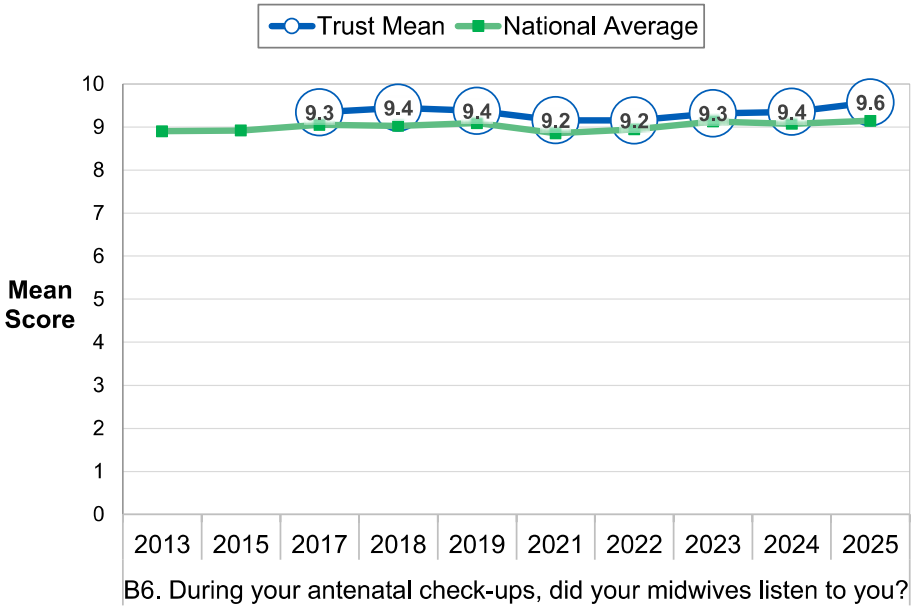
Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2021: 170; 2022: 133; 2023: 124; 2024: 128; 2025: 115



Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 113; 2018: 130; 2019: 119; 2021: 176; 2022: 135; 2023: 127; 2024: 130; 2025: 116

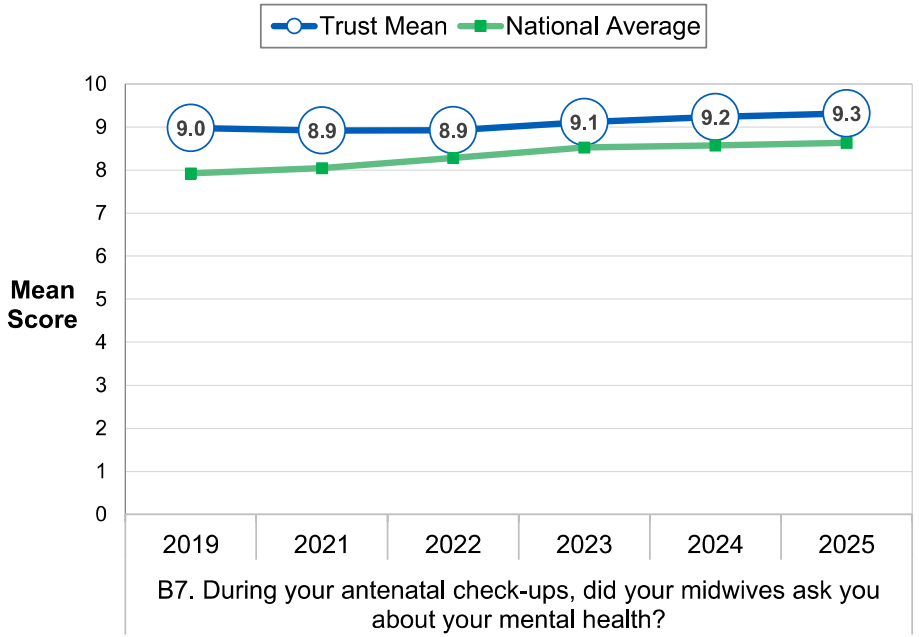
Section 1. Antenatal Care

Antenatal check ups



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 112; 2018: 130; 2019: 119; 2021: 176; 2022: 135; 2023: 127; 2024: 131; 2025: 115

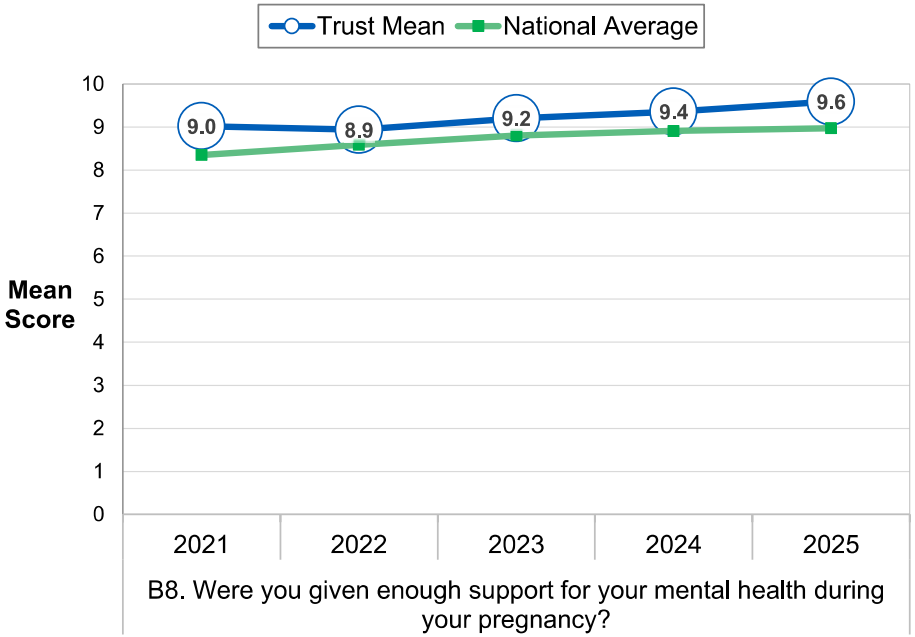


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 116; 2021: 175; 2022: 135; 2023: 127; 2024: 131; 2025: 116

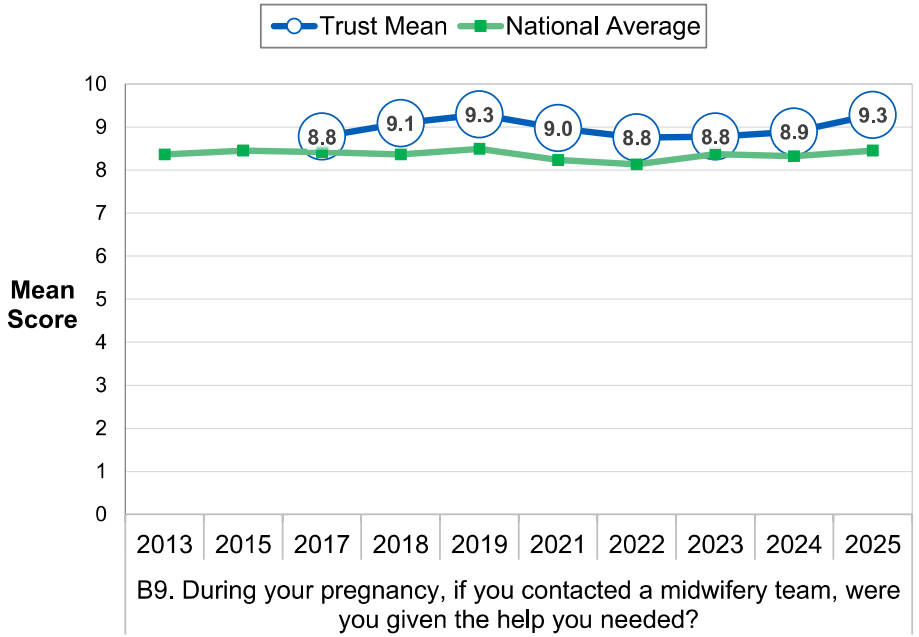
Section 1. Antenatal Care

During your pregnancy



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want or need support have been excluded.
Number of respondents: 2021: 119; 2022: 90; 2023: 84; 2024: 87; 2025: 76

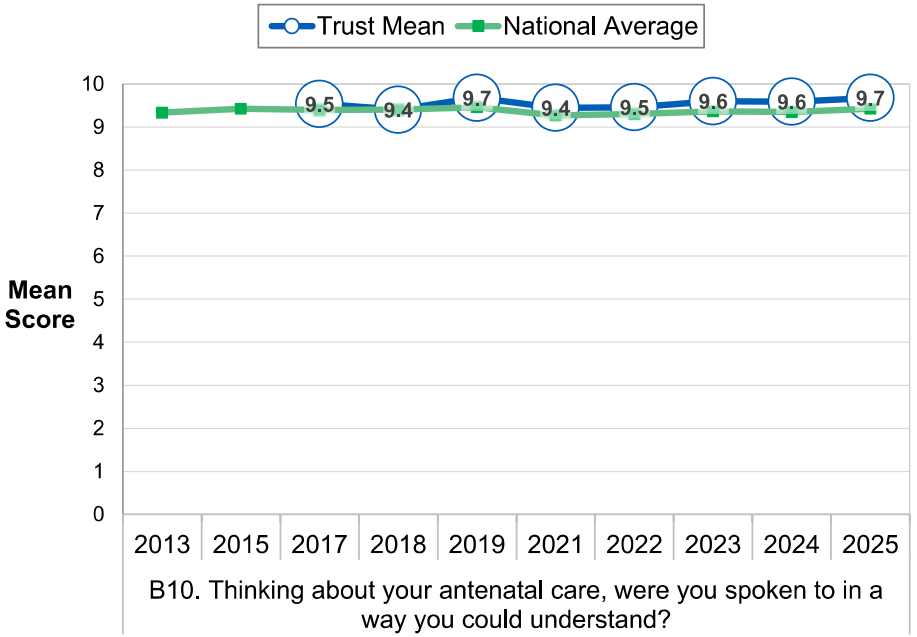


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they did not contact a midwifery team have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 96; 2018: 120; 2019: 105; 2021: 163; 2022: 129; 2023: 122; 2024: 128; 2025: 111

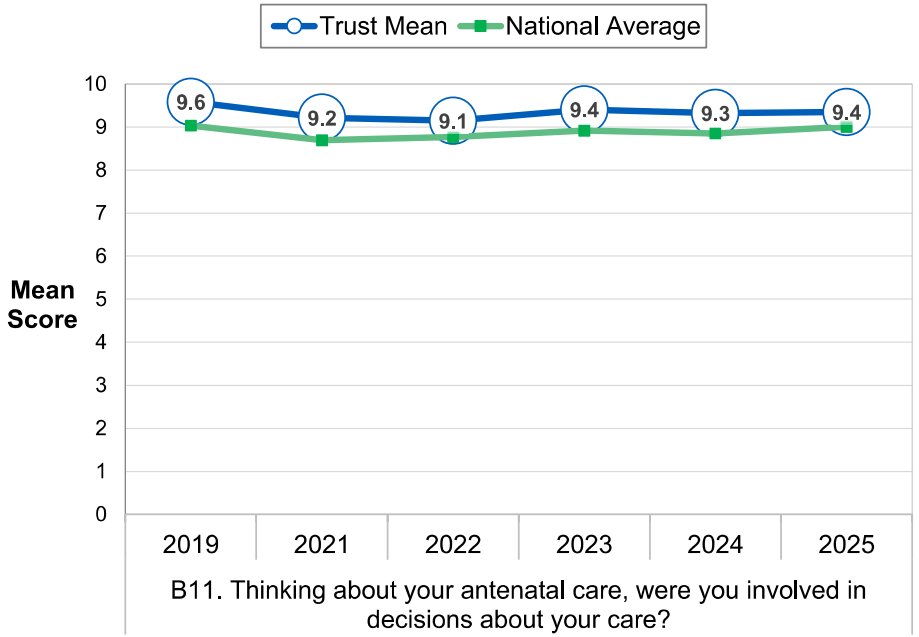
Section 1. Antenatal Care

During your pregnancy



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 112; 2018: 128; 2019: 118; 2021: 176; 2022: 135; 2023: 127; 2024: 131; 2025: 115

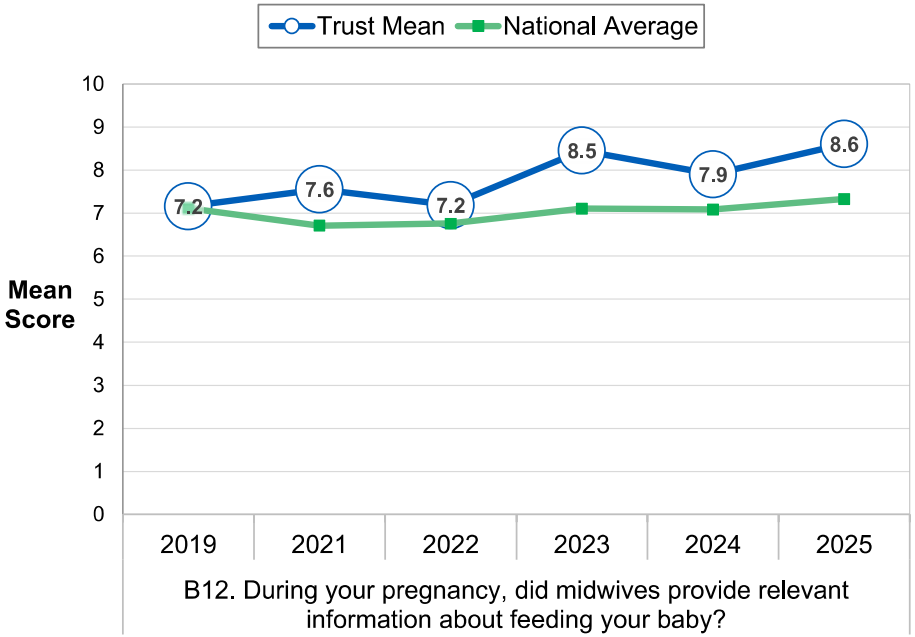


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want or need to be involved have been excluded.
Number of respondents: 2019: 118; 2021: 176; 2022: 135; 2023: 126; 2024: 126; 2025: 114

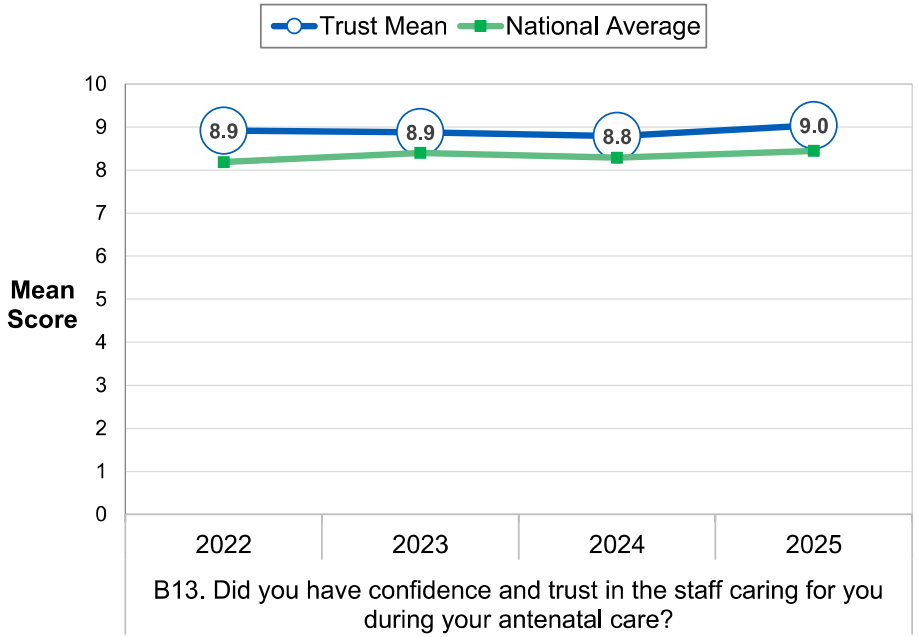
Section 1. Antenatal Care

During your pregnancy



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 115; 2021: 172; 2022: 132; 2023: 126; 2024: 125; 2025: 115

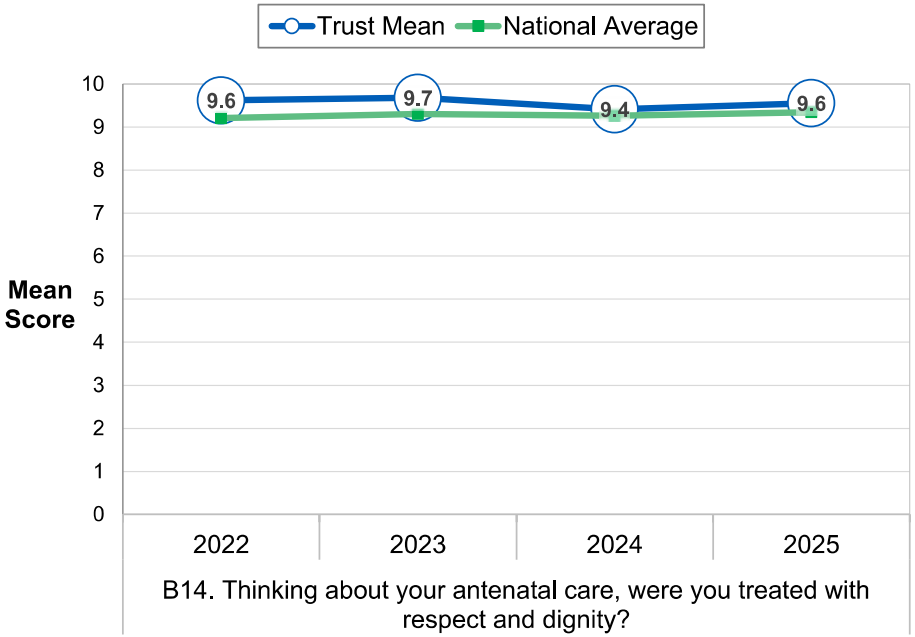


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 135; 2023: 127; 2024: 131; 2025: 117

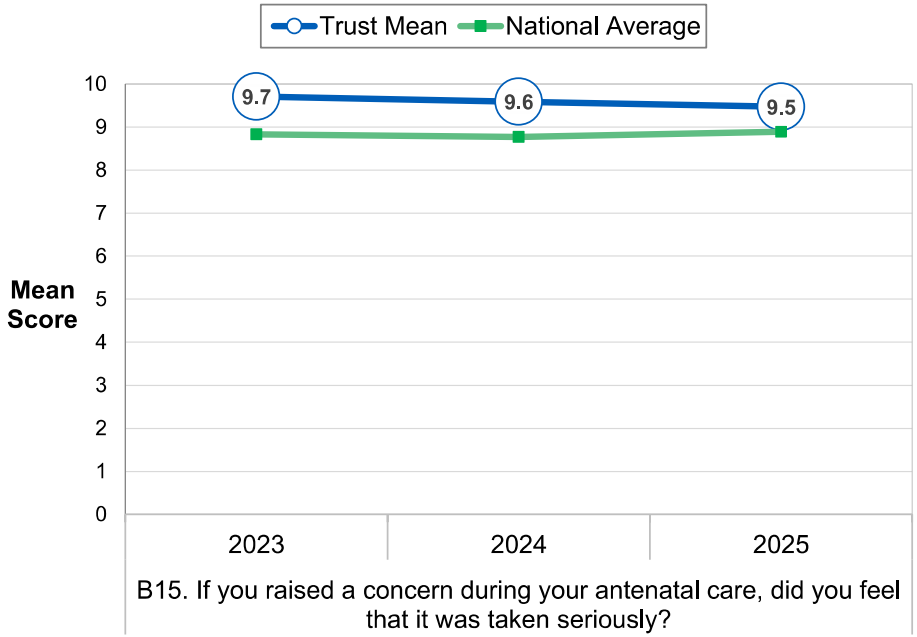
Section 1. Antenatal Care

During your pregnancy



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 135; 2023: 127; 2024: 131; 2025: 117

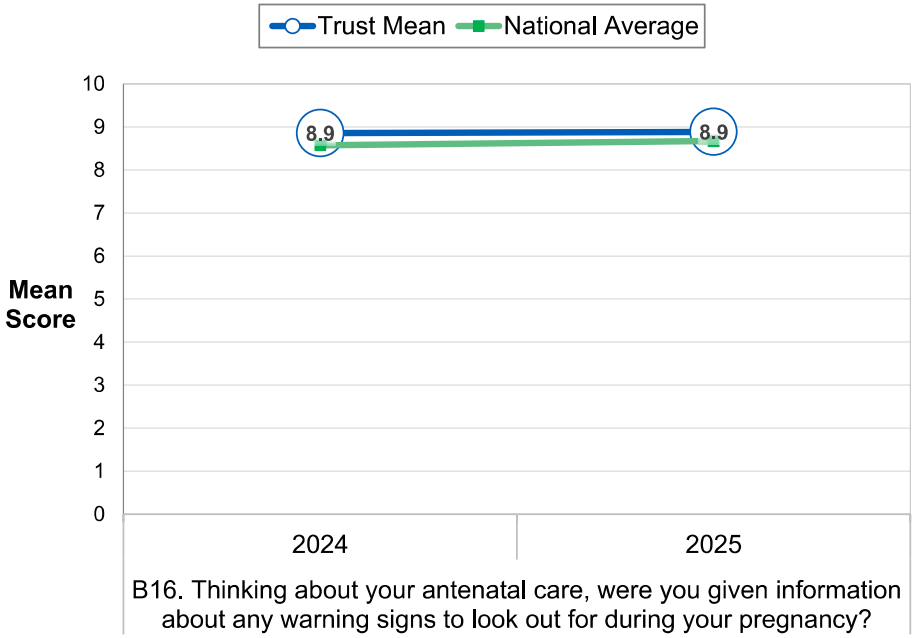


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't raise any concerns have been excluded.
Number of respondents: 2023: 86; 2024: 96; 2025: 94

Section 1. Antenatal Care

During your pregnancy



Significant change 2025 vs 2024	No change

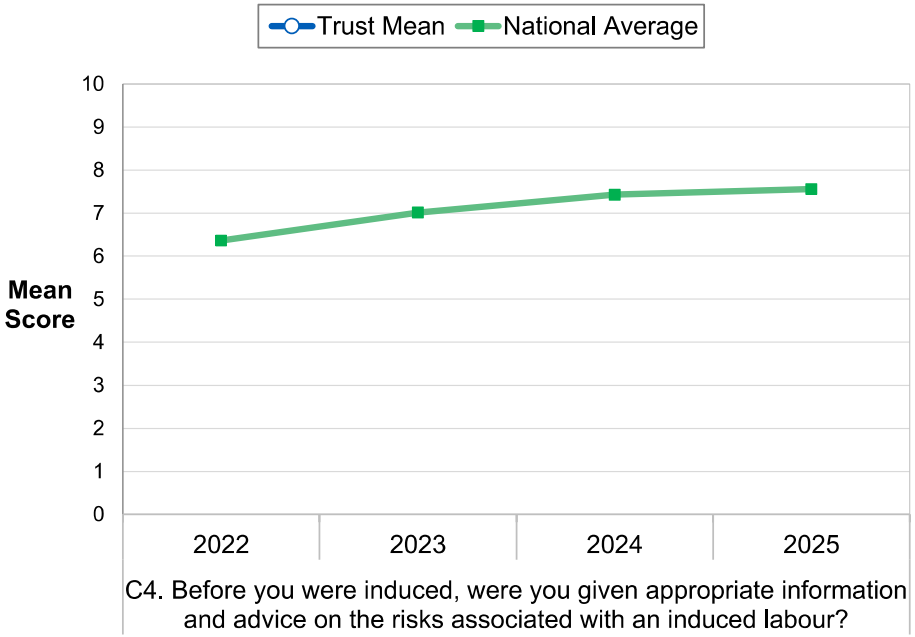
Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2024: 130; 2025: 116

Change over time

Section 2: Labour and Birth

Section 2. Labour and Birth

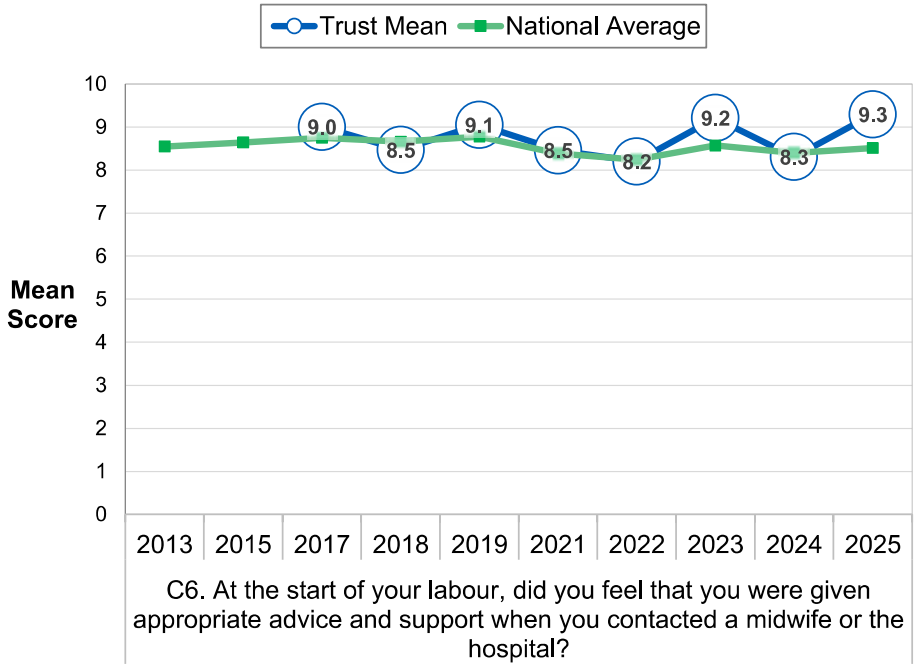
Your labour and birth



C4. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

Significant change 2025 vs 2024	-

Answered by those who were induced. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: -; 2023: -; 2024: -; 2025: -



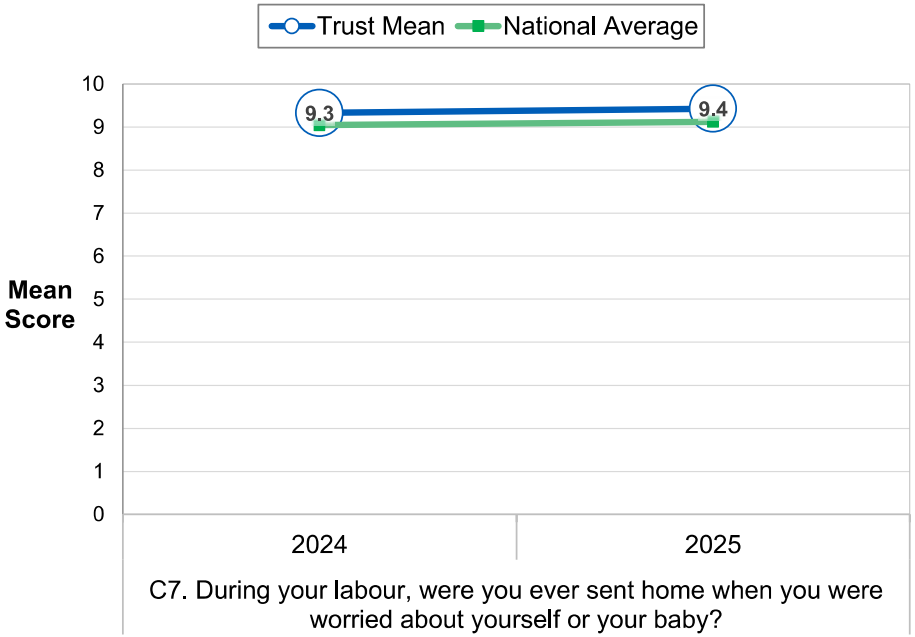
C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

Significant change 2025 vs 2024	No change

Answered by those who went into labour. Respondents who stated that they did not contact a midwife or the hospital have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 88; 2018: 94; 2019: 94; 2021: 133; 2022: 90; 2023: 85; 2024: 87; 2025: 74

Section 2. Labour and Birth

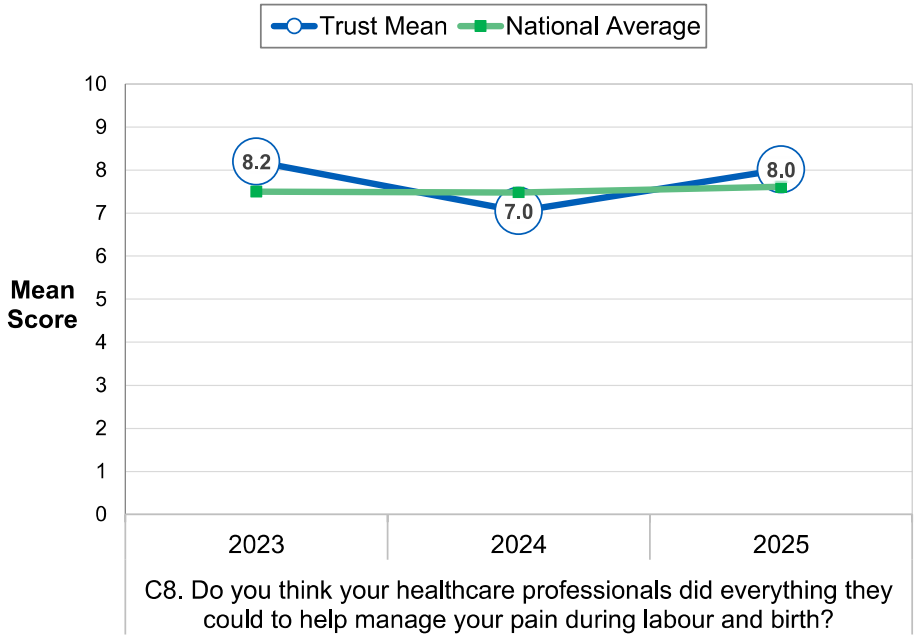
Your labour and birth



C7. During your labour, were you ever sent home when you were worried about yourself or your baby?

Significant change 2025 vs 2024	No change

Answered by those who went into labour. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2024: 99; 2025: 77



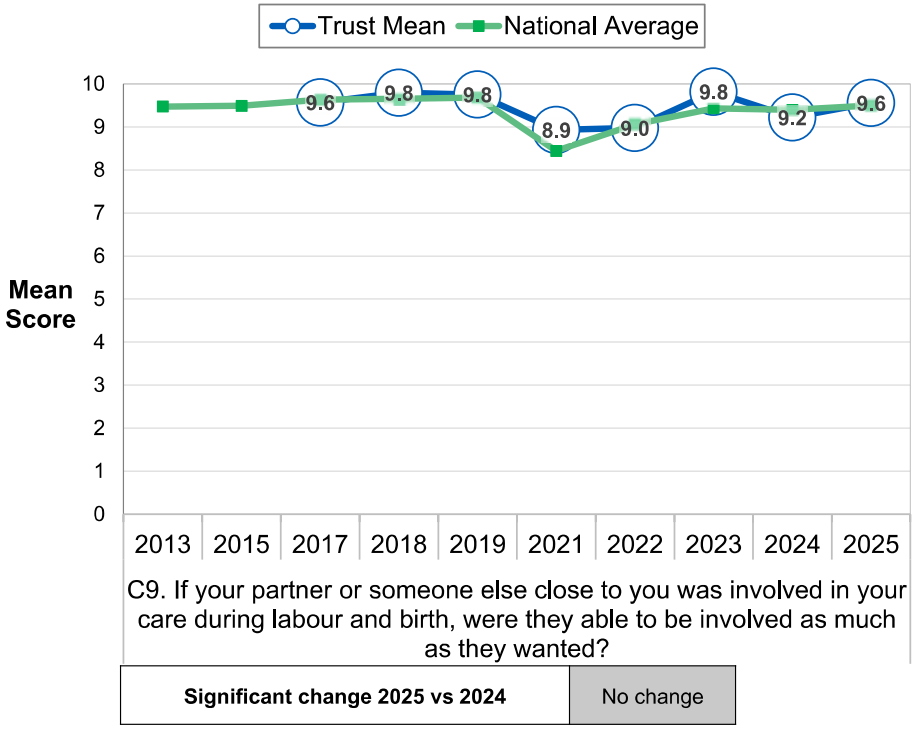
C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?

Significant change 2025 vs 2024	No change

Answered by those who had a labour. Respondents who stated that they didn't know or couldn't remember, or did not need any help with pain relief have been excluded.
Number of respondents: 2023: 95; 2024: 91; 2025: 74

Section 2. Labour and Birth

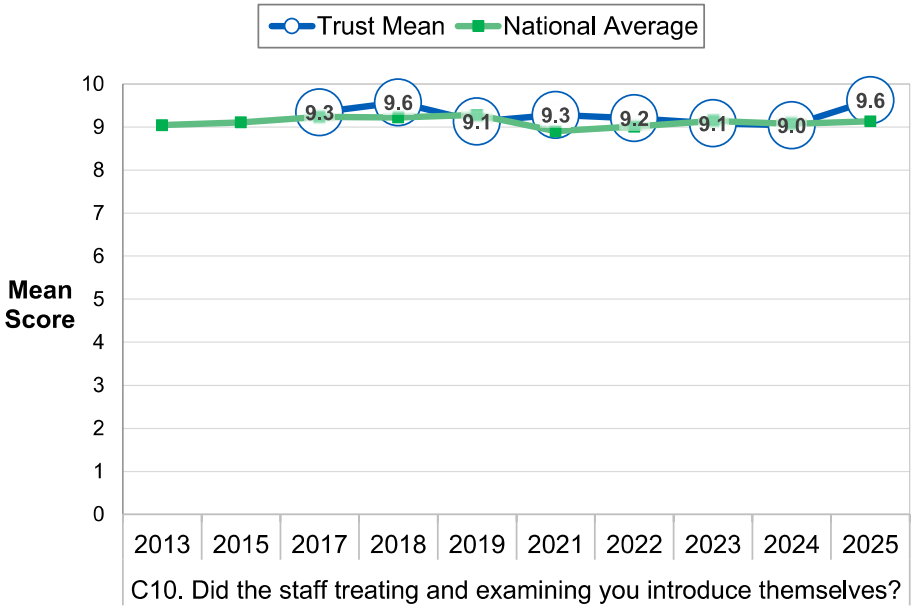
Your labour and birth



Answered by all. Respondents who stated that they did not have a partner or companion with them, did not want their partner or companion to be involved, or that their partner or companion did not want to or could not be involved have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 118; 2018: 132; 2019: 119; 2021: 173; 2022: 135; 2023: 127; 2024: 128; 2025: 115

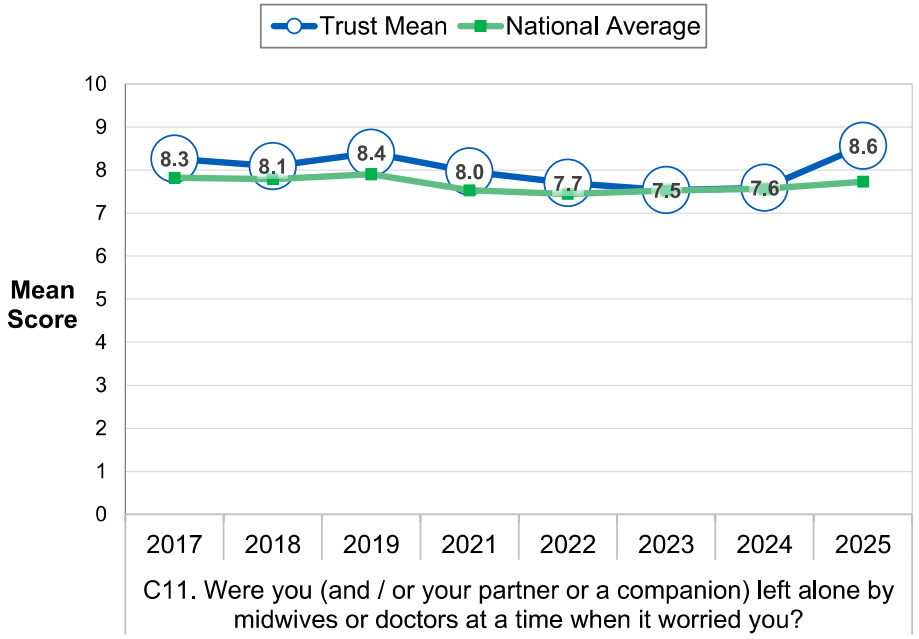
Section 2. Labour and Birth

Staff caring for you



Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 119; 2018: 138; 2019: 119; 2021: 178; 2022: 138; 2023: 128; 2024: 128; 2025: 112

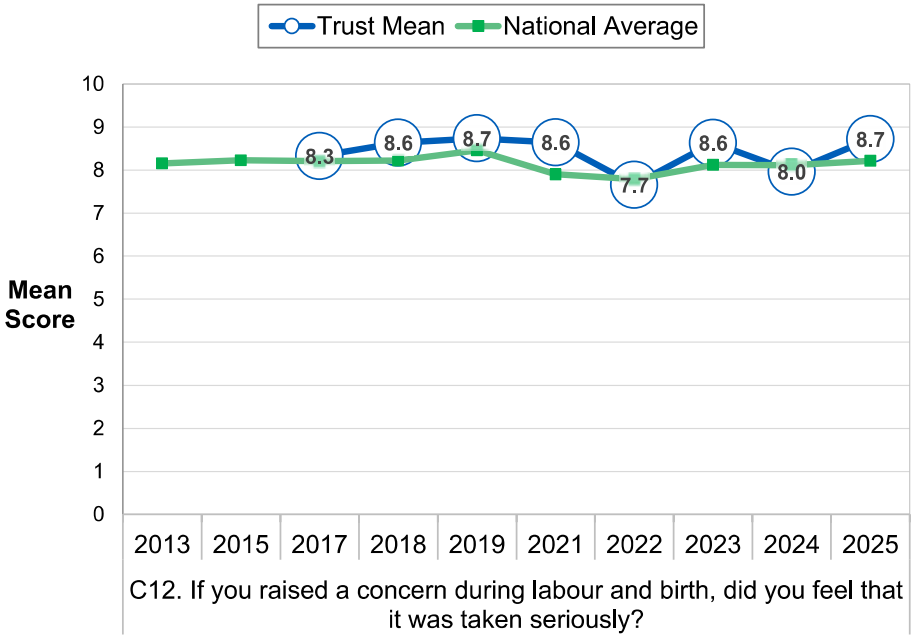


Significant change 2025 vs 2024	No change

Answered by all.
Number of respondents: 2017: 118; 2018: 137; 2019: 121; 2021: 180; 2022: 139; 2023: 129; 2024: 131; 2025: 117

Section 2. Labour and Birth

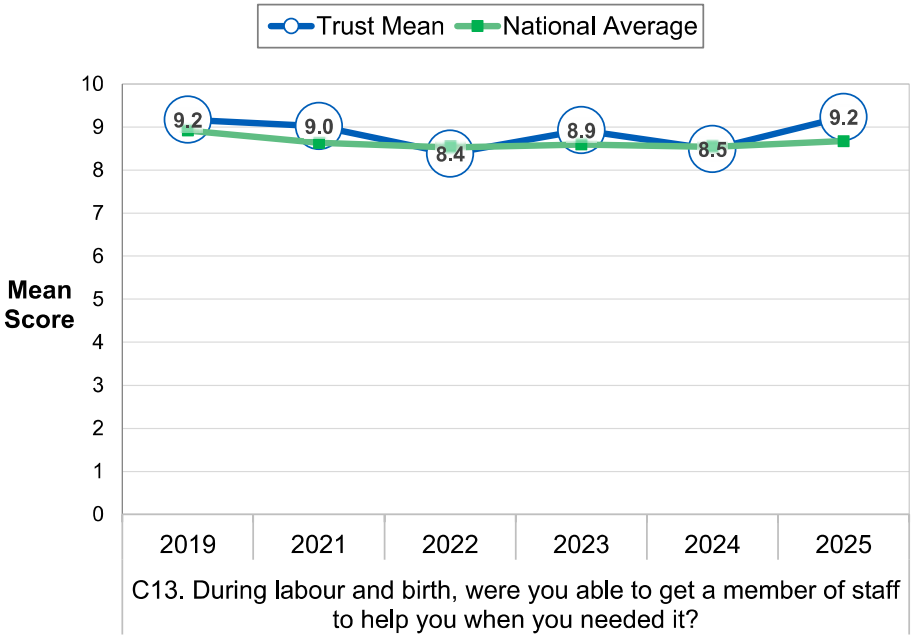
Staff caring for you



C12. If you raised a concern during labour and birth, did you feel that it was taken seriously?

Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't raise any concerns have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 74; 2018: 92; 2019: 77; 2021: 107; 2022: 77; 2023: 81; 2024: 79; 2025: 78



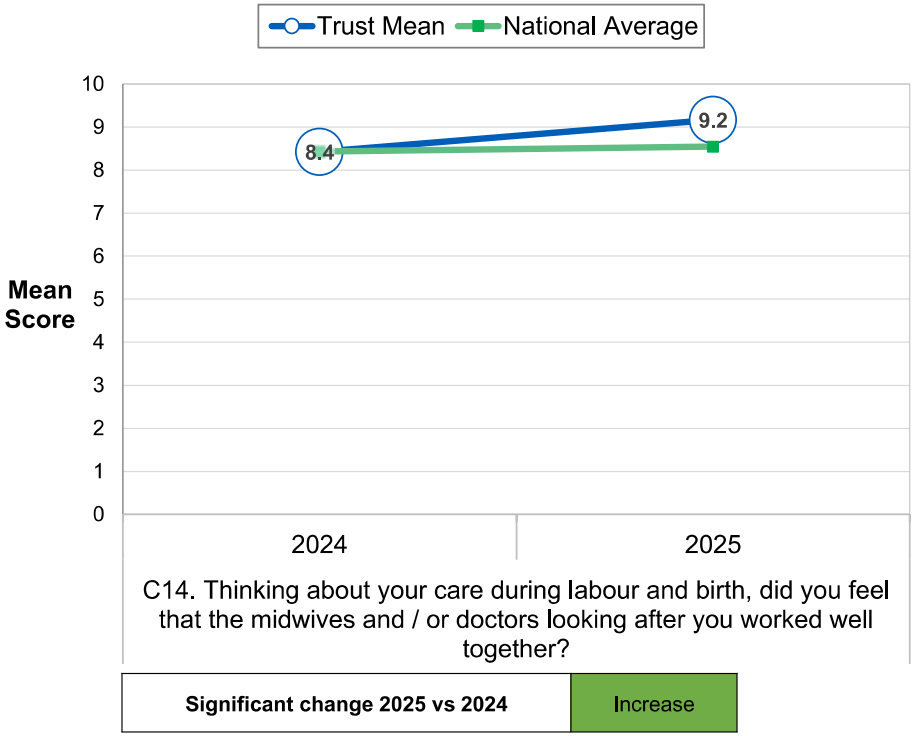
C13. During labour and birth, were you able to get a member of staff to help you when you needed it?

Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want or need this have been excluded.
Number of respondents: 2019: 117; 2021: 173; 2022: 134; 2023: 125; 2024: 124; 2025: 113

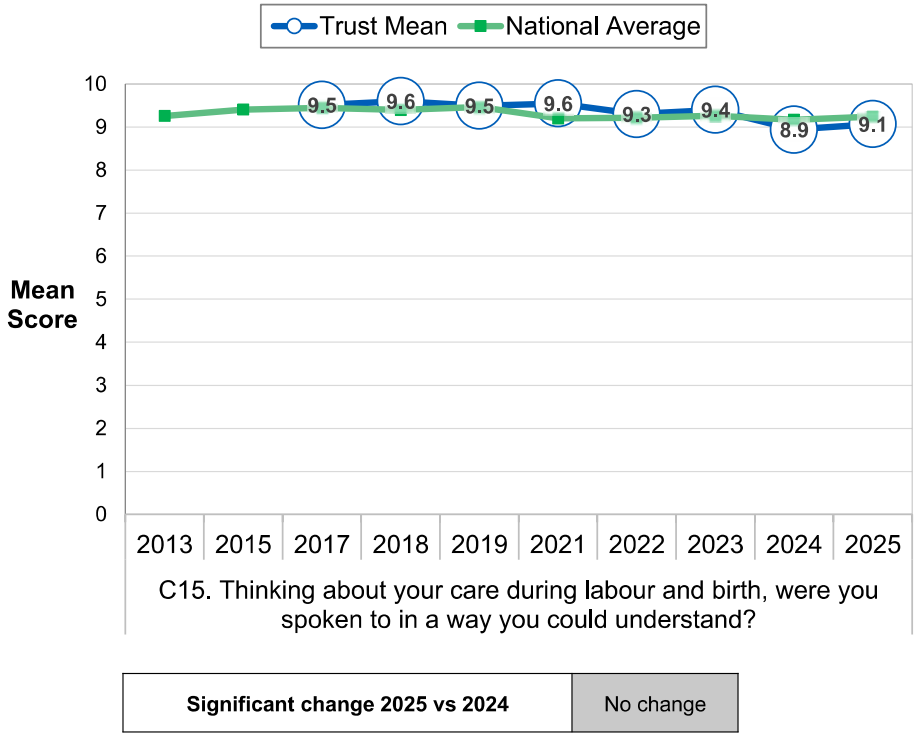
Section 2. Labour and Birth

Staff caring for you



Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2024: 126; 2025: 114

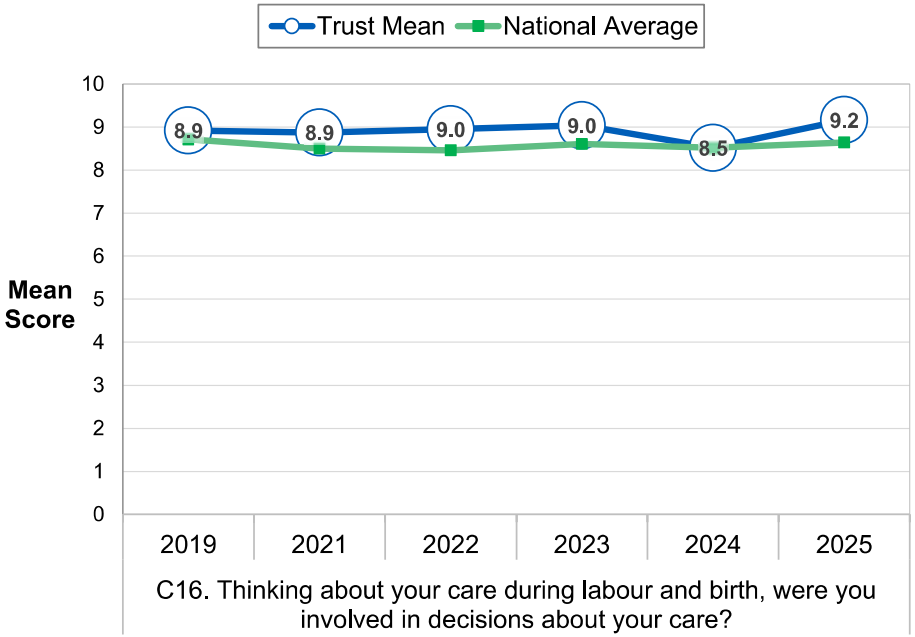


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 117; 2018: 137; 2019: 122; 2021: 179; 2022: 138; 2023: 128; 2024: 127; 2025: 115

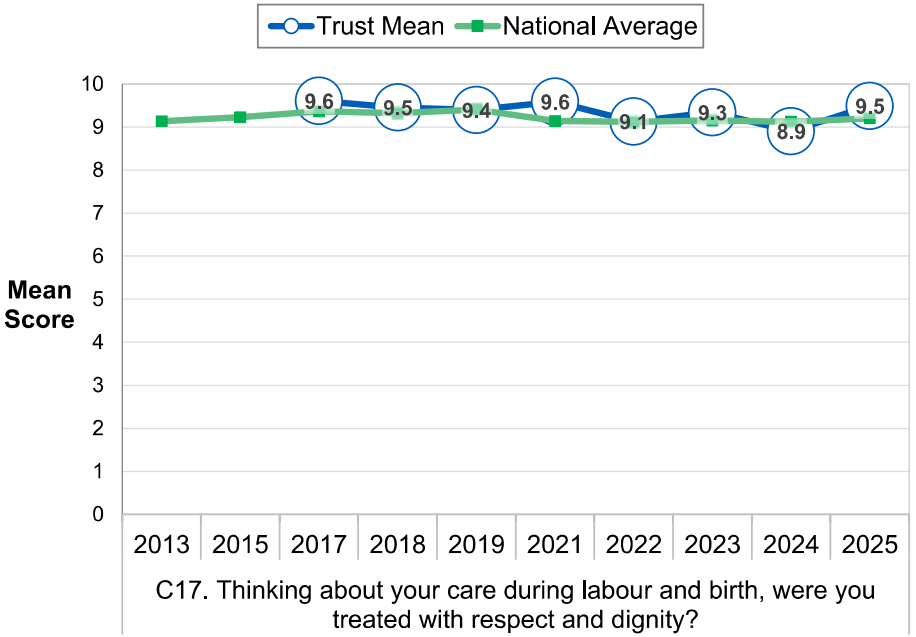
Section 2. Labour and Birth

Staff caring for you



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want or need to be involved have been excluded.
Number of respondents: 2019: 120; 2021: 176; 2022: 138; 2023: 126; 2024: 129; 2025: 113

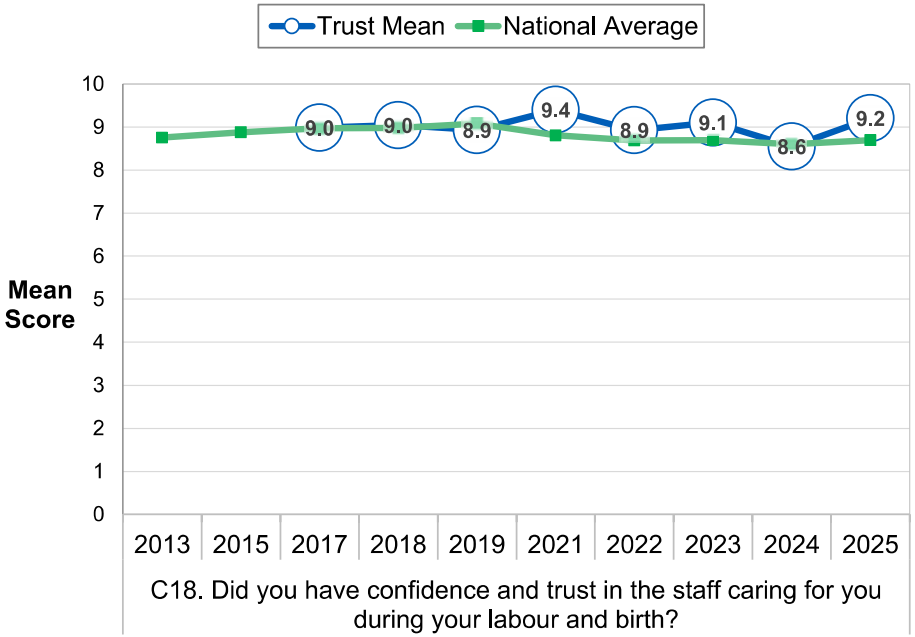


Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 120; 2018: 138; 2019: 122; 2021: 180; 2022: 138; 2023: 128; 2024: 129; 2025: 116

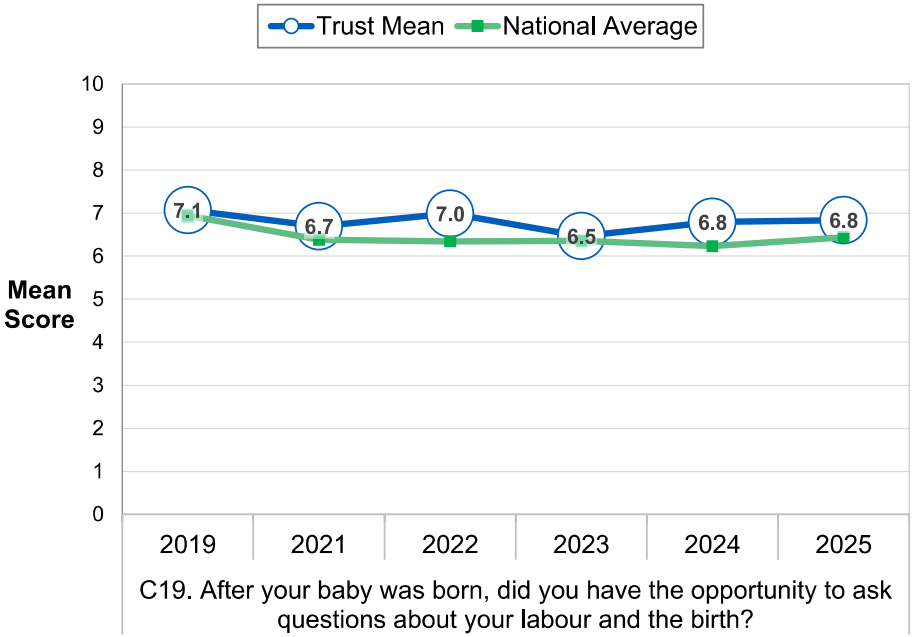
Section 2. Labour and Birth

Staff caring for you



Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 120; 2018: 137; 2019: 121; 2021: 180; 2022: 138; 2023: 128; 2024: 129; 2025: 116

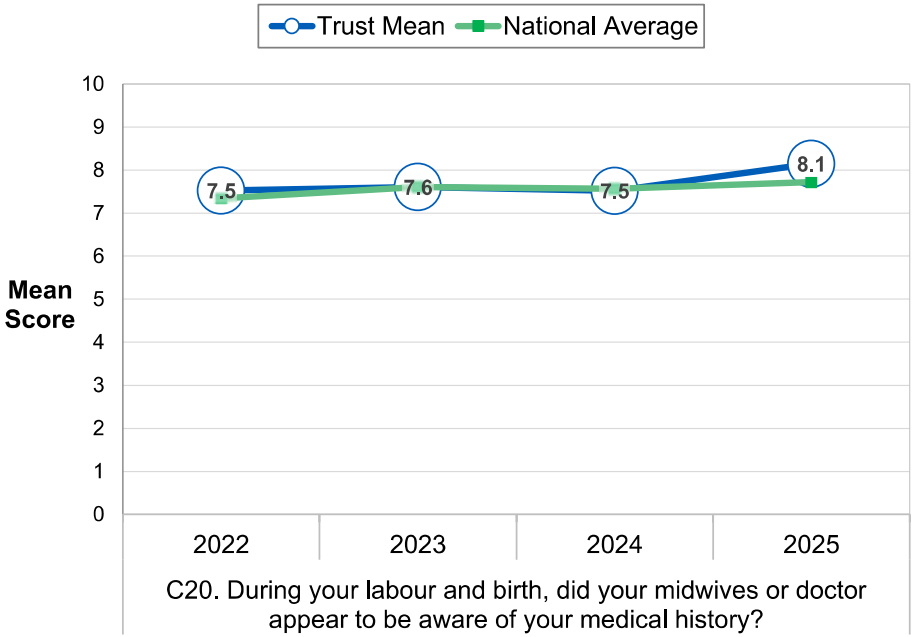


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or that they did not want or need this have been excluded.
Number of respondents: 2019: 111; 2021: 156; 2022: 127; 2023: 118; 2024: 112; 2025: 105

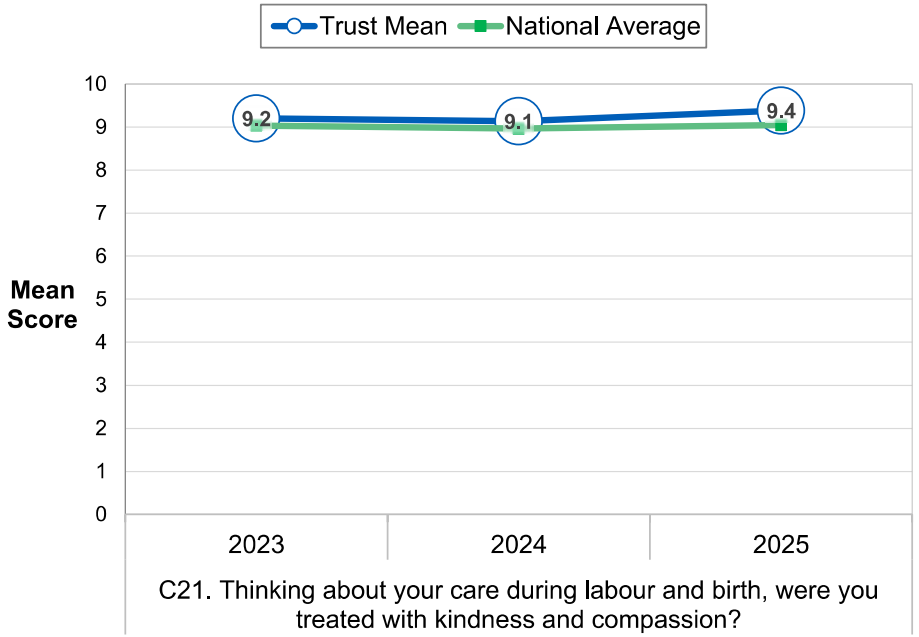
Section 2. Labour and Birth

Staff caring for you



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 131; 2023: 112; 2024: 114; 2025: 102



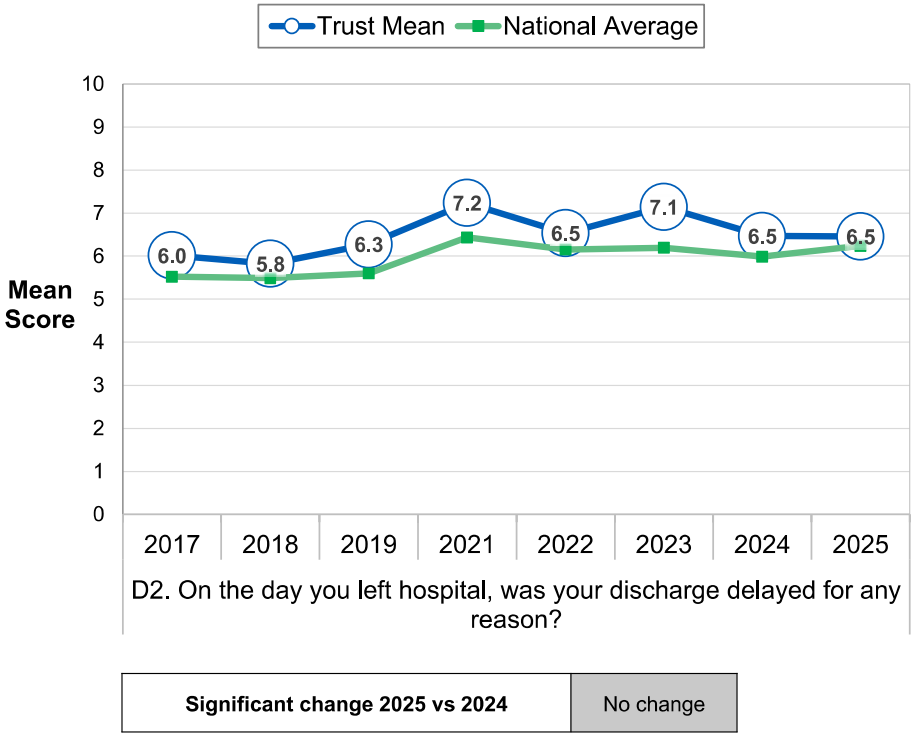
Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2023: 128; 2024: 129; 2025: 117

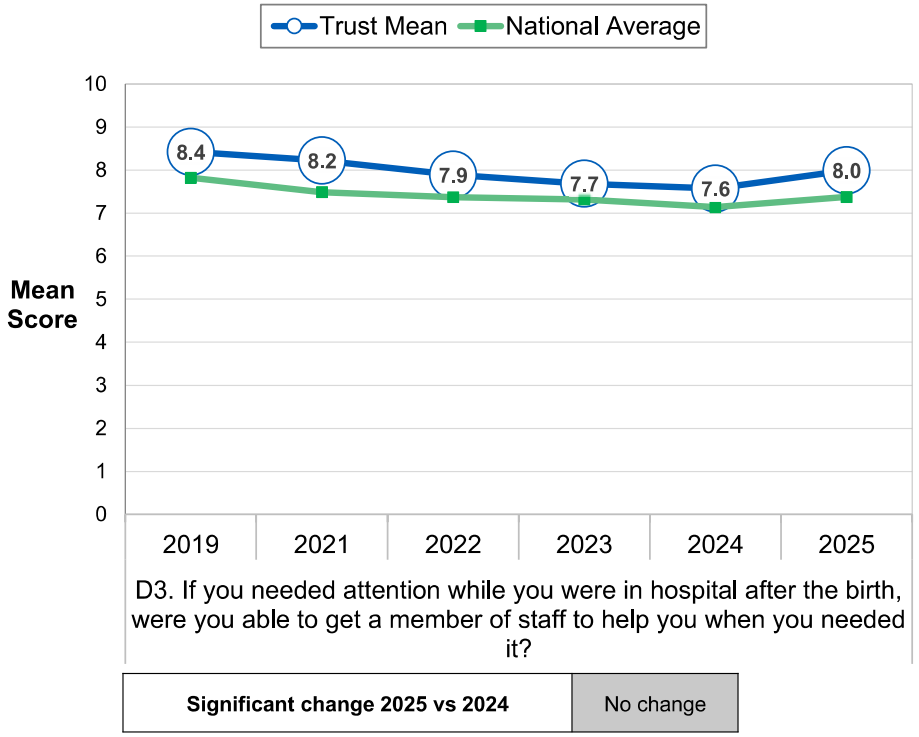
Change over time

Section 3: Care in the ward after birth

Section 3. Care in the ward after birth

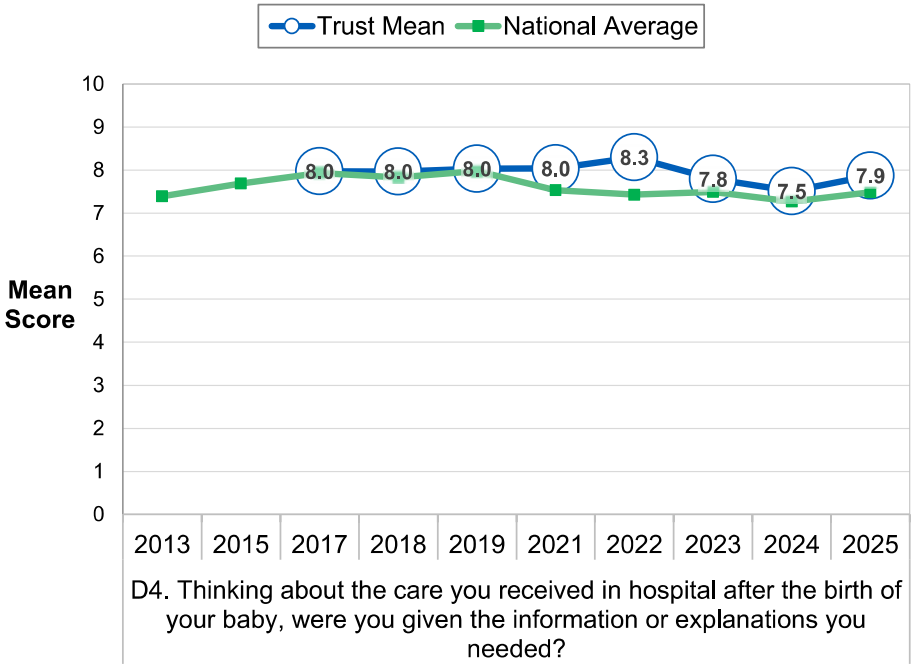


Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Number of respondents: 2017: 112; 2018: 133; 2019: 119; 2021: 172; 2022: 136; 2023: 126; 2024: 127; 2025: 116



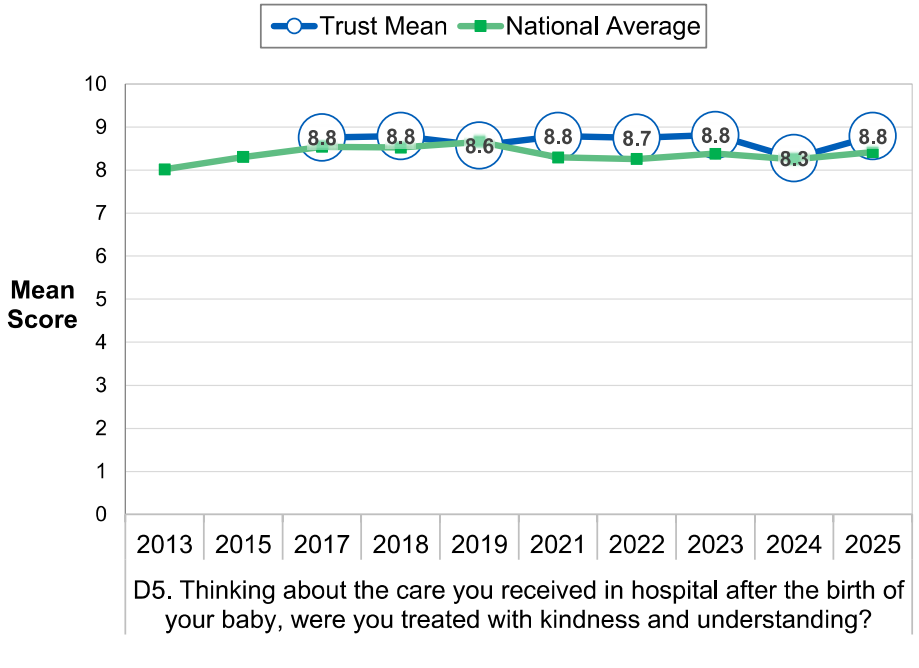
Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Respondents who stated that they didn't know or couldn't remember or did not want or need this have been excluded.
Number of respondents: 2019: 112; 2021: 150; 2022: 122; 2023: 114; 2024: 117; 2025: 108

Section 3. Care in the ward after birth



Significant change 2025 vs 2024	No change

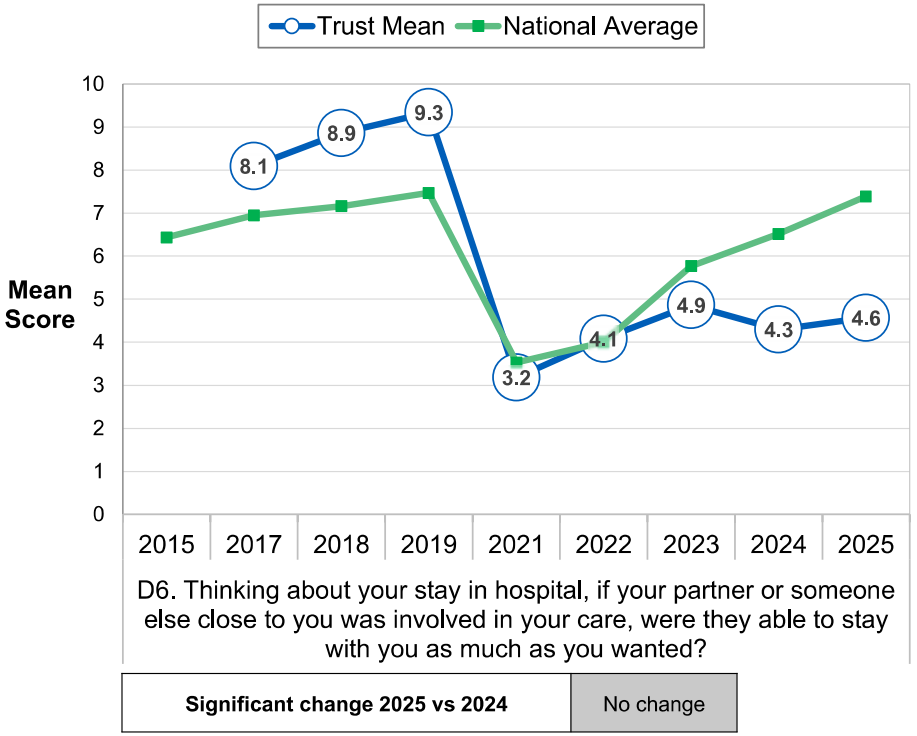
Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 112; 2018: 133; 2019: 118; 2021: 170; 2022: 136; 2023: 122; 2024: 126; 2025: 113



Significant change 2025 vs 2024	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 111; 2018: 134; 2019: 120; 2021: 171; 2022: 136; 2023: 125; 2024: 128; 2025: 116

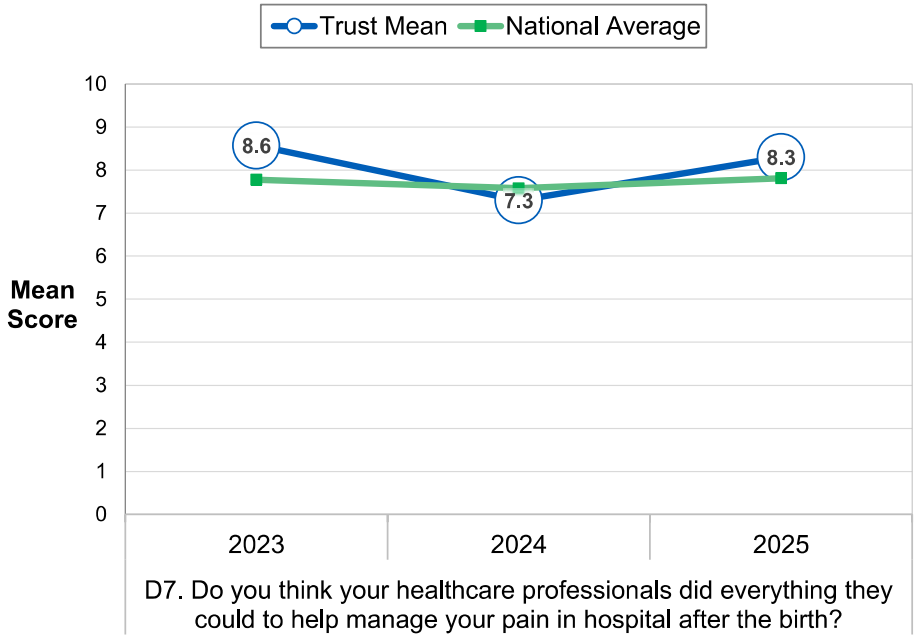
Section 3. Care in the ward after birth



D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Significant change 2025 vs 2024	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Number of respondents: 2015: -; 2017: 108; 2018: 129; 2019: 117; 2021: 104; 2022: 121; 2023: 122; 2024: 122; 2025: 110



D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

Significant change 2025 vs 2024	Increase

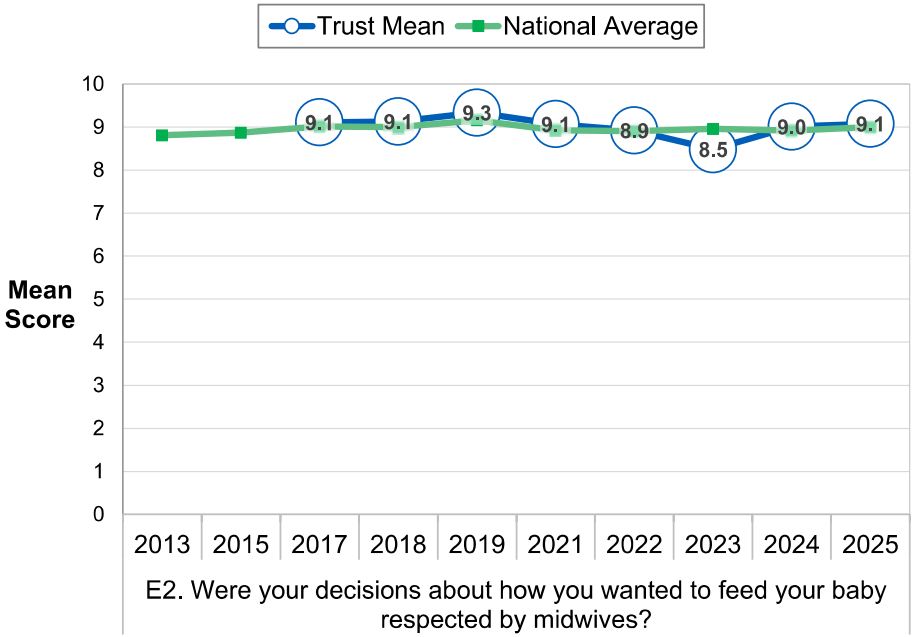
Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Respondents who stated that they didn't need any help with pain relief or didn't know or couldn't remember have been excluded.
Number of respondents: 2023: 108; 2024: 111; 2025: 104

Change over time

Section 4: Postnatal Care

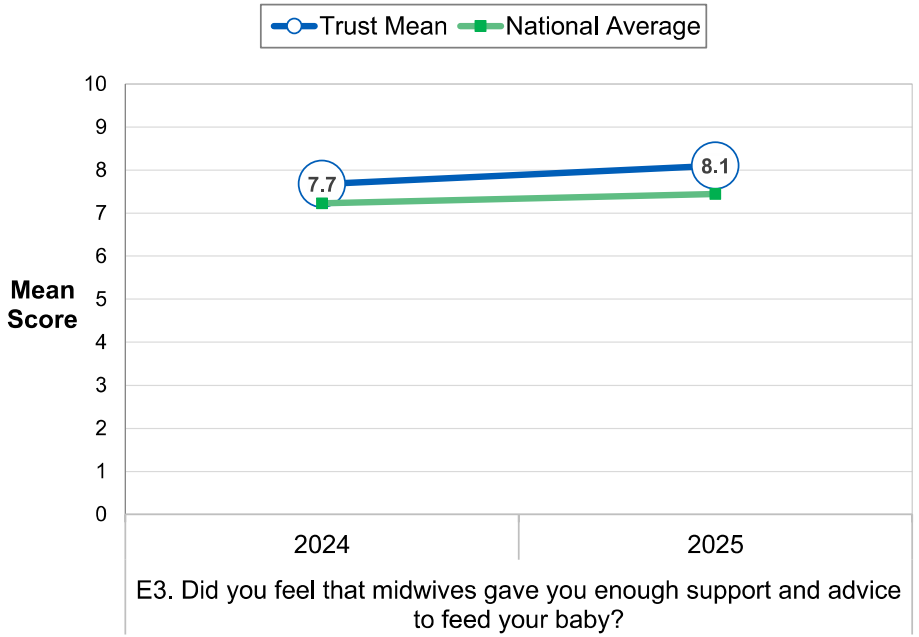
Section 4. Postnatal Care

Feeding your baby



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 117; 2018: 132; 2019: 118; 2021: 180; 2022: 136; 2023: 128; 2024: 130; 2025: 117

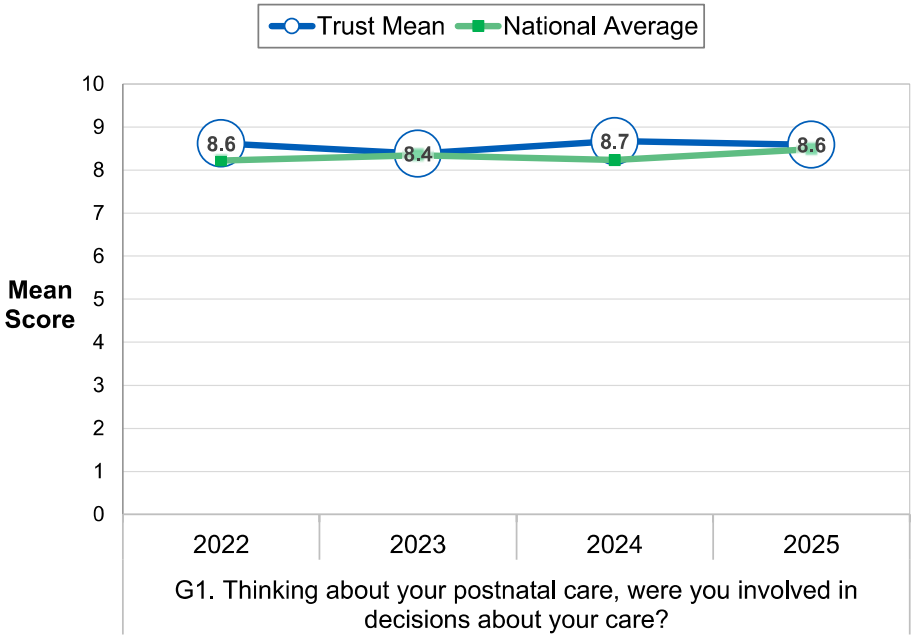


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want or need this have been excluded.
Number of respondents: 2024: 123; 2025: 114

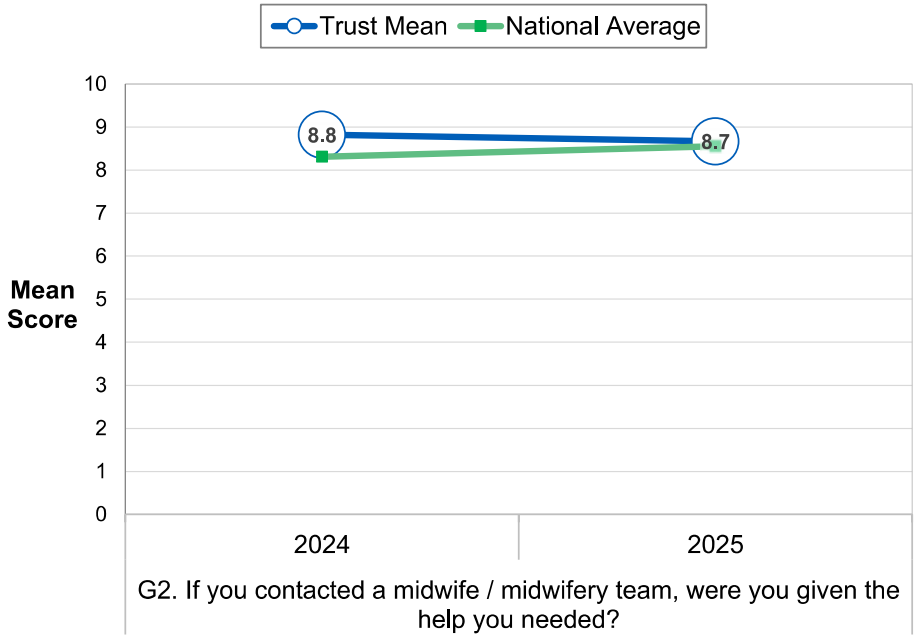
Section 4. Postnatal Care

Care at home after birth



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want or need to be involved have been excluded.
Number of respondents: 2022: 130; 2023: 122; 2024: 122; 2025: 113

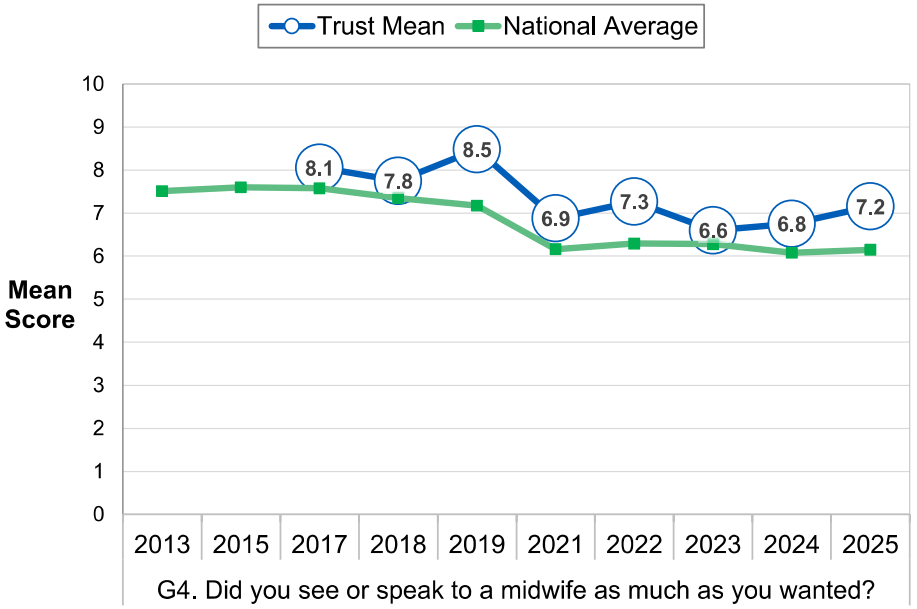


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they did not contact a midwife or midwifery team have been excluded.
Number of respondents: 2024: 125; 2025: 105

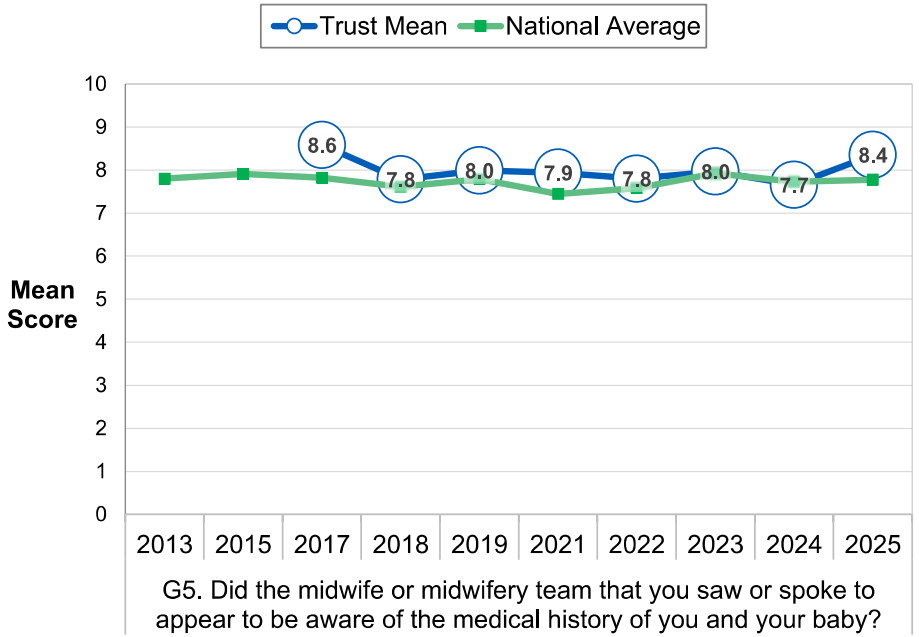
Section 4. Postnatal Care

Care at home after birth



Significant change 2025 vs 2024	No change

Answered by all.
Number of respondents: 2013: -; 2015: -; 2017: 111; 2018: 130; 2019: 112; 2021: 163; 2022: 126; 2023: 123; 2024: 131; 2025: 117

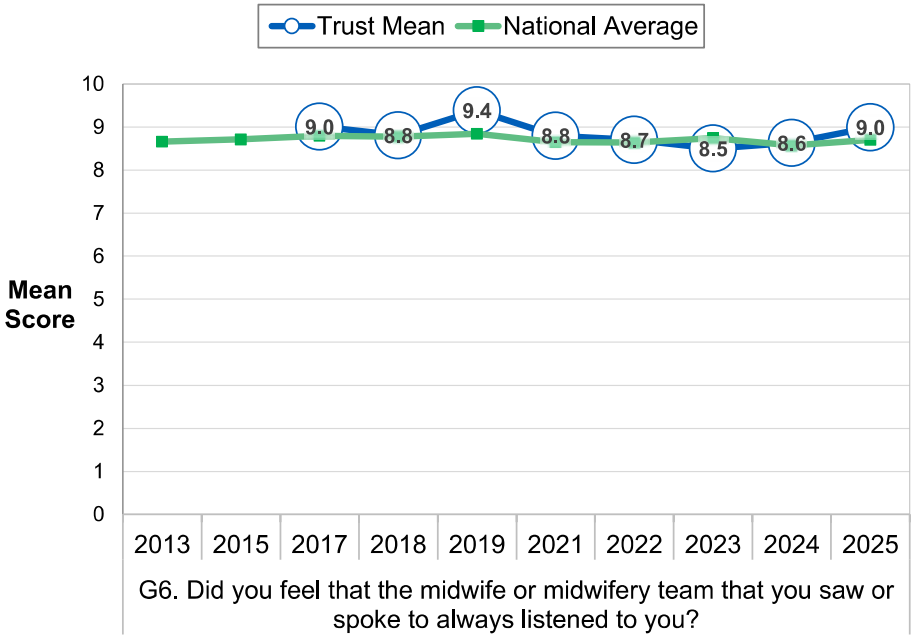


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 105; 2018: 116; 2019: 106; 2021: 152; 2022: 118; 2023: 109; 2024: 118; 2025: 109

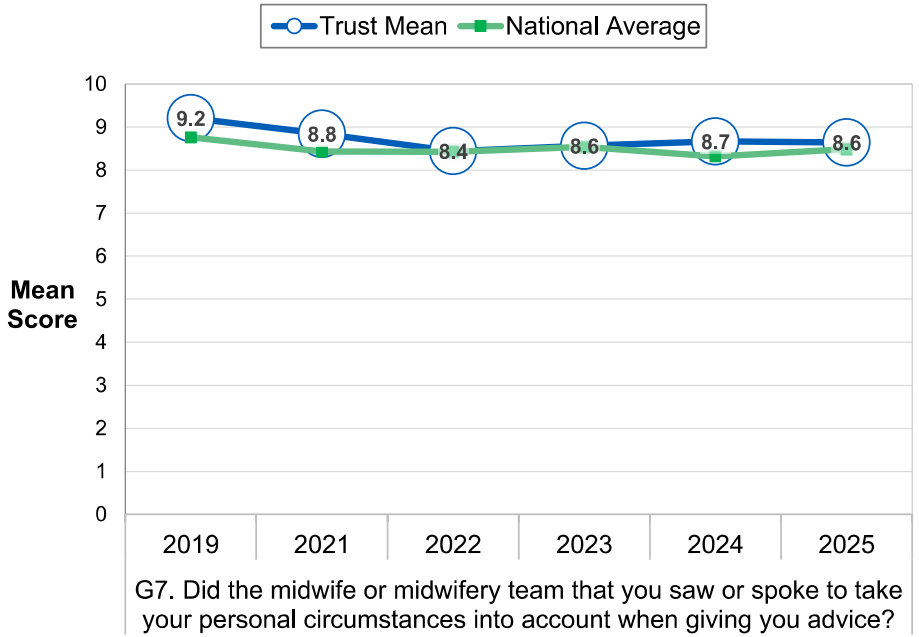
Section 4. Postnatal Care

Care at home after birth



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 112; 2018: 129; 2019: 113; 2021: 162; 2022: 126; 2023: 123; 2024: 129; 2025: 117

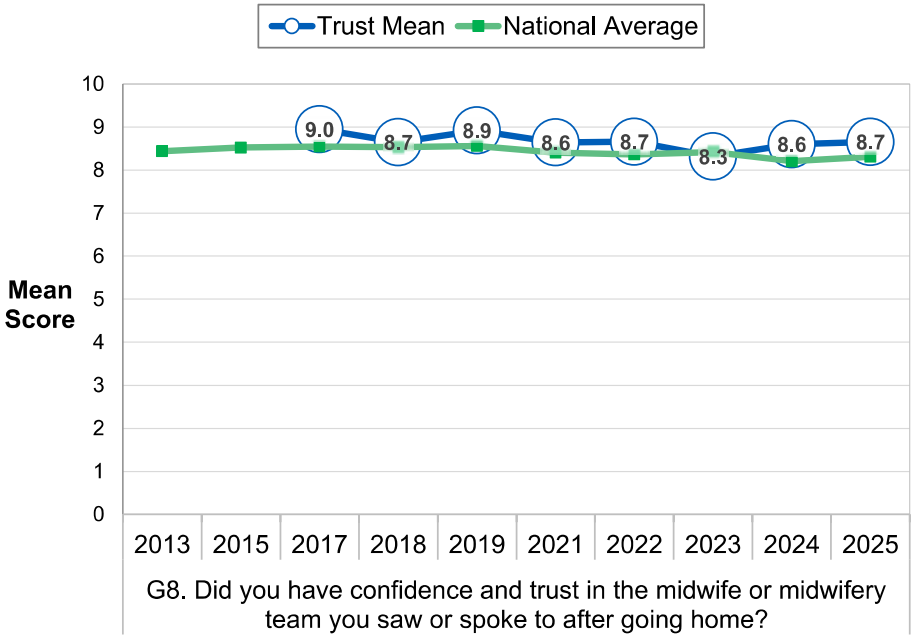


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 109; 2021: 158; 2022: 122; 2023: 120; 2024: 122; 2025: 112

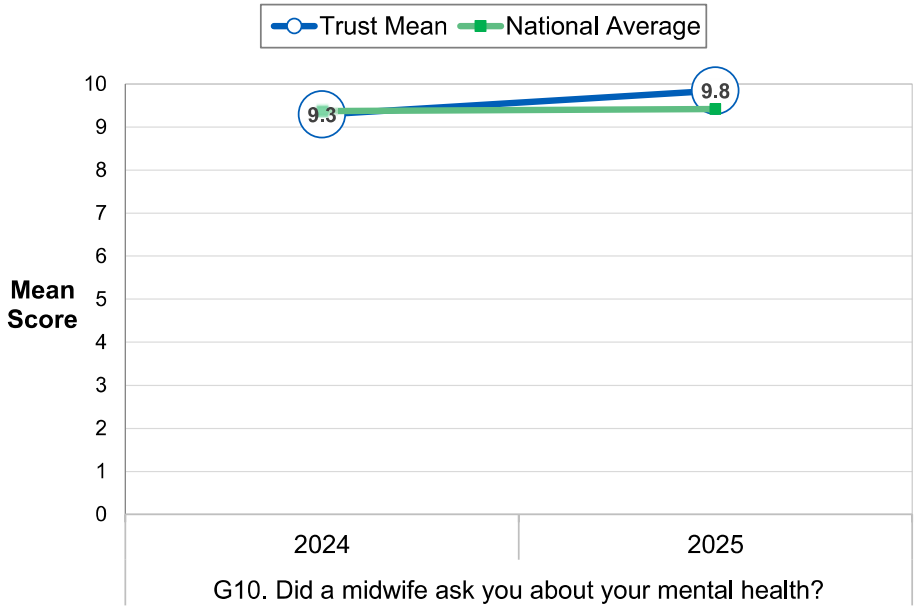
Section 4. Postnatal Care

Care at home after birth



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 112; 2018: 130; 2019: 112; 2021: 162; 2022: 126; 2023: 122; 2024: 130; 2025: 117

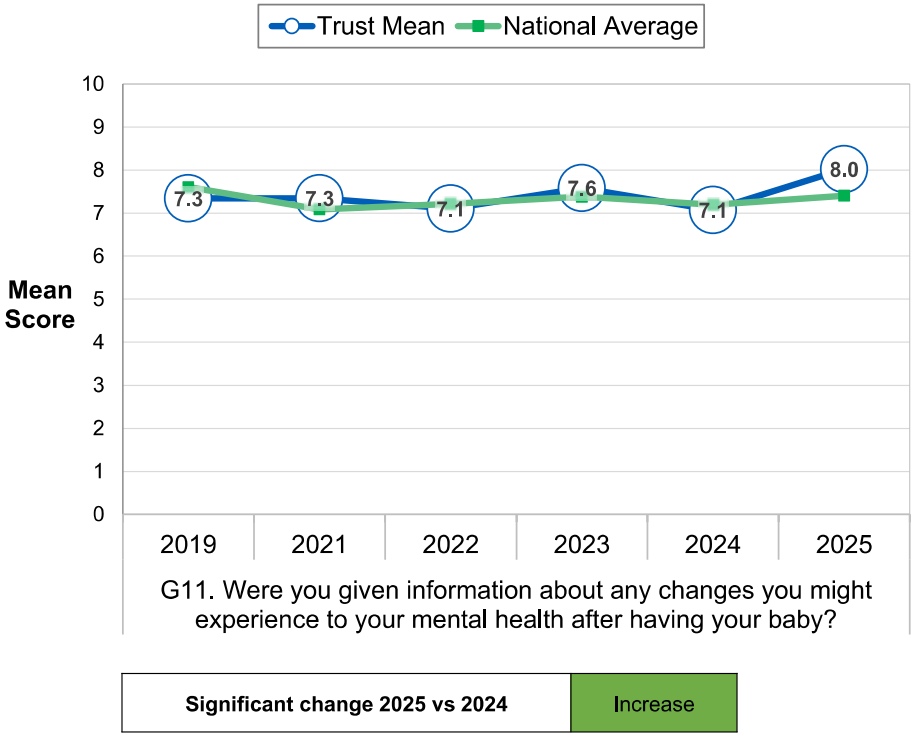


Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2024: 126; 2025: 115

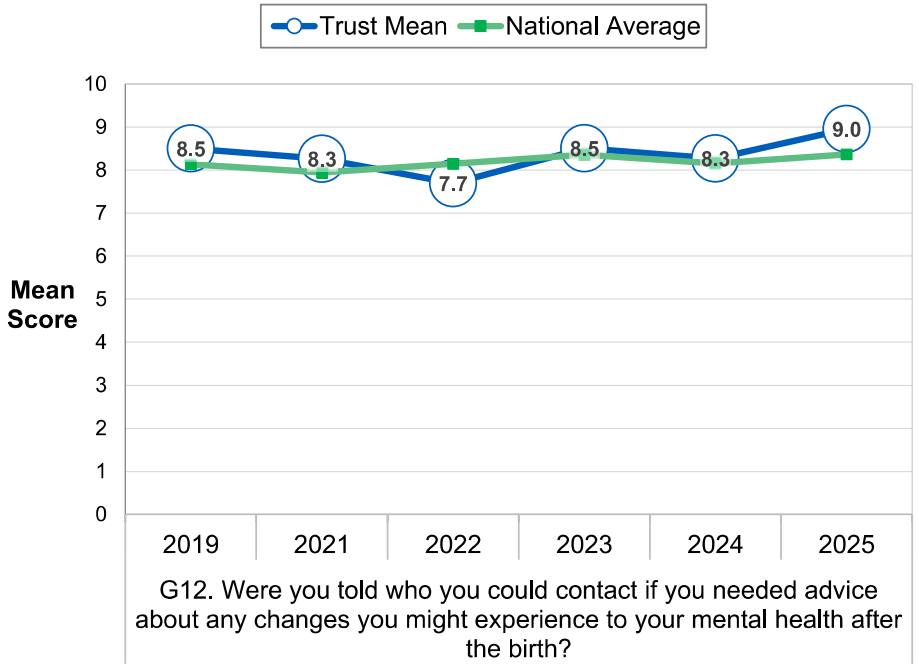
Section 4. Postnatal Care

Care at home after birth



Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 116; 2021: 173; 2022: 130; 2023: 125; 2024: 125; 2025: 113

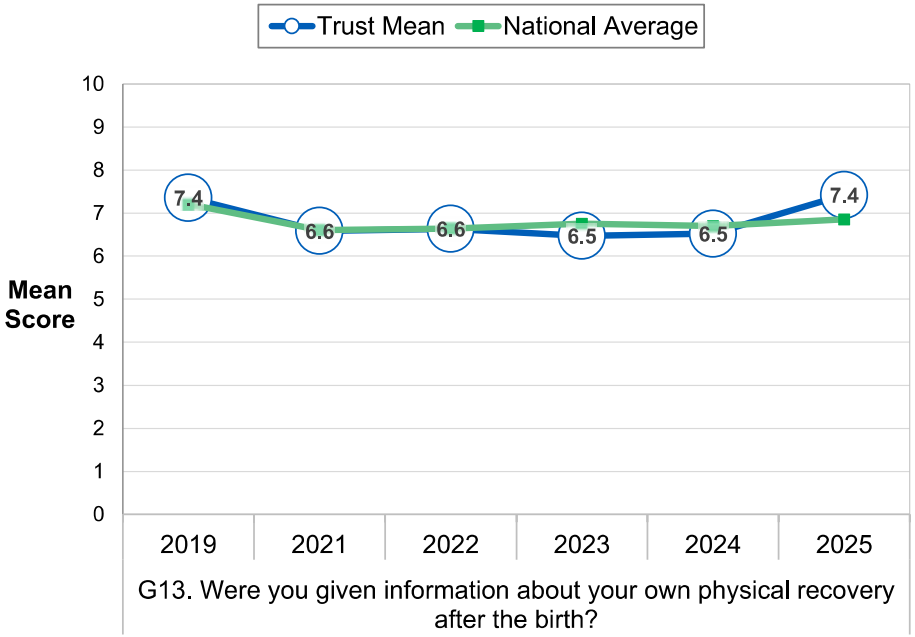


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 103; 2021: 159; 2022: 121; 2023: 118; 2024: 112; 2025: 110

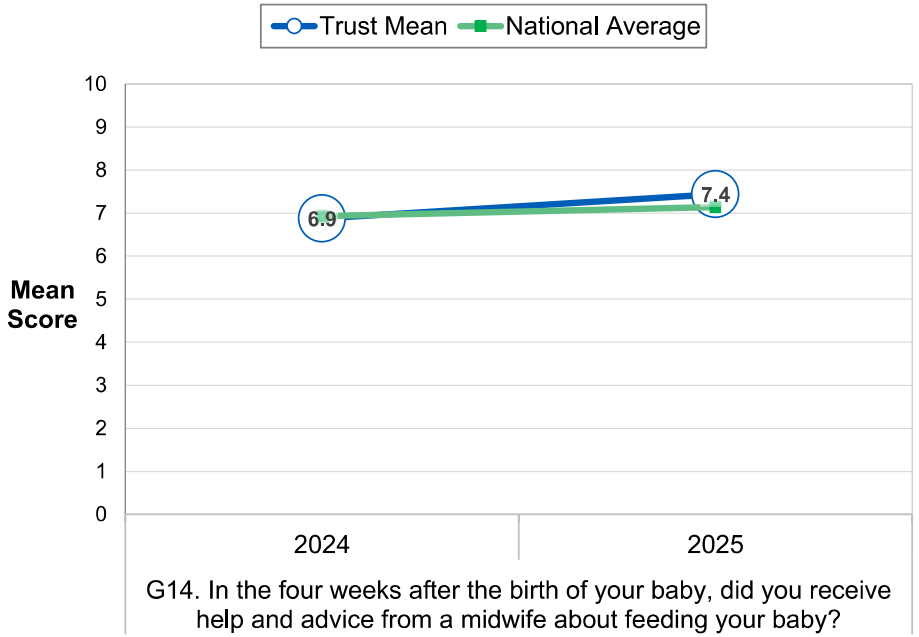
Section 4. Postnatal Care

Care at home after birth



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not need this information have been excluded.
Number of respondents: 2019: 111; 2021: 177; 2022: 131; 2023: 126; 2024: 122; 2025: 110

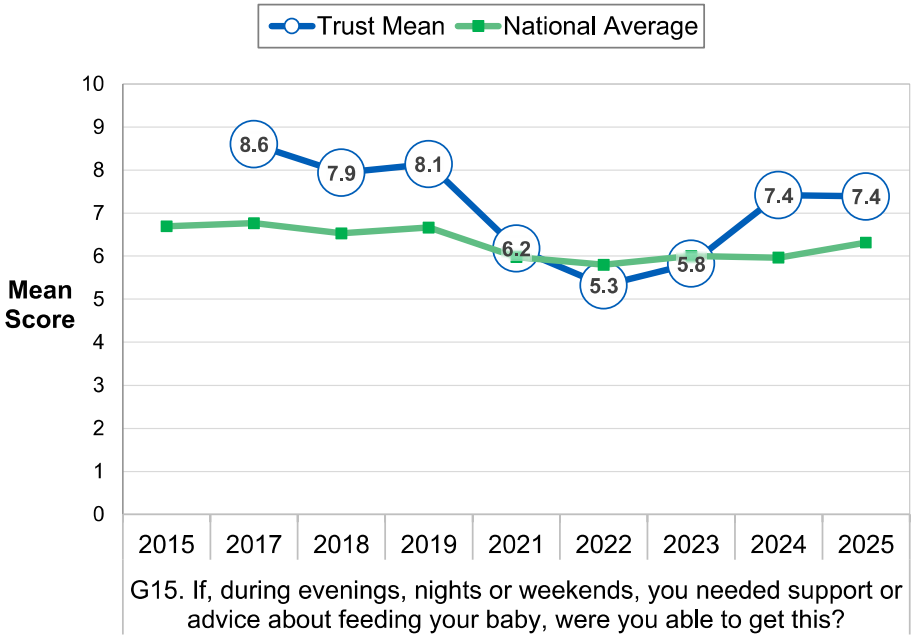


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not need any help and advice have been excluded.
Number of respondents: 2024: 107; 2025: 101

Section 4. Postnatal Care

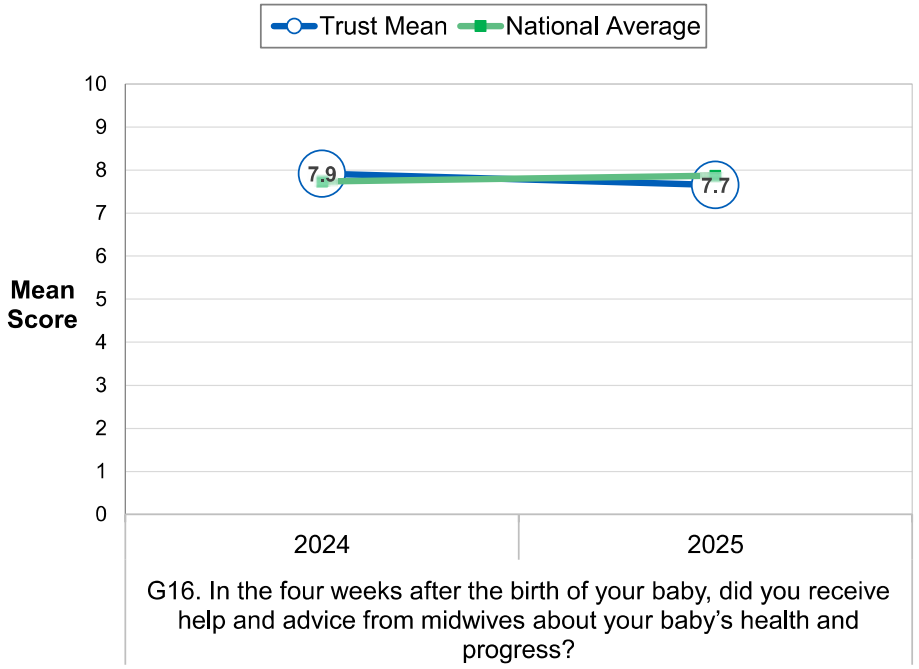
Care at home after birth



G15. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not need support or advice about feeding their baby have been excluded.
Number of respondents: 2015: -; 2017: 45; 2018: 62; 2019: 44; 2021: 79; 2022: 52; 2023: 56; 2024: 53; 2025: 51



G16. In the four weeks after the birth of your baby, did you receive help and advice from midwives about your baby's health and progress?

Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or didn't need any help and advice have been excluded.
Number of respondents: 2024: 116; 2025: 103

Change over time

Section 5: Triage: Assessment and Evaluation

CareQuality Commission

Survey Coordination Centre

NHS

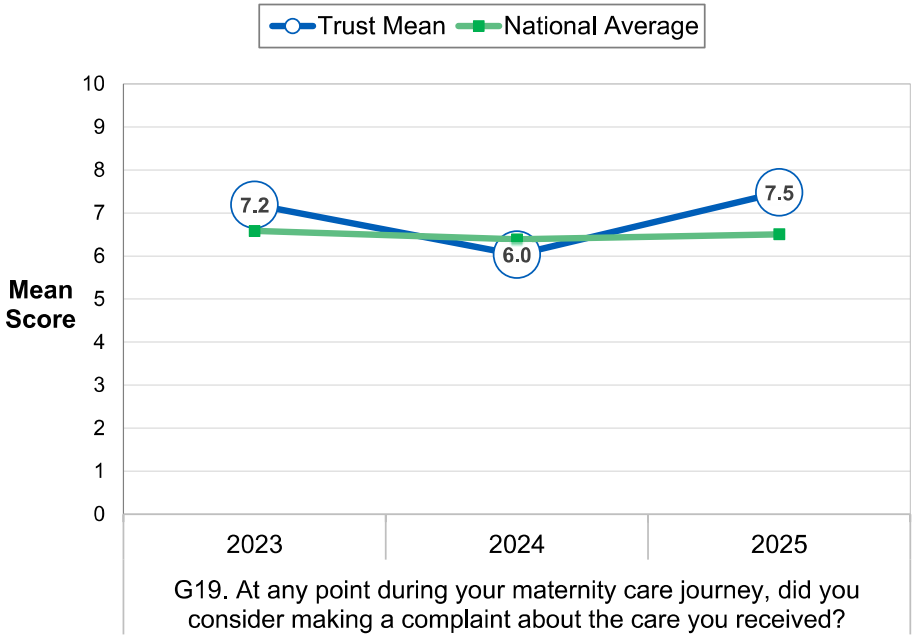
Section 5. Triage: Assessment and Evaluation

Please note, no data is available for this section as the questions have been revised for 2025 and are no longer comparable to previous year's data.

Change over time

Section 6: Complaints

Section 6. Complaints



Significant change 2025 vs 2024	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2023: 126; 2024: 131; 2025: 115

Comparison to Other Trusts

CareQuality Commission

Survey Coordination Centre

NHS

Comparison to other trusts

The questions where your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- B2. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?
- B9. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?
- B12. During your pregnancy, did midwives provide relevant information about feeding your baby?
- C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?
- C10. Did the staff treating and examining you introduce themselves?
- C13. During labour and birth, were you able to get a member of staff to help you when you needed it?
- C14. Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together?
- C16. Thinking about your care during labour and birth, were you involved in decisions about your care?
- F2. Thinking about the last time you contacted the telephone triage line, did you feel that you got the advice you needed?
- G10. Did a midwife ask you about your mental health?
- G19. At any point during your maternity care journey, did you consider making a complaint about the care you received?

Comparison to other trusts

The questions where your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- B6. During your antenatal check-ups, did your midwives listen to you?
- B7. During your antenatal check-ups, did your midwives ask you about your mental health?
- B8. Were you given enough support for your mental health during your pregnancy?
- B13. Did you have confidence and trust in the staff caring for you during your antenatal care?
- B15. If you raised a concern during your antenatal care, did you feel that it was taken seriously?
- C11. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?
- C18. Did you have confidence and trust in the staff caring for you during your labour and birth?
- E3. Did you feel that midwives gave you enough support and advice to feed your baby?
- G11. Were you given information about any changes you might experience to your mental health after having your baby?
- G12. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?
- G15. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

Comparison to other trusts

The questions where your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Comparison to other trusts

The questions where your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

For further information

Please contact the Survey Coordination Centre:
maternity@surveycoordination.com

Care Quality Commission
Survey Coordination Centre
NHS

Quality and People's Committee

February 2026 Mortality Score Card

Date of meeting	Date report produced
24th February 2026	10th February 2026

Author(s)		Report approved by	
Name and title:	Mr Chris Manlow – Director of Patient Safety Maria Patterson-AD patient safety	**Name and title:**	Mark Roberts DMD for Kate Lissett-Chief Medical Officer (on leave)
		Date:	12th February 2026

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

Executive summary

The report is for quarterly assurance to ensure learning from deaths. This report relates to the mortality data period September 2024 – August 2025

Key Highlights

1. Mortality performance continues to improve under the methodology now used. Latest HSMR is 104.6 September 24 to August 25. Non-elective HSMR+ is 104.7, which is within the expected range.
2. Elective HSMR+ rate is has fallen to 96.4 which is within the expected range. The rolling 12-month trend shows a downward trajectory over the last six periods. SHMI is 95.6 and statistically as expected' and has shown a downward trend.
3. Emergency weekend HSMR+ has changed banding and is now statistically higher than expected. Emergency weekday HSMR+ remains within the expected range. The increase in the emergency weekend HSMR+ is due to an increasing crude mortality rate over the last three rolling 12-month periods and a stable expected rate, causing the gap between the two to widen.
   The crude mortality rate has shown a declining trend and at a steeper trajectory than the decline of the expected rate, closing the gap between the two. This has had a positive impact on the HSMR+.
   Mortality coding: Due to staffing capacity there is a delay in coding mortality data. This data is classified as R69 uncoded date falling outside of 41 diagnosis groups. This will potentially negatively affect the accuracy and quality of our mortality data.

4. Perinatal services have seen an increase in neonatal deaths. Cases that meet criteria have been referred Maternity and Neonatal Safety Investigations (MNSI) for review, a perinatal mortality review toll meeting will also be held. The Trust is also undertaking 2 patient safety incident investigations. A case review meeting will be held on 19th March with external engagement.
5. There are significant capacity issues in the coding team continue which will likely reduce the accuracy and timeliness of our mortality data

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
Hospital Mortality	Satisfactory	HSMR+ increased – Expected due to the implementation of a new methodology SHMI - decreased
Unadjusted Mortality Rate	Satisfactory	Remains steady
Mortality Analysis	Satisfactory	Increased – anticipated and under review prior to CUSUM alerts
Focused Mortality Reviews	Satisfactory	

Appendices

N/A

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

Mortality Surveillance Group, Patient Safety Group, Quality Assurance Committee

Key recommendations and actions requested

The Quality Assurance Committee is asked to accept the report and note the mortality data trends.

How does this report further our Trust strategy?

Reviewing the care provided to people who have died, and gaining the feedback from the bereaved will help improve care for all service users by identifying problems associated with poor outcomes, and working to understand how and why these occur so that meaningful action can be taken.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	
Quality of services provided	To provide learning to aid the improvement of service provision and indicate any issues with care
Sustainable and efficient use of resources	

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality, Safety and Patient Experience	This supports the Board in providing visible and effective leadership to ensure the organisation addresses significant issues identified in reviews and investigations.
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	

Risk
N/A

Risks lodged on Datix:
N/A

External Standards affected by this report and associated risks
Care Quality Commission National guidance – Learning from deaths

February 2026 Mortality Score Care Summary Report

Introduction

The document 'National Guidance on Learning from Deaths' provides a framework for NHS Trusts for identifying, reporting, investigating and learning from deaths in care. From April 2017, Trusts have been required to collect and publish, on a quarterly basis, specified information on deaths by submitting a paper to the Public Board.
Data sourced, includes data from the Trust, Department of Health (DH), and Dr Foster. The report is generated for the Trust Board, Quality Improvement Group, and Mortality Surveillance Group.

This is a summary report a longer report provided to QPC is available on request.

Summary

Torbay & South Devon NHS Foundation Trust Data.

Safety Indicator	Data Source	Target	RAG
Hospital Standardised Mortality Ratio (HSMR+) September 2024-August 2025	Dr Foster's latest benchmark month	Below the 100 line with an aim for a yearly HSMR+ ≤90	12-month average 104.6 Within expected Range ↑
Summary Hospital Mortality Index (SHMI) August 2024-July 2025	DH SHMI data	Within the 'as expected' Range	95.6 ↑
SHMI alerts	DH SHMI data	2 of the 10 SHMI diagnosis groups is statistically higher than expected- Gastrointestinal Haemorrhage, Congestive Heart Failure	
Unadjusted Mortality Rate	Trust Data	Yearly Average ≤3%	2.99% →
Mortality Analysis	Trust Data Dr Foster DH HSMR data	New CUSUM alerts (Cumulative Sum)	1 new CUSUM alert- residual codes- unclassified

Mortality Reviews and Learning	Trust Data	Deep dive work has been commissioned regarding stroke deaths and the National emergency laparotomy audit.	Same

Assurance and Recommendations

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from the previous report
Hospital Mortality	Satisfactory	HSMR+ increased – Expected due to the implementation of a new methodology SHMI - decreased
Unadjusted Mortality Rate	Satisfactory	Remains steady and in line with regional/national peers
Mortality Analysis	Satisfactory	Increased – anticipated and under review prior to CUSUM alerts
Focused Mortality Reviews	Satisfactory	Review underway regarding sepsis, stroke, surgical and renal mortality.

Recommendations

Members of the Quality and Peoples committee are asked to:

- to receive and note the mortality data and analysis, including the implications for patient safety and quality.
- discuss the findings and analysis shared and confirm whether further assurance is needed at this stage.
- Note the ongoing safety review and safety improvement work ongoing within maternity's services and the actions being taken.

1.0 Mortality coding:
Mortality coding has a back log to November 2025, approximately 7000 episodes pre-February 2026.These uncoded episodes are still included in the data and will be submitted to SUS. This impacts negatively on mortality statistics.

2.0 Mortality data and trends
The HSMR for elective admissions has reduced to 96 for Sept 24 to Aug 25 compared to the previous report where this was 126.5 (within the expected range also). Looking at the data, the overall spell/superspell volumes have remained relatively stable, but the observed number of deaths has declined. The Trust will continue to monitor this trend.

2.1 CUSUM Alerts
CUSUM is short for ‘cumulative sum’ These review the sum of the differences between expected outcomes and actual outcomes over a series of patients. Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold.

There is one new CUSUM alert that was not present in the last report Residual codes, unclassified (this was present for Relative Risk previously) – Alert in June 25. R69 data is part of the Residual codes, unclassified group and not one of the 41 diagnosis groups monitored within HSMR so will not be included in the metric. This is a reflection of the coding challenges detailed above. As no robust diagnosis is available within this data, risks will also be low (expected) and will impact SMR. A one-month lag has therefore been applied and this report to exclude the month with the highest volume of R69 superspells and deaths, September 25. Data for this report is therefore based on discharges from September 24 to August 25.

6 ongoing CUSUM alerts are being monitored. Many of these alerts are caused by variations in mortality in small numbers of patients.
Sepsis has been flagged as an outlier – currently auditing and preliminary results show improvement
-Renal failure has been flagged as an alert. A large piece of work has been completed auditing a sample of cases which highlighted that patients had multiple comorbidities, no care factors were identified- although earlier referral to the service may have been beneficial. There was a significant change in service delivery model in April; the trend is now improving.

The number of patients and deaths in these categories is very small, and therefore small differences in numbers will produce a large statistical effect. This will cause the trend to fluctuate markedly.

These trends will be monitored by the mortality steering group, **and further analysis will be commissioned if necessary.**

2.3 New Groups with a statistically higher relative Risk

2.3.1 There are **three new groups** with a Relative Risk that is statistically higher than expected, that were not apparent in the previous report.

- Congestive heart failure, non-hypertensive
- Gastrointestinal haemorrhage
- Peri-, endo-, and myocarditis, cardiomyopathy (small numbers)

The MSG commissioned a review of coding accuracy for gastrointestinal and congestive cardiac failure cases. The findings are detailed below.

2.3.2 Gastrointestinal Haemorrhage

This category of patients is flagging under SHMI as higher than expected mortality. Overall, it is within expected limits. Numbers are relatively small so this may be a statistical effect rather than a real increase. A coding audit audit has been undertaken which found coding to be largely accurate. The MSG will continue to monitor this metric and commission further work to understand this if the trend continues to deteriorate.

2.3.3 Congestive cardiac failure

An audit of coding has been undertaken which found coding to be largely accurate, although a small number of patients had comorbidities. The MSG will continue to monitor this metric and commission further work to understand this if the trend is deteriorating.

3.0 Focused Mortality Reviews

3.1 National Emergency Laparotomy Audit.

The Trust has flagged as an outlier for morbidity and mortality for emergency laparotomy under the National emergency Laparotomy Audit (NELA) programme, the data period was **April 2023 to April 2024**. The National 30-day mortality during this period reduced to 8.1% whereas the Trust mortality for this period was 15.5% and was outside of control limits. NELA calculates risk assessments based on the actual number of deaths to the patients predicted risk of death based on identification of demographic risk factors and comorbidities.

This data was discussed at the mortality surveillance group (MSG), and a case note review is underway with initial findings indicating that 25% of cases had underestimated risk. The Trust is also undertaking a local prospective NELA audit with a focus on the pathway for elderly and frail patients.

We have undertaken a deep dive into local trust data which found that 30-day mortality fell to lowest level in 10 years (8.1% vs 11.7%), which is within National average. Thus, indicating we are currently providing safe service. Key messages from the deep dive are:

- Timeliness of diagnostic pathway following arrival to hospital
- Timeliness of IV antibiotic administration
- Direct comms between requesting and reporting teams around CT scanning

- Critical care bed capacity
- Geriatrician input to care for older patients

3.2 Stroke
The Trust triggered as an outlier for mortality as reported by the Sentinel Stroke National Audit Programme (SSNAP) for 2023-24. The Mortality Surveillance Group (MSG) has commissioned work to review the coding of stroke data to ensure accuracy of reporting, this work reported to MSG in January 2026. The team highlighted the importance of this work and also highlighted that the data is based on findings from 2023-24. A key focus on the trust to improve mortality is getting patients to the stroke unit within four hours. Some success has been seen here with the Trust reaching 40-50% (target is 60%) of patients reaching the stroke unit within 4 hours towards the end of 2025-this figure is at risk when the Trust is under pressure regarding patient flow across urgent and emergency services. The Trust is also striving to ring fence 3 acute stroke beds. Out of hours medical cover for the stroke service is also under review to enhance patient safety and quality of care. A stroke improvement programme continues with engagement of system partners. This work remains ongoing with oversight at MSG.

3.3 Urgent and Emergency Care
Mortality review work looking at the effect of long waits in the ED has been ongoing since 2022. We are currently reviewing data for 2025, and this will be presented at MSG in April and summarised May Quality and People's committee.

4.0 Perinatal mortality (Quarter 2 and 3).

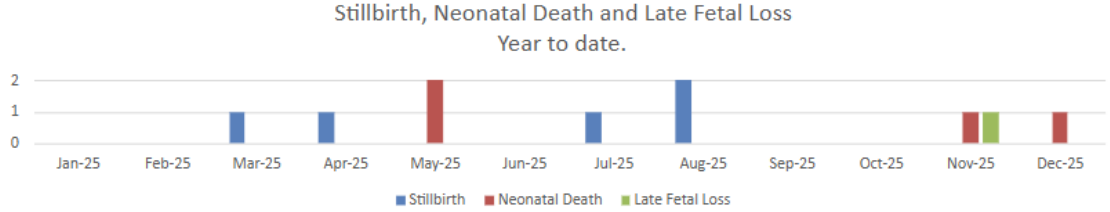
4.1 This reports details perinatal still births or neonatal deaths in quarter 2 and 3. Definitions.

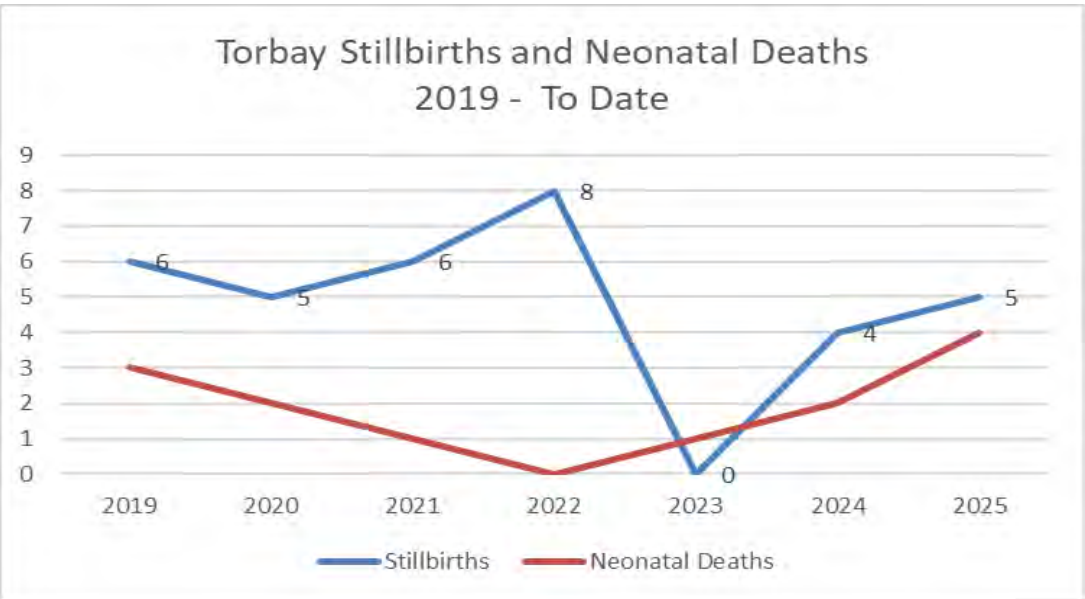
Stillbirth: when a baby is born dead after 24 completed weeks of pregnancy. It occurs in around 1 in every 200 births in England.
Early neonatal death**:** the death of a newborn within the first seven days of life.

Perinatal services have seen an increase in neonatal deaths. Cases that meet criteria have been referred Maternity and Neonatal Safety Investigations (MNSI) for review, a perinatal mortality review toll meeting will also be held. The Trust is also undertaking 2 patient safety incident investigations. A case review meeting will be held on 19th March with external engagement.

The chart below shows the cases of stillbirth, neonatal death and late fetal loss since January 2025. The second chart depicts mortality rats since 2019.

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





4.2 Current Perinatal mortality cases:

- **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 at 22 weeks - 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.
- **December 2025** – Neonatal Death following spontaneous delivery at 18 weeks gestation, maternal infection following a CVS.

4.3 Perinatal mortality actions:

- Perinatal services are being supported by the Maternity Safety Support Programme (MSSP). Due to an increased number of incidents 2 insight meetings were held to review themes and trends.
- 2 internal PSII's are underway related to perinatal mortality cases supported with external perinatal expertise from MSSP.
- Once these reports are completed a thematic review meeting is planned for March 19th to review all cases, identify themes and learning. This meeting will be supported by MSSP, executive lead for safety, perinatal leaders and the central patient safety team.
- The maternity team are unable to attend the MSG in April and have been scheduled to attend in July to present on overall perinatal mortality.

5.0 Child Deaths quarter 2 & 3
A child death review must be carried out for all children regardless of the cause of death, both expected and unexpected, including death of a live-born baby, and birth of a baby not attended by a healthcare professional determined to be born alive (it does not include stillbirths, late foetal loss or termination of pregnancy.

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area, or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

Quarter 2 & 3 2025/26:
In quarters 2 and 3 there were no unexpected deaths of children.

1 expected child death occurred of an 11-year-old child with a cancer diagnosis who was receiving cancer treatment. The cause of death was of Embryonal sarcoma of liver.

Delays remain in receiving postmortem reports this is exacerbated for children due to a shortage of paediatric pathologists.

6.0 Medical Examiner service
The Medical Examiners service became statutory on the 9th September 2024. As such, the independent Medical Examiner's Office hosted at TSDFT now scrutinises 100% of the deaths in the hospital and community settings, which are not directly referred to the coroner. In October 2025 the medical examiners mechanism for reporting deaths transferred to the Trust DCIQ incident reporting system, this will enable improved safety insight and triangulation of data.

On 1st October 2025 the mortality module on the Trust incident reporting system went live to ensure robust capture of ME requests for Structured Judgement Reviews (SJRs). During Q3 2025/2026, the medical examiners referred fifteen deaths to the Trust for further review via SJR due to possible care factors impacting upon the outcome or due to concerns raised by bereaved families. The Trust's patient safety team will work with the medical examiner team to provide assurance that all deaths escalated by the medical examiner service have been reviewed.

7.0 Deaths of a patient with a Learning disability or Autism
Patients with learning disabilities currently have a life expectancy at least 15-20 years shorter than that of other people. The Learning Disabilities Mortality Review (LeDeR) programme requires an independent case review following the deaths of people with Learning Disabilities. These feeds back any thematic learning to the Trust and our partner organisations. In addition, any deaths occurring in the Acute or community Hospital settings undergo independent review by the Medical Examiners and a Structured Judgement Review by one of the Trust's GP advisers to identify any potential learning at the earliest opportunity.

During Q3 2025/2026, the Trust submitted 2 LeDeR review referrals. We have not been notified that any deaths have resulted in focused LeDeR reviews. No themes have emerged

All cases are reviewed by the medical examiner. No concerns have been raised medical examiners during this period.

8.0 Learning from deaths & structured judgment review

We are currently revising our learning from deaths policy. This should be published trustwide later in the year.

The trust uses the Royal College of Physicians Structured Judgment (SJR) review methodology to review deaths selected by the Medical Examiner service or meeting local criteria for review. These reviews then trigger a Patient Safety Investigation where deemed necessary. SJR's form a key part of our Learning from Deaths strategy. The SJR reviews are completed by the relevant clinical teams and then held centrally by the Safety team on the Datix system. Training continues to increase uptake and use of the system.

The quarterly Mortality Surveillance Group (MSG) continues to have clinical engagement and oversight. A monthly mortality huddle is used to drive progress and flag any emerging issues. MSG will continue work to improve coding accuracy and data coding to ensure accuracy of mortality data, and commission focused work to understand areas of increased mortality (following safety intelligence, CUSUM alerts, mortality trends.

9.0 Challenges / Risk

The Coding team is adapting to the new Elixhauser/ Bottle methodology; however, there are limitations around capturing comorbidity/frailty (related to our IT systems), which can potentially lead to an underestimate or "risk of death" and thus an overestimation of our HSMR. There are also significant capacity issues in the trust coding team. This may affect the timeliness and quality of our mortality data. Currently, we have a coding backlog which current data suggests is affecting the trusts mortality reporting accuracy.

Accessing Mortality data is difficult for clinical teams due to poor IT. Poor IT systems and multiple paper-based, manual systems represent areas of risk for the trust in managing patient referrals and records.

Uptake of the SJR system has so far been limited. This is due to IT issues and issues around allocation of clinicians to the role within specialties. Work is ongoing to correct this.

10.0 Recommendations

Members of the Quality and Peoples committee are asked to:

- to receive and note the mortality data and analysis, including the its implications for patient safety and quality.
- discuss the findings and analysis shared and confirm whether further assurance is needed at this stage.
- Note the ongoing safety review and safety improvement work ongoing within maternity's services and the actions being taken.

Glossary of Terms

HSMR (Hospital Standardised Mortality Ratio) - the case-mix adjusted mortality rate relative to the national average. This now uses the Elixhauser/ Bottle methodology to capture predicted mortality.

The Standardised Hospital Mortality Indicator (SHMI) is the ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital, which resulted in a death either in-hospital or within 30 days post-discharge from the hospital. The expected number of deaths is calculated from a risk-adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping. The cumulative risk of dying within the spell for each patient within the selected group gives the number of expected deaths This report includes the following assurance recommendations:

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

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

Torbay and South Devon NHS Foundation Trust

People and Quality Assurance Committee

NHS Resolution Maternity Incentive Scheme – Year 7

Date of meeting	Date report produced
27 January 2026	19 January 2026

Author(s)		Report approved by	
Name and title:	Joanna Bassett - Director of Midwifery Andy Simpson - Public Health and Personalised Care Manager (Compliance Support Lead)	**Name and title:**	Nicola McMinn Chief Nurse and DIPC

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

Executive summary

The purpose of the report is to provide the Committee with a self-assessment of the Trust's position in relation to achieving the standards set out within the CNST Maternity Incentive Scheme. A summary of the evidence provided by the Internal Audit report that supports the self-assessment is provided to enable the Trust Board to complete the declaration form to be submitted to NHS Resolution.

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
Appendix 1	Significant	Improvement
Appendix 2	Satisfactory	N/A
Appendix 3	Satisfactory	N/A
Appendix 4	Satisfactory	N/A

Section 2.2	Satisfactory	N/A
Section 2.3	Satisfactory	No change
Section 3.1	Satisfactory	Improvement

Appendices

Appendix 1. Assurance Southwest (ASW) audit report
Appendix 2. DLMNS confirmation of SBLCBv3
Appendix 3. CMO confirmation of SBLCBv3
Appendix 4. Action plan for rotational medical and obstetric staff training

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

Due to the timeframes associated with the Internal Audit review and subsequent publication of the report, this has not been presented through the usual specialty governance processes. The internal audit report was approved by the Director of Midwifery and Chief Nursing Officer. It has also been circulated to the Care Group Leadership team and Perinatal Quadrumvirate

Key recommendations and actions requested

The Trust Board is asked to agree to the overarching assurance rating and take satisfactory assurance as to completing and signing the Board declaration based on the following actions:

i) Review the report and evidence that supports declaration of compliance with CNST Standards
ii) Confirm that the necessary oversight is in place around the assessment of compliance against the Saving Babies Lives Care Bundle version 3.
iii) Approve the action plan to recover multiprofessional training and neonatal resus training for rotational medical staff to 90% by the end of February 2026.
iv) Receive assurance that the MNVP Lead is meeting with the Perinatal leadership team at a minimum of bi-monthly
v) Decide on an appropriate timeframe to maintain the Neonatal Nursing Action Plan.
vi) Confirm the Trust position of compliance against all 10 Safety Actions that enables the Chief Executive Officer to sign the declaration form on behalf the Trust

How does this report further our Trust strategy?

This report describes the quality of maternity care that is accessible and available to the pregnant population and their families in Torbay and South Devon. It also describes the mechanisms that are in place that monitor this care.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	This report supports the aims described by demonstrating best practice guidance in the delivery of care to promote the health and wellbeing of pregnant people and babies
Quality of services provided	
Sustainable and efficient use of resources	The content of this report is a summary of the Trust's status and evidence in relation to compliance with NHS Resolution's Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 7 standards. Achievement of the 10 Safety Actions will result in a minimum rebate of the Trust's contribution to the incentive fund (calculated at 10% of our maternity premia).

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality and Patient Experience:	The maternity Incentive scheme sets clear safety standards for Trusts in relation to maternity services. Demonstration that these standards have been met result in the Trust being eligible for a rebate on their maternity incentive scheme contribution and a share of any unallocated funds

Risk: Risk ID (as appropriate)	
Risk	**Risk ID**
NA	

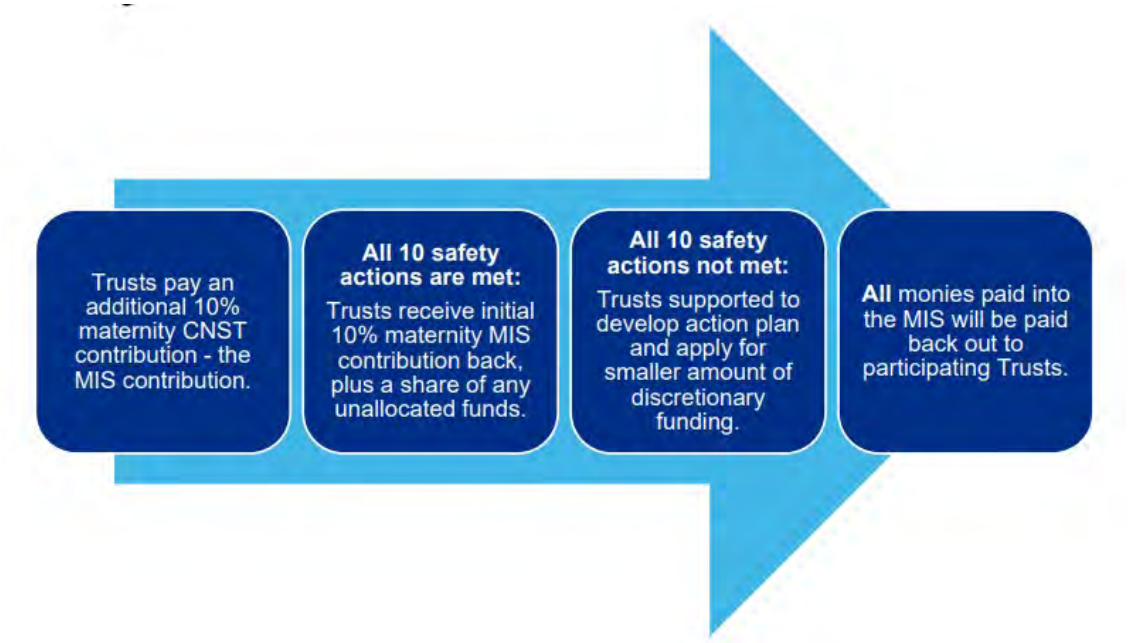
External Standards affected by this report and associated risks
NHS England licence and regulations National policy, guidance– Maternity Incentive Scheme (MIS) NHS Resolution CQC

NHS Resolution Maternity Incentive Scheme – Year 7

1.0 Introduction and background

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

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



Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

Maternity incentive scheme year seven: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **3 March 2026** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.
    - There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **3 March 2026**.
    - Any reports covering an earlier time-period may prompt a review of a previous MIS submission. *If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution that year's MIS funds that were awarded, irrespective of it being a prior financial year.*
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

2.0 CNST Self-Assessment Summary of 10 Maternity Safety Action

For CNST Year 7 the Trust utilised an Internal Audit process to review the evidence submitted thus providing an objective oversight. All evidence collated to support the submission against the criteria set out in the NHS Resolution's guidance for the Maternity incentive scheme (MIS) was reviewed to provide an independent assessment of the quality of the evidence being presented, prior to the Board's review and the planned submission to NHS Resolution by 12 noon on the 3rd of March 2026.

The review was conducted, as a desktop exercise, in conjunction with reviews for University Hospitals Bristol and Weston NHS Foundation Trust, University Hospitals Plymouth NHS Trust and Royal Devon University Healthcare NHS Foundation Trust. The review was undertaken during the period 8 – 19 December 2025 for all Trusts involved. The internal audit report is set out in **Appendix 1**.

The evidence to support the 10 safety actions is stored electronically within the Maternity Services Shared Drive Dir Man (\\sdhfs03): CNST 2025 year 7. This can be accessed by the senior staff within the maternity services to demonstrate compliance as required. The Chief Nurse also has access to this evidence.

Separate to the Trust oversight, the LMNS were required to approve specific pieces of evidence for all Devon Providers. These were approved at the LMNS Strategic Board meeting on November 24th, 2025.

2.1 Red rated standards

The Committee will note that there are zero red rated standards, this means the Trust can declare compliance with CNST Year 7.

2.2 Amber rated standards.

The Committee will note that there are three amber rated standards, all of which will meet compliance subject to review and approval of this submission. These include the following compliance requirements:

SA6 – Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three (SBLV3)?

The DLMNS, on behalf of the ICB, have provided confirmation that that the SBLV3 implementation tool demonstrates our current compliance of 91.3%, which is an improvement on last year's 87.14%; therefore, sufficient progress has been made against trajectory (**Appendix 2**).

There is also a requirement to obtain signed declaration from the Chief Medical Officer confirming that they are assured that the Saving Babies Lives Care Bundle is in place as agreed with the ICB. (**Appendix 3**)

SA8 – Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?

The Trust is compliant in 20 out of 22 elements for SA8, the two areas of non-compliance are in the training of rotational medical staff who commenced work after the 1st of July 2025. Full compliance can be reported if an action plan to recover this position to 90% within a maximum 6-month period from their start date with the Trust is in place and has been approved. **Board approval of the action plan for rotational medical and obstetric staff training is required (formally recorded in Trust Board minutes).** The action plan demonstrates the actions required to ensure that rotational medical staff training compliance is at 90% within 6-months and is available as part of this document **(appendix 4).**

SA9 – Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?
The Trust is compliant with all 9 elements for SA9, however ASW identified that although the new MNVP lead has participated in bi-monthly quad meetings since August 2025, this has not been fully reflected in QAC and Board papers.

This report provides retrospective assurance that the MNVP lead has participated at the bimonthly QUAD meetings since August 2025 as follows:

- QUAD meeting 26/08/2025, Helen Wiggins MNVP lead attended
- QUAD meeting 30/10/2025, Helen Wiggins MNVP lead attended

2.3 Additional development actions for CNST MIS year 8

SA4 - Year 8
Trust Board should assess the safety implications of not meeting BAPM neonatal staffing standards and determine an appropriate timeframe for maintaining an action plan to achieve compliance with the British Association of Perinatal Medicine national nursing staffing standards.

SA7 - Year 8
The Trust should ensure that all Terms of Reference clearly state that the MNVP Lead is a quorate member of the relevant safety and governance groups.

SA9 - Year 8
The Trust should align the scope of learning from incident reporting with the principles of PSIRF. This means moving beyond a focus solely on incidents involving moderate or significant harm and instead addressing trends, themes, and including near miss and low harm events.

3.1 Assurance recommendations and summary

The Maternity Service has worked extremely hard to ensure that processes and systems are in place to meet the requirements set by NHS Resolution. These 10 key actions are designed to drive safety improvements within maternity and neonatal care.

The Committee are now required to review the evidence provided to assure themselves of achievement of the standards.

The Chief Executive will need to sign the Board declaration on behalf of the Board. This declaration will also need to be countersigned by the Accountable Officer for Devon LMNS.

This report includes the following assurance recommendations:

- Review the report and internal audit evidence (appendix 1) that supports declaration of compliance with CNST Standards.
- Confirm that the necessary oversight is in place around the assessment of compliance against the Saving Babies Lives Care Bundle version 3 (appendix 2 and 3).

- Approve the action plan to recover multiprofessional training and neonatal resus training for rotational medical staff to 90% by the end of February 2026 (appendix 4).
- Receive assurance that the MNVP Lead is meeting with the Perinatal leadership team at a minimum of bi-monthly (section 2.2).
- Decide on an appropriate timeframe to maintain the Neonatal Nursing Action Plan.
- Confirm the Trust position of compliance against all 10 Safety Actions that enables the Chief Executive Officer to sign the declaration form on behalf the Trust.

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Appendix 4	Satisfactory	N/A
Section 2.2	Satisfactory	N/A
Section 2.3	Satisfactory	No change
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Appendices

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Appendix 2. DLMNS confirmation of SBLCBv3v Page 42
Appendix 3. CMO confirmation of SBLCBv3 Page 45
Appendix 4. Action plan for rotational medical staff training Page 46

Appendix 1. Assurance Southwest (ASW) audit report

ASW Assurance
Sharing excellence in governance

NHS

Torbay and South Devon NHS Foundation Trust

Final Internal Audit Report: CNST Year 7 - Maternity Evidence Review

Report Reference: TSD25/26

January 2026

Distribution List (for action):

- Jo Bassett, Director of Midwifery
- Nicola McMinn, Chief Nurse and Director of Infection Prevention and Control
- Andy Simpson, Public Health and Personalised Care Manager

Additional Copies (final report, for information):

- Emily Long, Director Corporate Governance and Trust Secretary
- James Corrigan, Interim CFO
- Grant Thornton, External Audit
- Penny Smith, Chief Finance Officer, Devon Integrated Care Board
- Charli Mardon, Devon Maternity and Local Neonatal System Programme Manager

Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the 2025/26 Audit and Assurance Plan, we have reviewed the evidence being collated within Midwifery to support the submission against the criteria set out in the NHS Resolution's guidance for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) – year seven; to provide an independent assessment of the quality of the evidence being presented, prior to the Board's review and the planned submission to NHS Resolution by 3 March 2026.

MIS continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The original ten Safety Actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS
England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.

Trusts that can demonstrate they have achieved all ten of the Safety Actions in full will recover their element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-often threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved.

The Local Maternity and Neonatal System (LMNS) play a key role in supporting and providing assurance to organisations across an Integrated Care System (ICS). The LMNS ensures that a Trust is able to demonstrate required safety and quality standards, support development of evidence and oversight through system meetings, and sharing of learning that supports the Trust's overall declaration of compliance with CNST MIS Year 7.

LMNS leads receive and validate the Trusts' progress on Safety Action 6, implementation of the Saving Babies' Lives Care Bundle (SBLCBv3) through structured quarterly meetings and assesses whether the organisation is anticipated to achieve the locally agreed improvement trajectory. Similarly, for Safety Action 7, the LMNS has a responsibility for commissioning System Maternity Neonatal Voices Partnership with formal job descriptions, remuneration, and governance structures.

To strengthen rigor to ensure appropriate levels of assurance, representatives from the LMNS have attended all feedback sessions for each Safety Action as part of this audit. This has enabled a higher level of candour and transparency between the System and Trust, which will support the Integrated Care Board (ICB) sign off of the Trusts declaration of compliance.

The Trust is due to submit the self-assessment to the Board in February 2026 prior to submission to NHS Resolution by 12 noon on the 3 March 2026.

Objectives and Scope of the Audit

We reviewed evidence collated within Midwifery to support the submission against the criteria set out in the NHS Resolution's guidance for the MIS – year seven; to provide an independent assessment of the quality of the evidence being presented, prior to the Board's review and the planned submission to NHS Resolution by 12 noon on the 3 March 2026.

The review was conducted, as a desktop exercise, in conjunction with reviews for University Hospitals Bristol and Weston NHS Foundation Trust, University
Hospitals Plymouth NHS Trust and Royal Devon University Healthcare NHS Foundation Trust. The review was undertaken during the period 8 – 19 December 2025 for all Trusts involved. Following the review of each Safety Action we met with the Safety Action Lead/ Senior Responsible Officer to go through our queries and any additional information that will need to be collated by the Trust before the declaration. Following each of these meetings we provided by email, a summary of the outcome and a list of additional evidence required.

OVERALL CONCLUSION

Based on the evidence provided in support of the Trust's CNST MIS self–assessment, it is our opinion that at the time of undertaking this review, there is adequate evidence to support 'full compliance' with seven of the ten Safety Actions.

We have assessed the remaining three Safety Actions as *'requiring further explanation' (*including provision of additional detail and/or adjustment prior to submission). Where additional evidence is made available prior to submission of the assessment to NHS Resolution, it is possible that these Safety Actions could be re-assessed to demonstrate full compliance with the Safety Action element.

It is important to note that NHS Resolution has indicated significant changes for the Year 8 assessment. Until the new guidance is issued (expected in April 2026), the Trust should continue to follow the Year 7 CNST MIS guidance.

Our assessment of each Safety Action is summarised in the table below:

	Criteria for CNST MIS	Trust Assessment	Our Assessment
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	✓	✓
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	✓	✓
3	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	✓	✓
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	✓	✓
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	✓	✓
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?	✓	–
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	✓	✓
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?	✓	–
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	✓	–
10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?	✓	✓

Key for the Assessment Table above and throughout the report

Rating	Description
✓	Evidence provided is appropriate or requires minimal additional evidence. Any issues that were identified are not significant.
–	Evidence provided is appropriate, however in our opinion requires further explanation/detail/adjustment prior to submission.
✗	Evidence provided does not demonstrate compliance with the Element of the Safety Action.

We would like to acknowledge the help and assistance given by the Director of Midwifery, Public Health and Personalised Care Manager and Safety Action Leads, during the course of this review.

Rating of Recommendations

Recommendations raised in this report have been rated in accordance with the organisation's risk matrix.

Report Data

Date of Work Undertaken	8-19 December 2025
Date of Issue of Draft Report	07 January 2026
Date of Return of Draft Report	10 January 2026
Date of Approval of Final Report	12 January 2026
Lead Auditor	Hanna Somerwill, Audit and Assurance Manager – Specialist Services Gill Travers, Audit and Assurance Manager – Specialist Services
Client Lead Manager(s)	Jo Bassett, Director of Midwifery
Client Lead Director	Nicola McMinn, Chief Nurse and Director of Infection Prevention and Control
Governance/Regulatory Links	CNST MIS Maternity Standards Year 7

Action Plan

Unique ID	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1649	**For SA4 - Year 8** In light of recent developments in other local units, the Trust Board should assess the safety implications of not meeting BAPM neonatal staffing standards and determine an appropriate timeframe for maintaining an action plan to achieve compliance with the British Association of Perinatal Medicine national nursing staffing standards.	**Moderate (6)**	Agree	The Trust is set to remain part of the Maternity Improvement Programme, with sustainability expected to be a key component of this workstream and will continue to form part of the Trust's broader improvement journey. A formal statement on the BAPM Action Plan will be included within the CNST MIS declaration. The Board paper will highlight that a regional approach will be required and seek the boards views on an appropriate timeframe for maintaining an action plan to achieve compliance with the BAPM standards.	CNST MIS year 7 Paper to the Board and Mins of the February Board Meeting noting that a regional decision solution will be required and that the Trust Board have discussed an appropriate timeframe for maintaining an action plan.	Jo Bassett, Director of Midwifery.	04/02/2026
1650	**For SA6 – Year 7 Declaration** In order to meet compliance with SA6 the declaration provided by the ICB will need to be presented alongside the Trust's CNST MIS declaration to the Trust Board in February 2026.	**Moderate (12)**	Agree	The Saving Babies Lives declaration provided by the Integrated Care Board ICB will be taken to the Board in February 2026.	Minutes and or papers to the February Board Meeting demonstrating that the Saving Babies Lives declaration provided by the Integrated Care Board ICB has been presented.	Jo Bassett, Director of Midwifery.	04/02/2026

Unique ID	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1651	**For SA6 – Year 7 Declaration Best Practice** The Trust may wish to present to the Trust Board in February 2026 the letter agreed with the Integrated Care Board and signed by the Chief Medical Director, confirming that the Saving Babies' Lives Care Bundle (Version 3) is, or will be, fully implemented as agreed with the ICB, alongside the Trust's MIS declaration.	**Moderate (6)**	Agree	The Saving Babies Lives declaration provided by the ICB and signed by the Trust's Medical Director confirming that the Saving Babies' Lives Care Bundle (Version 3) is, or will be, fully implemented will be taken to the Board in February 2026.	Minutes and or papers to the February Board Meeting demonstrating that declaration provided by the ICB and signed by the Trust's Medical Director confirming that the Saving Babies' Lives Care Bundle (Version 3) is, or will be, fully implemented has been taken to the January 2026 Board.	Jo Bassett, Director of Midwifery.	04/02/2026
1654	**For SA7 – Year 8** The Trust should ensure that all relevant Terms of Reference clearly state that the MNVP Lead is a quorate member of the following groups: • Safety Champion Meetings • Maternity Governance Group • Neonatal Governance Group • PMRT Review Meeting • Patient Safety Meeting • Guideline Committee	**Moderate (6)**	Agree	The Trust will ensure all relevant Terms of Reference are updated to reflect this requirement. This will be completed once year 8 guidance has been realised.	Updated ToRs stating that the MNVP Lead is a Quorate Member of the relevant groups.	Jo Bassett, Director of Midwifery.	30/04/2026

Unique ID	Recommendation	Risk rating	Agree/ disagree	Management action (SMART)	Evidence required to close action	Action lead/ manager responsible	Action date
1653	**For SA8 – Year 7 Declaration** To ensure compliance with SA8, the action plan for rotational medical and obstetric staff training must be approved by the Trust Board in February 2026. This approval should be formally recorded in the Trust Board minutes.	**Moderate (12)**	Agree	The action plan for rotational medical and obstetric staff training will be presented to the Trust Board in February 2026 for its approval.	CNST MIS year 7 Paper to the Board and Mins of the February Board Meeting noting approval of action plan.	Jo Bassett, Director of Midwifery.	04/02/2026
1652	**For SA9 – Year 8 Best Practice** The Trust should align the scope of learning from incident reporting with the principles of PSIRF. This means moving beyond a focus solely on incidents involving moderate or significant harm and instead addressing trends, themes, and including near miss and low harm events. Doing so will maximise learning opportunities across all types of incidents.	**Moderate (9)**	Agree	As part of our Maternity and Neonatal improvement, learning from incidents from the PSIRF model will form part of this overarching plan. Learning reports will cover all incidents, not only those resulting in moderate or significant harm and will therefore include analysis of trends and themes arising from near misses and low-harm events.	Revised Learning reports.	Jo Bassett, Director of Midwifery.	31/03/2026
1655	**For SA9 - Year 7 Declaration** At the declaration to Board in February 2026, the Trust should provide retrospective assurance that the MNVP lead has participated at the bimonthly QUAD meetings since August 2025.	**Moderate (12)**	Agree	Retrospective assurance that the MNVP lead has participated at the bimonthly QUAD meetings since August 2025, will be provided to the Trust Board in February 2026.	CNST MIS year 7 Paper to the Board and Mins of the February Board Meeting noting retrospective assurance.	Jo Bassett, Director of Midwifery.	04/02/2026

* Recommendation Unique ID is generated by our K10 Vision Audit Management System so these may not appear in consecutive order.

Opportunities for System Improvement

As this year's CNST audit was conducted in conjunction with three other NHS Trusts, we identified several areas for improvement relating to the Saving Babies' Lives Care Bundle (Year 8) for the Trust's consideration.

These improvement opportunities have been shared with all four organisations participating in this year's CNST MIS Evidence Review. As these are general recommendations intended to support system-wide improvement, some may already have been implemented by the Trust.

However, given the current financial constraints and recruitment challenges across organisations, while these improvements would be beneficial, implementation may not be feasible at this time. The identified opportunities improvement are as follows:

Area	Description
Data Quality	The Trust should ensure that regular data quality audits are conducted on the source data used within the Saving Babies' Lives audit, so that the information entered into the system can be relied upon.
Continuation of Removed Audits	The Trust should continue conducting any audits that were removed from Saving Babies' Lives this year, as these were originally identified as key interventions to reduce harm.
Single System Wide Saving Babies' Lives Dashboard	As the three Devon Trusts transition to a single Electronic Patient Record system, the LMNS should consider developing a system-wide Saving Babies' Lives dashboard. This dashboard should be used by each Trust to monitor and demonstrate progress on each intervention on a monthly basis.
Using Latest Ratified Versions of Guidelines	A review should be conducted of all guidelines published on the Devon LMNS Saving Babies' Lives NHS Futures page to confirm that the most current, ratified versions are being used as evidence and that these versions are readily accessible to staff.
Development of a System-wide PMRT Review Group	The LMNS should develop and the Trust should contribute to a system-wide PMRT Review Group to maximise consistency, assist with peer review and realise the benefits of collaborative learning and shared best practice.

Safety Action 1 - Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

What We Checked

The evidence provided to demonstrate compliance with Safety Action (SA) 1 was reviewed. Following our review, we provided feedback at a meeting with Safety Action Leads and provided a breakdown of additional evidence that was required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days?	✓	No issues identified.	No additional evidence required.
For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	✓	No issues identified.	No additional evidence required.
Has a review using the PMRT of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	✓	No issues identified.	No additional evidence required.
Were 75% of all reports completed and published within 6 months of death?	✓	No issues identified.	No additional evidence required.
For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT?	✓	No issues identified.	No additional evidence required.
Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans. A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	✓	No issues identified.	No additional evidence required.
Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	✓	No issues identified.	No additional evidence required.

Safety Action 2 - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

What We Checked

The evidence provided to demonstrate compliance with SA2 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/Issues to Address
Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	✓	No issues identified.	No additional evidence required
Did July's 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	✓	No issues identified.	No additional evidence required.

Safety Action 3 - Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

What We Checked

The evidence provided to demonstrate compliance with SA3 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	✓	No issues identified.	No additional evidence required.
Or Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards.	**N/A – Transitional C re Pathway in place.**		
For units commencing a new QI project			
By 2 September 2025, register the QI project with local Trust quality/service improvement team.	**N/A – Continuing wi h a QI project**		
By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.			
Or - For units continuing a QI project from the previous year			
Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	✓	No issues identified.	No additional evidence required.
By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period.	✓	No issues identified.	No additional evidence required.

Safety Action 4 - Can you demonstrate an effective system of clinical workforce planning to the required standard?

What We Checked

The evidence provided to demonstrate compliance with SA4 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Obstetric Medical Workforce			
Locum currently works in their unit on the tier 2 or 3 rota? **Or** They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP) **Or** They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	✓	No issues identified.	No additional evidence required.
Has the Trust Implemented the RCOG guidance on engagement of long-term locums in full? Trusts should demonstrate full compliance through audit of any 6-month period from February 2025 to 30 November 2025.	✓	No issues identified.	No additional evidence required.
Is the Trust compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	✓	No issues identified.	No additional evidence required.
Do you have evidence that the Trust position with the above has been shared with Trust Board?	✓	No issues identified.	No additional evidence required.
Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?	✓	No issues identified.	No additional evidence required.
Do you have evidence that the Trust position with the above has been shared with the LMNS?	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Anaesthetic Medical Workforce			
Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	✓	No issues identified.	No additional evidence required.
Neonatal Medical Workforce			
Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	✓	No issues identified	No additional evidence required
Is this formally recorded in Trust Board minutes?	✓	No issues identified.	No additional evidence required.
If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	✓	No issues identified.	No additional evidence required.
Was the above action plan shared with the LMNS?	✓	No issues identified.	No additional evidence required.
Was the above action plan shared with the Neonatal ODN?	✓	No issues identified.	No additional evidence required.
Neonatal Nursing Workforce			
Does the neonatal unit meet the BAPM national standards of nursing staffing?	✓	The Trust is currently non-compliant with BAPM nursing workforce standards. An action plan has been in place for several years to address the need for additional Qualified in Speciality (QIS) trained staff. **No additional evidence required for year 7.** **To note** - There is a national shortage of QIS-trained nurses. To address this, the South West Neonatal Network has introduced a regional QIS programme, which takes approximately 2–2.5 years to complete. While the Trust currently has nurses enrolled in this programme, this alone will not resolve workforce challenges due to ongoing staff turnover. Best practice would involve the region implementing a recruitment incentive scheme for neonatal nursing, alongside collaboration with education providers to promote the role and encourage newly qualified nurses to remain within the region.	

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
		For Year 8 In light of recent developments in other local units, the Trust Board should assess the safety implications of not meeting BAPM neonatal staffing standards and determine an appropriate timeframe for maintaining an action plan to achieve compliance with the British Association of Perinatal Medicine national nursing staffing standards.	
Is this formally recorded in Trust Board minutes?		No issues identified.	No additional evidence required.
Was the above action plan shared with the LMNS?		No issues identified.	No additional evidence required.
Was the above action plan shared with the Neonatal ODN?		No issues identified.	No additional evidence required.

Safety Action 5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?

What We Checked

The evidence provided to demonstrate compliance with SA5 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this).		No issues identified.	No additional evidence required.
Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. Every report should include an update on all of the points below: • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. • The midwife to birth ratio • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour • Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?		No issues identified.	No additional evidence required.
FOR INFORMATION ONLY We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: • Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).		No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
• Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.			
Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.		No issues identified.	No additional evidence required.
Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.		No issues identified.	No additional evidence required.
Where deficits in staffing levels have been identified must be shared with the local commissioners.		No issues identified.	No additional evidence required.
Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must supernumerary status: (defined as having a rostered planned supernumerary co-ordinator at the start of every shift) to ensure that there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator at the start of a shift.		No issues identified.	No additional evidence required.
FOR INFORMATION ONLY a workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward co-ordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.		No issues identified.	No additional evidence required.
Evidence from an acuity tool (may be locally developed) , local audit and/or local dashboard figures demonstrating 100% compliance with the provision of one to one care in active labour.		No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Development of the improvement plan will enable the Trust to declare compliance with this subrequirement. This improvement plan does not need to be submitted to NHS Resolution.		No issues identified.	No additional evidence required.

Safety Action 6 - Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

What We Checked

The evidence provided to demonstrate compliance with SA6 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of the additional evidence required to demonstrate compliance.

What We Found

The LMNS has confirmed that the Trust's latest position for Saving Babies Lives V3, is 91.3% compliant, which is an improvement on last year's 87.14% compliance.

In addition to reviewing the three evidential requirements for SA6 we have also undertaken a deep dive into 20 interventions across the six elements of Saving Babies Lives V3. For all 20 interventions reviewed, we can confirm the guidelines covered the requirements listed and where appropriate we were able to review suitable audit evidence and action plans.

The Trust has a number of additional pieces of evidence to locate before it can declare compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment?		The evidence reviewed suggests compliance, however, the Trust Board has not yet been informed of the results of the Saving Babies' Lives Version 3 verification by the LMNS.	**For the Year 7 Declaration** In order to meet compliance, the declaration provided by the ICB will need to be presented alongside the Trust's MIS declaration to the Trust Board in February 2026.
Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with locally agreed improvement trajectory?		No issues identified.	No additional evidence required.
Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: • Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory.		No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.			
Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?		No issues identified.	No additional evidence required.
If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.		No issues identified.	**For the Year 7 Declaration** As the Trust and Devon LMNS do not use the Implementation Tool, the Trust may wish to present to the Trust Board in February 2026 the letter agreed with the ICB and signed by the Chief Medical Director, confirming that the Saving Babies' Lives Care Bundle (Version 3) is, or will be, fully implemented as agreed with the ICB, alongside the Trust's CNST MIS declaration.

As the CNST audit was conducted with three other NHS Trusts, we identified several areas for improvement related to the Saving Babies' Lives Care Bundle (Year 8) for the Trust's consideration, detailed in the Opportunities for System Improvement section on Page 9. These are general system-wide observations, so some may not apply to the Trust. The identified areas of weakness are as follows:

Area	Control Weakness
Data Quality	Data quality audits were not consistently carried out to confirm the accuracy of source data used in the Saving Babies' Lives audits, creating a risk of inaccurate reporting and false assurance.
Continuation of Removed Audits	Due to limited resources, some Trusts have stopped undertaking audits from the Saving Babies' Lives programme that were removed nationally because improvement targets were not being met. These audits were originally key interventions to reduce harm, so continuing them would be best practice, especially as they may support future improvement work.

Area	Control Weakness
Single System Wide Saving Babies' Lives Dashboard	Compliance with Saving Babies' Lives audits was monitored inconsistently across organisations, with some tracking improvement trajectories more effectively than others. As all three Trusts transition to a single Electronic Patient Record (EPIC), there is an opportunity to develop a system-wide Saving Babies' Lives dashboard. This dashboard should enable each Trust to monitor and demonstrate progress on interventions monthly, helping to identify trends and track performance over time.
Using Latest Ratified Versions of Guidelines	The latest ratified guidelines were not always shared with the LMNS, or, when shared, were not accessible to staff, creating a risk of inconsistent clinical practice and delayed implementation of evidence-based care, which may compromise patient safety and reduce assurance.
Development of a System-wide PMRT Review Group	Currently, each Trust operates its own PMRT Review Group. Since these groups require external representation, best practice would be to establish a system-wide PMRT Review Group to enhance consistency, support peer review, and promote collaborative learning and shared best practice.

Safety Action 7 - Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

What We Checked

The evidence provided to demonstrate compliance with SA7 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Do you have evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge?		No issues identified.	No additional evidence required.
Has progress on the coproduced action above been shared with Safety Champions?		No issues identified.	No additional evidence required.
Has progress on the coproduced action above been shared with the LMNS?		No issues identified.	No additional evidence required.
Do you have evidence of Maternity Neonatal Voices Partnership (MNVP) infrastructure being in place from your LMNS/ICB, including all of the following: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost.	**N/A – as per technical guidance as MNVP infrastructure is not in place.** **To note –** The Devon MNVP is not yet fully operational as infrastructure is not fully in place. Although staffing levels are now adequate, the service is still building towards full functionality/capacity and is expected to be fully established by MIS Year 8. This shortfall and the plans to address it have been escalated through the Perinatal Quality Oversight Model (PQOM) at Trust, ICB, and regional levels. Although this requirement is currently marked as not applicable, the Trust has provided supporting evidence. Based on our review, we identified areas for improvement, as the Trust will need to demonstrate compliance with this requirement next year.		

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
	The LMNS, as commissioners of the MNVP contract, confirmed during the SA feedback meeting that these actions will be addressed and implemented for the next year: • The budget should clearly detail all elements, including allocated funds for IT, communications, engagement, training, and administrative support. • The Volunteer Involvement and Expenses Policy should state the date of its last review and the next scheduled review date. **Please note:** These actions fall outside the Trust's direct control so a recommendation will not be made.		
If the MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per the national guidance, is unobtainable. Has this been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? **In this event, as long as this escalation has taken place the Trust will not be required to provide any further evidence as detailed below to meet compliance for CNST MIS for this safety action.**	✓	No issues identified.	No additional evidence required.
Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee.	**N/A – as per technical guidance as MNVP infrastructure is not in place.** Although this requirement is currently marked as not applicable, the Trust has provided some supporting evidence. Our review identified that one of the two Terms of Reference (ToRs) provided did not meet the requirement, as it failed to include the MNVP Lead as a quorate member. Since the Trust will need to demonstrate compliance next year, all ToRs should be provided for the required goups as evidence and these documents should be updated. **For Year 8:** The Trust should ensure all relevant Terms of Reference explicitly state that the MNVP Lead is a quorate member of the required groups.		
Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	**N/A – as per technical guidance as MNVP infrastructure is not in place.**		

Safety Action 8 - Can you evidence the following 3 elements of local training plans and 'in-house', one day multiprofessional training?

What We Checked

The evidence provided to demonstrate compliance with SA8 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The Trust has a number of additional pieces of evidence to locate before it can declare compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Foetal monitoring and surveillance (in the antenatal and intrapartum period) training			
90% of obstetric consultants.	✓	No issues identified.	No additional evidence required.
90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor).	✓	No issues identified.	No additional evidence required.
For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	−	Action plan in place, this action plan has yet to be approved by the Board.	**For the Year 7 Declaration** To ensure compliance, the action plan for rotational medical staff training must be approved by the Trust Board in February 2026. This approval should be formally recorded in the Trust Board minutes.
90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres.	✓	No issues identified.	No additional evidence required.
Maternity emergencies and multi-professional training			
90% of obstetric consultants.	✓	No issues identified.	No additional evidence required.
90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota.	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		No issues identified.	**For the Year 7 Declaration** To ensure compliance, the action plan for rotational obstetric staff training must be approved by the Trust Board in February 2026. This approval should be formally recorded in the Trust Board minutes.
90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives.		No issues identified.	No additional evidence required.
90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).		No issues identified.	No additional evidence required.
90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors.		No issues identified.	No additional evidence required.
90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA.		No issues identified.	No additional evidence required
For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		No issues identified.	No additional evidence required
Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole CNST MIS reporting period? This should not be a simulation suite.		No issues identified.	No additional evidence required.
Neonatal basic life support (NBLS) training			
90% of neonatal Consultants or Paediatric consultants covering neonatal units.		No issues identified.	No additional evidence required.
90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births.		No issues identified.	No additional evidence required.
For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?		No issues identified.	No additional evidence required.
90% of neonatal nurses (Band 5 and above).		No issues identified.	No additional evidence required.
90% of Advanced Neonatal Nurse Practitioner (ANNP).		No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
For Information 90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.		No issues identified.	No additional evidence required.
90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) maternity theatre midwives and bank midwives employed by the Trust.		No issues identified.	No additional evidence required.
In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance. **Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of CNST MIS compliance**		No issues identified.	No additional evidence required.

Safety Action 9 - Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

What We Checked

The evidence provided to demonstrate compliance with SA9 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The Trust has a number of additional pieces of evidence to locate before it can declare compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025? (including the following)		No issues identified.	No additional evidence required.
Has a non-executive director (NED) has been appointed and is visibly working with the Board Safety Champion (BSC)?		No issues identified.	No additional evidence required.
Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context.		No issues identified.	No additional evidence required.
Does the regular review include a review of thematic learning informed by Patient Safety Incident Response Framework (PSIRF), training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?		No issues identified.	No additional evidence required. **For Year 8 – Best Practice** The Trust should align the scope of learning from incident reporting with the principles of PSIRF. This means moving beyond a focus solely on incidents involving moderate or significant harm and instead addressing trends, themes, and including near miss and low harm events. Doing so will maximise learning opportunities across all types of incidents.

Element	Audit Assessment of Evidence	Issues identified	Additional Evidence Required/ Issues to Address
Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	✓	No issues identified.	No additional evidence required.
Ongoing engagement sessions with staff as per previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.	✓	No issues identified.	No additional evidence required.
Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the CNST MIS reporting period)? 2 April - 30 November.	✓	No issues identified.	No additional evidence required. **For Year 8** The claims scorecard should be presented in an alternative format, as the current screen-printed image is not sufficiently legible. A clear and high-quality image or appropriately formatted version should be provided to ensure the Board has accurate and unobstructed oversight.
Evidence in the Trust Board minutes that Board Safety Champion(s) and the MNVP lead (where infrastructure is in place as per SA7) are meeting with the Perinatal leadership team at a minimum of bimonthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented. Where the infrastructure is in place, this should also include the MNVP as per SA7.	−	The Trust has had an MNVP Lead in post since July 2025, and their attendance at QUAD meetings is evidenced within the meeting minutes. However, the wording within the assurance report provided by QUAD to the Board has not been updated to reflect this change and does not acknowledge the MNVP Lead's participation in these meetings.	**For the Year 7 Declaration** At the declaration to Board in February 2026, the Trust should provide retrospective assurance that the MNVP lead has participated at the bimonthly QUAD meetings since August 2025. **For Year 8** The QUAD Board reporting template should be amended to ensure it provides assurance that the MNVP Lead has participated in QUAD meetings.
Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	✓	No issues identified.	No additional evidence required.

Safety Action 10 - Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?

What We Checked

The evidence provided to demonstrate compliance with SA10 was reviewed. Following our review, we provided feedback at a meeting with SA Leads and provided a breakdown of additional evidence required to demonstrate compliance.

What We Found

The required evidence has been provided, and our review therefore suggests compliance. Our assessment is below.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	✓	No issues identified.	No additional evidence required.
Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	✓	No issues identified.	No additional evidence required.
Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	✓	No issues identified.	No additional evidence required.
Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	✓	No issues identified.	No additional evidence required.
For any occasions where it has not been possible to provide a format that is accessible for eligible families, has a SMART plan been developed to address this for the future.	✓	No issues identified.	No additional evidence required.
Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	✓	No issues identified.	No additional evidence required.
Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	✓	No issues identified.	No additional evidence required.
Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this.	✓	No issues identified.	No additional evidence required.

Element	Audit Assessment of Evidence	Issues Identified	Additional Evidence Required/ Issues to Address
Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	✓	No issues identified.	No additional evidence required.
When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	✓	No issues identified.	No additional evidence required.

ASW Assurance – About Us

ASW Assurance is the largest provider of internal audit, counter fraud and consultancy services in the South West. We maintain a local presence and close engagement within each health community, with audit teams based in Bristol, Exeter, North Devon, Plymouth, Torquay and Cornwall, linked by shared networks and systems. More information about us, including the services we offer, our client base, our office locations and key people can be found on our website at www.aswassurance.co.uk.

ASW Assurance is a member of TIAN; a group of NHS internal audit and counter fraud providers from across England and Wales. Its purpose is to facilitate collaboration, share best practice information, knowledge and resources in order to support the success and quality of our client's services.

All audit and assurance assignments are conducted in conformance with the International Standards for the Professional Practice of Internal Auditing.

Confidentiality

This report is issued under strict confidentiality and, whilst it is accepted that issues raised may need to be discussed with officers not shown on the distribution list, the report itself must not be copied/circulated/disclosed to anyone outside of the organisation without prior approval from the Director of Audit and Assurance Services.

Inherent Limitations of the Audit

There are inherent limitations as to what can be achieved by systems of internal control and consequently limitations to the conclusions that can be drawn from this review. These limitations include the possibility of faulty judgment in decision-making, of breakdowns because of human error, of control activities being circumvented by the collusion of two or more people and of management overriding controls. Also there is no certainty that controls will continue to operate effectively in future periods or that the controls will mitigate all significant risks which may arise in future. Accordingly, unless specifically stated, we express no opinion about the adequacy of the systems of internal control to mitigate unidentified future risk.

Rating of Audit Recommendations

The recommendations in this report are rated according to the organisation's risk-scoring matrix and have been arrived at by assessing the risk in relation to the organisation as a whole.

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Appendix 2. DLMNS confirmation of SBLCBv3

Torbay & South Devon Foundation Trust
Torbay Hospital
Lowes Bridge
Torquay
TQ2 7AA

NHS Devon
Aperture House
Pynes Hill
Rydon Lane
Exeter
EX2 5AZ

01392 205 205

28/11/2025

Dear Jo,

Confirmation of Saving Babies Lives V3 compliance 2025: Sufficient Progress

Please find below confirmation of the current position for Saving Babies Lives, in line with the Maternity Incentive Scheme Year 7.

Quarterly QI discussions have been held between TSD & Devon LMNS, including:

• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
• Progress against locally agreed improvement aims.
• Evidence of sustained improvement where high levels of reliability have already been achieved.
• Regular review of local themes and trends with regard to potential harms in each of the six elements.
• Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.

These meetings were held on:

- Q1 (Q4 data)-17/04/2025
- Q2 (Q1 data)- 10/07/2025
- Q3 (Q2 data)- 22/10/2025

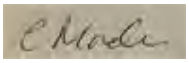
Following these meetings, I am satisfied that Torbay & South Devon Foundation Trusts has made sufficient progress (see Appendix I) against the improvement trajectory and action plans are in place where trajectories have not been met.

Since the submission of MIS year 6 compliance with Safety Action 6 has improved from 87.14% to 91.30%

	Percentage compliance				
Element	**Q2 2024/25**	**Q3 2024/25**	**Q4 2024/25**	**Q1 2025/26**	**Q2 2025/26**
Element 1: Smoking	100%	90.00%	100.00%	80.00%	90.00%
Element 2: Fetal Growth Restriction	95%	100.00%	100.00%	85.00%	95.00%
Element 3: Reduced Fetal Movement	50%	100.00%	100.00%	100.00%	100.00%
Element 4: Fetal Monitoring	60%	100.00%	100.00%	60.00%	100.00%
Element 5: Preterm Birth	81.48%	88.89%	85.19%	70.37%	84.62%
Element 6: Diabetes	100%	100.00%	100.00%	66.67%	100.00%
Overall	87.14%	94.29%	94.29%	75.71%	91.30%

- No non-compliant elements or interventions
- 8.69% partially compliant, which equates to 6 interventions:
    - All relate to data
    - 4 relate to preterm birth audit

Yours Sincerely



Charli Mardon
Devon Local Maternity & Neonatal System Programme Manager

Appendix I: Devon LMNS definition of 'sufficient progress' in 2025/26

Improvement on last year's CNST SA6 compliance figure

Or

Same level of compliance/lower compliance **IF** elements resulting in non-compliance are new (SBLCB v3.1)

Appendix 3. CMO confirmation of SBLCBv3

Torbay & South Devon NHS Trust
Lowes Bridge
Torbay Hospital
Torquay
TQ2 7AA

For the attention of the TSDFT Board,

Re: Clinical Negligence Scheme for Trusts, Maternity Incentive Scheme Compliance 2025

In line with Safety Action 6, I can confirm that whilst the Trust has not yet fully implemented Saving Babies Lives Care Bundles Version 3 (SBLCBv3), ICB confirmation of sufficient progress against locally agreed improvement trajectories has been received (please see letter from NHS Devon).

The trust is 91.30% compliant with the requirements of SBLCBv3.

- All required guidelines are compliant.
- 83% of audits are compliant with minimum targets.
- All required supporting documents are compliant (e.g. PMRT reports, training plans).

Many Thanks

Catherine Lissett

Chief Medical Officer
Torbay and South Devon NHS Foundation Trust

Appendix 4. Action plan for rotational medical and obstetric staff training

Action Plan Safety Action 8

Ref no.	Action Ref	Intervention Description	Action required, how will it be achieved.	How will the outcome be measured as evidence the action is complete? eg audit	Accountable Action Lead(s)	Deadline
1	SA 8.3	90% compliance of rotational Drs in Fetal monitoring taught training (except for GP trainees) • 64% at end of November 2025 • 5 rotational Drs remains non-compliant 2 are booked on to routine training before the MIS deadline. •	• Regular email reminders to individuals • Regular emails to Obstetric Medical service manager and face to face contact with Admin team leader to book • The Obstetric Fetal monitoring lead will provide a bespoke training session for the remaining resident Drs due to the restrictions in training that are presented with the implementation of CNST. • Monthly reporting at clinical governance to highlight trajectory • Report to be created to provide compliance • DOM made aware, monthly, of progress	Ongoing monthly audit of compliance Monthly presentation of statistics	Kate Campbell /Katherine Morgan (Education lead Midwife) Debbie Honeywell (Operational Service Manager) Mr Jamie Pruden Obstetric Fetal Monitoring Lead	Deadline for MIS March 2026

2	SA 8.7	90% compliance rotational Obstetric staff completing PROMPT • 74% at end of November 2025 • 2 staff non-compliant that are currently due to attend training before the MIS deadline	• Regular email reminders to individuals • Regular emails to Obstetric Medical service manager and face to face contact with Admin team leader to book. • These Doctors will be prioritised through the restrictions in training that will occur due to the implementation of EPIC. A bespoke session is being arranged to provide their training as they are unable to attend the one standard session before the deadline. • Monthly reporting at clinical governance to highlight trajectory • DOM made aware, monthly, of progress	Ongoing monthly audit of compliance Monthly presentation of statistics	Kate Campbell/ Katherine Morgan (Education lead Midwife) Debbie Honeywell (Operational Service Manager)	Deadline for MIS March 2026

Torbay and South Devon NHS Foundation Trust

Quality and People Committee

Working Lives of Resident Doctors report

Date of meeting	Date report produced
27 January 2026	20 January 2026

Author(s)		Report approved by	
Name and title:	Dr Catherine Lissett CMO	**Name and title:**	Dr Catherine Lissett CMO

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

Executive summary

Improving the working lives of NHS staff is a key strategic priority. While this commitment extends to improving the working lives of our entire workforce, it is evident from conversations with doctors in training that we collectively need to do better for them.

There are several reports related to the working lives of resident doctors presented over a year; this document aims to pull out and triangulate the key themes from the following reports (which vary in frequency) and include them as an appendix (when available).

1) **Guardian of Safe Working (GOSW) report:** This report is prepared by the Guardian of Safe Working Hours, a **senior, independent individual** within the organisation whose statutory duty is to **protect the safeguards** in the 2016 Terms & Conditions of Service (TCS) for Doctors and Dentists in Training. Their role exists to ensure that resident **doctors are not working unsafe hours**, and that the organisation is compliant with contractual safe-working requirements. NHS England expects that GOSWH reports should feed into a Board sub-committee quarterly *and* provide annual assurance to the full Board.

   This Executive summary will provide comments on the independent Guardians' recommendations.

2) **Getting the basics right for resident doctors,** also known as the 10-point plan. This was established in August 2025, and it is required that progress on this be reported to the Board annually (and described in the Board Assurance

framework (BAF)). In the short term, until we are fully compliant, we plan to report twice yearly to this committee. The next report is due in Spring 2026.

3) **General Medical Council (GMC) National Training Survey (NTS):** is a national, annual survey of the quality of postgraduate medical training for doctors in training. NTS data is triangulated with local exception reporting data, National Education and Training Survey (NETS) data and internal quality panel data. The GMC NTS report identifies priority 1 and priority 2 areas for our organisation where programmes or departments are significant outliers.

This thematic report will be presented quarterly to the Quality and People committee, ideally supported by the Resident Doctor Peer Representative's attendance. An annual report will be presented to the Public Board.

This is the first in the new format and includes one report: The Quarterly report prepared by the **Guardian of Safe Working Hours (GOSW).**

Dr Blandford (GOSW), the report's Author, notes: Overall exception report numbers remain similar. The majority (93) related to additional hours, with a small number (10) related to service support. In general, the reports have progressed appropriately.

The highest reporting areas are Simpson (23), Cromie (22), and New Forrest (17). In keeping with previous reports, the most affected grade is our most recently qualified doctors, with F1s accounting for 55 of 110 reports.

The report identifies 2 immediate safety concerns: one related to the transfer of an unwell patient and the other related to staffing on a surgical ward.

Whilst we would aim for most patients to have a consultant review (excepting stroke patients and those requiring percutaneous coronary intervention (PCI)) before moving to an inpatient ward-based setting, when operational pressures are present, it is acceptable to move a patient to the ward without a consultant review, if the ward is adequately staffed and senior medical staff can review the patient. There will always be a balance between the risks on the ward and those at the “front door”, and the exception reporting process will help us examine if we get it right.

The report regarding staffing on Cromie ward notes that the reporting doctor had to leave the clinic to provide ward cover, which meant the doctor lost an educational opportunity. Dr Blandford recommends we consider developing a surgical resident doctor manager (similar to the role in medicine). I will share this recommendation with the Care group leadership team; however, note that there will be changes taking place over the next 6 months that may change the situation, specifically, the introduction of E rostering for resident doctors, as well as recent staffing issues in the surgical directorate that may have impacted this situation. I note reports in surgery remain lower than those across medicine.

The report notes significant improvements in exception reports across Turner ward. Currently, there is a “registrar “level resident doctor on the ward to support the more junior residents. In the longer term, the oncology and haematology team is reviewing the role and senior staffing of this ward with a view to considering a different approach going forward.

Dr Blandford notes ongoing relatively high reporting from New Forrest ward. I will confirm the current staffing levels and present this verbally in the committee meeting.

Finally, a new reporting process will come into place on the 4th of February, and a potential significant increase in the number of reports is expected. The assurance ratings in this report are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from the previous report
Immediate Safety Concerns	(i) Patient movement = Satisfactory (other processes to address this) (ii) General surgical resident cover = Limited	New New
Turner	Significant	Improved
New Forrest	Limited	Static

Appendices

Appendix 1: Guardian of Safe Working Hours report

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

n/a

Key recommendations and actions requested

The Committee are asked to AGREE the recommended assurance ratings and to take on board the assurance ratings detailed in the table for those matters reviewed.

The Committee is also asked to note the GOSW recommendations and the actions suggested by the CMO as the author of this summary.

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

Resident doctors are key to delivering safe, effective, high-quality care. They are the medical workforce of the future.

Ensuring optimal working conditions and training for these doctors will help us attract and retain trainees within the organisation and region. This will help us address healthcare inequalities.

.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Well-trained medical staff who have not worked excessive hours and who work in a good working environment will drive the health of our population and ensure high-quality service. **“Staff experience drives patient experience”**
Quality of services provided	
Sustainable and efficient use of resources	

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

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

External Standards affected by this report and associated risks
National Policy on Terms and Conditions for Resident (Junior) Doctors Contract 2016. Version 13 to be implemented 4.2.2026. NHS England » Getting the basics right for resident doctors

Appendix 1:
Guardian of Safe Working Hours Report

Date of meeting	Date report produced
27th January 2026	9th January 2026

Author(s)		Report approved by	
Name and title:	Dr Claire Blandford GOSW	**Name and title:**	Dr E Thomas Deputy MD and CA Lissett CMO

Introduction and background

The following report aims to ensure Resident Doctors are working contracts compatible with their Contractual Terms and Conditions of Service 2016, that are sustainable and fair and that they are able to claim money/time off in lieu should they need to work extra hours to maintain patient safety/attend educational opportunities or complete career enhancing objectives.

Exception reporting is encouraged and supported by the Trust. There have been 110 Exception Reports in the period 1st October 2025 up 31st December 2025. This is an absolute increase of 6 exception reports from the previous report however the previous report period was just 2 months and this one is 3 months.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
General Medicine	52	48	4	
Emergency Medicine	3	3	0	
Acute Medicine	11	11	0	
General Surgery	29	26	3	
Geriatric Medicine	9	6	3	
ENT	3	3	0	
O&G	2	2	0	
Paediatrics	1	1	0	
Total	**110**	**100**	**10**	

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	55
F2	9
CT1-3	45
ST 4-9	1
Total	110

Table 3 – Nature of Exception

Additional Hours	93
Immediate Safety Concerns	2
Pattern of Work	2
Educational Opportunities	3
Service Support	10

Table 4 – Outcome of Exceptions

TOIL	33
Payment	53
Work Schedule Review	6
Agreed no further action required	8
Unresolved	10

Comments on Exception Reporting

Simpson Ward & Cromie are the areas of highest reporting this quarter.

Tabulation by area

Unit/Location	Total Number of Reports
Ainslie Ward	2
Allerton Ward	6
AMU	3
Cheetham Hill Ward	1
Cromie Ward	22
EAU	2
Ella Rowcroft Ward	1
Emergency Department	3
George Earl Ward	3

Louisa Cary Ward	1
McCallum Ward	13
Midgley Ward	3
New Forrest Ward	17
On call ENT	3
On call Medical Ward Cover	4
Simpson Ward	23
SRU	1
Turner Ward	3
Warrington Ward	2
Womens Health Unit	2

Assurance and Recommendations

1. **Immediate Safety Concern** reports:

   Two submitted this period.

   a) 1 x Midgely ward relating to a new admission, acutely unwell patient who was moved directly to the ward without prior 'post-take' review. This resulted in the reporting doctor staying an additional 55mins beyond their rostered finish time. Datix submitted and event has been escalated to AMDs and site managers for their information by resident's reviewing clinical supervisor. Payment arranged for resident for additional hour.

   b) Inadequate staffing on Cromie ward, only 1 F1, no SHO cover all day reg cover only for 0.5 day. Gap had been highlighted to senior doctors earlier in the week who in turn informed rota coordinators. Reporting doctor was required on the day to leave clinic to provide ward cover. Immediate safety report highlighted as educational loss of opportunity for this doctor rather than resulting in excess hours worked. No direct patient safety issue. Post report GOSW contacted surgical ops manager for comment – they highlighted that within surgery there is no dedicated resident doctor rota management post unlike in medicine and as such the work falls to the various practice managers in the division. However due to their workloads and competing priorities they acknowledged this aspect of the work is frequently "not done to a high standard".

   Recommendation:

   a) Internal processes to follow-up regarding the issue of movement of acute admissions to ward areas without senior medical review having occurred

   b) Development of a surgical resident doctor manager role – we have had other immediate safety concern reports in previous periods highlighting issues with timely resolution of resident doctor gaps in surgery as well as numerous mentions in the text of exception reports.

2. **Turner** ward was specifically highlighted in the last GOSW report due to high numbers of exceptions but also a concerning lack of senior supervision for the residents placed there, especially the F1 doctor post. Triggered a quality review from the Foundation school with immediate action points for the trust, including the immediate appointment of a doctor with 5+years of experience to the ward. Feedback since from the residents, collated by Residents Doctor Representative Committee (RDRC), shows considerable improvement both with the workload from the appointment of a more senior resident to this ward as well as the

support from senior clinicians. Exception reports this quarter from Turner were just 3 this period, compared to 33 (in a two month period) in the previous report.

Recommendation: Trust to continue with these changes and maintain the appointment of a more senior resident post on this ward in order to avoid regression to the previous situation.

3. **New Forrest (NF)** whilst numerically not the highest reporting area this quarter still remains an area of concern (17 reports, 3rd highest this period). Previous reports have highlighted NF as having high levels of exception reporting and a recommendation was made to avoid moving doctors away from this ward and to look at increasing workforce by +1. Exploration via RDRC indicates that residents are routinely leaving work late by 45-60mins most days yet are too fatigued and mentally exhausted to engage with exception reporting. Temporary improvement in workload was attributed to the presence of a ward SpR level post however this post's cessation in November has worsened the situation for the residents on this ward since. RDRC are encouraging exception reporting to gain an accurate picture of the situation and remain in close contact with residents on that ward.

   Recommendation: As before, aim to avoid moving doctors away from this ward. Reinstatement of the more senior SpR post (RDRC thought there might be a new post holder in place from January or February onwards ?). Continue to promote exception reporting.

4. Fines – no new fines this quarter for rota breaches to report.

   Recommendation: for the Committee to note the above

5. This report is based on the data received. There will be an unreported element of additional work completed by our resident doctor/ LEDs, which, for various reasons, is not being captured.

   Recommendation: for the Committee to note the above

6. Planned introduction of the exception reporting reform processes due to commence 4th February 2026. The impact of this on exception reporting numbers is hard to predict but information from other centres who have been early adopter sites indicates that we should expect an increase in reporting, potentially of 50-100% increase in current rate. These reforms will also increase substantially the workload of the medical staffing personnel who will need to approve and process these forms and will likely increase the GOSW workload too.

   Recommendation: for the Committee to note the above and be aware there is potentially going to be an increase in payments required for additional hours worked by the resident doctor body.