



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Date: Thursday 7 May 2026

Time: 12.30 pm to 2.30 pm

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

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TSDFT Public Board of Directors

The Board Room - Hengrave House

07/05/2026 12:30 - 14:30



Torbay and South Devon
NHS Foundation Trust

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**MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM AND MS TEAMS
AT 11.15 AM ON THURSDAY 5TH MARCH 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
	Mr C Saxby	Non-Executive Director
	Mr S Tapley	Chief Strategy and Planning Officer
	Mr R Williams	Non-Executive Director
In Attendance:	Ms O Bath	Staff Governor
	Mrs S Colley	Public Governor
	Mrs L Densham	Deputy Lead Governor
	Mr R Edwards	The Surgical Consortium
	Mrs S Fox	Corporate Governance Manager
	Ms L Fuller	Acting Deputy Director of People and Education
	Mrs A Hall	Member of the Public
	Mr M Joyce	Public Governor (part)
	Mr J O'Donovan	Public Governor (part)
	Ms J Piper	Acting Chief People Officer
	Mr A Postlethwaite	Public Governor
	Mr S Wadham-Sharpe	Deputy Chief Operating Officer
	Mr V Williams	Public Governor (part)

WELCOME AND INTRODUCTIONS

19/03/26 The Chairman welcomed all those in attendance.

PRELIMINARY MATTERS

20/03/26 Apologies for Absence, Quoracy and Declarations of Interest

Apologies for absence were received from Emily Long, Director of Corporate Governance and Trust Secretary, Adel Jones, Chief Operating Officer and Paul Richards, Non-Executive Director.

No declarations of interest were received and the Chair confirmed the meeting as quorate.

21/03/26 Unconfirmed Minutes of the Meeting held on Thursday 8th January 2026

The Board received the minutes of the meeting held on Thursday 8th January 2026, circulated with the agenda pack. The action log was reviewed, and updates were received on outstanding actions.

One amendment was agreed to state, in respect of item 06/01/26 Chief Executive's report and new Emergency Department, that Robert Williams had found the seating to be comfortable and spacious rather than 'it was comfortable and spacious'

(post meeting note – actioned)

The Board APPROVED the Unconfirmed Minutes from the Public Board meeting held on 8th January 2026 as a true and correct record, noting the amendment agreed detailed above.

22/03/26 Patient Story

Unfortunately it had not been possible to source a patient story for the meeting. It was acknowledged these were an important part of the meeting and should take place wherever possible. The Chief Nurse provided the Board with assurance that they would take place in future.

23/03/26 Report from the Chairman

The Chair briefed the Board on the following:

- The 2026/27 planning round continued, with Trusts under significant scrutiny to submit compliant plans. The Trust was an outlier in terms of its financial deficit, with a three year plan in place to reach a break-even position.
- The Trust had been planning to take a decision at this meeting on whether to serve notice or not on the Adult Social Care Section 75 agreement. Following a request from Torbay Council and the Integrated Care Board (ICB) to give them an opportunity to present a further option for consideration, the Board would now be meeting later in the month to take a decision. The Trust had explained to the ICB the cost of any deferral to the decision-making process and that the Trust would expect any proposal to cover this if the decision had to be delayed.
- The need to ensure the Board had adequate time to consider an alternative Adult Social Care proposal, with the report being received in good time, was noted.
- Trust representatives had attended a Corridor Care summit recently where the impact of corridor care was discussed. NHS England had sent Trusts a definition of corridor care and the expectation that there are regular reports on any breaches.
- It was suggested that corridor care had become normalised in the NHS and feedback from organisations at the meeting suggested that whilst patients were appreciative of the care they received, it placed staff under intense pressure and was distressing for them to provide care in inappropriate locations.
- Implementation of the timely ambulance handover protocol had impacted on corridor care,. In addition, there was no evidence to suggest the level of care provided to patients had deteriorated.
- It was noted that attendances to the Emergency Department would significantly reduce if there were alternative methods of care provided for

inappropriate attendances and advance planning in terms of the needs of the Trust's population should inform where and how care could be provided.

- The national team had identified 10 key areas of focus in respect of corridor care. Work was taking place to develop the Trust's response and put an action plan in place. This would be shared with the Board. **Action: SWS**
- The Board was informed that when Martin Beaman took over the role of Chair, Ashish Ghadiali would become Chair of Charity Committee and Liz Edwards-Smith would become Chair of Quality and People Committee.

The Board received and noted the Chairman's report.

24/03/26

Chief Executive's Report

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

- The Chief Executive stated the Trust's ambition to not allow corridor care to be normalised in the Trust and agreed with the need for alternative sources of care to be provided, outside of the Emergency Department. An example of this was the Trust's Frailty Hub.
- The Trust had undertaken a provider capability self-assessment, which was a mandatory annual assessment to evaluate leadership capacity to manage challenges and improve performance. The Trust had scored itself partially confirmed for five of the six categories and confirmed for one (quality of care). Following assessment by NHS England, the Trust has been provided with an overall capability capacity rating of Amber/Red for 2025/26. It was felt this was a fair assessment of the Trust's current position and reflective of progress made and work still to be undertaken.
- The Board had not yet received the Cardiology Case for Change paper from the ICB. It was understood the ICB planned to discuss the paper in public later in the month and it was hoped it would be shared with the Trust before that meeting so it could be shared with staff and governors.
- A business case for the replacement of the Trust's Catheter Laboratories was being developed and it was hoped work would commence in September 2026.
- Concern had been raised by some Non-Executive Directors around the cost of maintaining Teignmouth Hospital and that a decision had not yet been made around the future of the building and the services it provided. It was expected an options appraisal paper would be presented to the Board in May.
- The Trust had been formally informed it would be removed from the Recovery Support Programme (RSP). The RSP indicators detailed the improvements made in performance over the year, noting the work that still needed to be done to achieve financial balance. The Board wished to place on record its thanks to Allison Williams and the RSP team for their support during this process.
- The timeline attached to the Pathology move was queried. The Chief Executive explained that the Target Operating Model had been approved, but it did not contain a lot of detail. A significant amount of work was taking place across each modality around combined laboratories and an acute laboratory on each site. The challenge for the Trust was that its pathology portacabin was end of life and options were currently being explored for alternative

locations which were likely to result in moves needing to take place ahead of networked solutions being agreed. A series of staff meetings had been held where staff had expressed concern in respect of the wider proposals, and in particular if there needed to be a two stage move.

- Issues raised by staff included the need for 2-3 combined service laboratories, the need for a more cost-effective model, and a request to have sight of the detail that underpinned the proposals to ensure safe and effective care could be provided. Pathology staff had also asked for the Trust's assurance that the proposals would not affect the care provided.
- A further update would be provided in the next report to the Board. **Action: JT**

The Board noted the report of the Chief Executive.

25/03/26

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.

It was noted that no significant changes had been made to the BAF since the last meeting and that the BAF objectives would be reviewed to ensure they remained aligned to the Trust's strategic plans ready for 2026/27.

The need to ensure the BAF was used to drive the Board and Committee agendas was acknowledged.

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

FOR REVIEW

26/03/26

Our Plan for Better Care

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

- The Board was reminded of the Our Plan for Better Care workstreams:
 - o Leadership
 - o Strategy
 - o Performance
 - o Finance
 - o People
- The Plan had been established to support the Trust's exit from the RSP and to provide a focus to ensure better care was provided for the Trust's population.
- A close down report for the year 2025/26 would be provided to the next Board meeting and the arrangements and programme for 2026/27.
- It was noted that the 3-5 year strategy objective was green with the strategy presented to the Board at this meeting in Private and would be presented to the Public Board in May for formal approval.
- The Trust had decided it could no longer be the lead provider for Children and Family Health Devon and was managing the process to hand over responsibility to Devon Partnership Trust. There had been some unexpected

issues to manage over the past few weeks, but these had now been resolved. Transfer letters were due to be issued to affected staff shortly and a joint Executive to Executive meeting with Devon Partnership Trust would be held to formally hand over the transfer agreement.

- Significant progress had been made in respect of organisational development and learning, noting that work still needed to take place in respect of culture plans.
- Progress made over the last year was recognised, with many areas of the Our Plan for Better Care now being embedded as business as usual. For 2026/27 the Plan would be shaped around the Trust's strategy and transformation programme.
- Concern was raised around how the Plan would be reconciled with the Trust's transformation programme. It was noted this was an item for discussion at the next Board Development Session.
- The markers as measures for improvement were queried, noting that the Quality and People Committee would receive the Integrated People Performance Report which would address the people elements and provide a link to quality and patient safety. There was a need, however, to understand how impacts would be measured and the differences made to culture.
- It was suggested it would be useful to consider lessons learnt over the past year, in particular around data provided to support this work to ensure only data that supported decision-making was requested of the Trust's teams.
- Thanks were provided to the Acting Chief People Officer and her team for the improvements made in the supply of metrics and a suggestion that there needed also to be metrics provided in respect of patient experience and feedback.

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.**
- **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.**

ESCALATION AND ASSURANCE REPORTING: BOARD SUB-COMMITTEES, CHARITY AND SUBSIDIARIES

27/03/26

Audit and Risk Committee

The Board was briefed on the following:

- Progress had been made in respect of risk management, but more work was required to ensure it was fit for purpose.
- Concerns remained in respect of Cyber Security and the need for system working in this area, alongside the right resource provided to deliver the service.
- Significant general systems improvements had been made, alongside the promptness of closing down Internal Audit recommendations, to allow the

Head of Internal Audit Opinion to hopefully move from limited to satisfactory at the end of 2025/26.

The Board received and noted the Committee Chair's Report.

28/03/26 Finance and Operations Committee

The Board was briefed on the following:

- The fragility of the Trust's estate continued to be of concern with around £60m of urgent backlog maintenance.
- The Committee received a briefing on the ERIC (Estates Returns Information Collection) process which measured the efficiency and effectiveness of the Trust's estate management processes. The report stated the Trust was managing this well and was a reflection of the hard work undertaken by the Estates teams. This report, did, though, mask the risks and fragility of the Trust's estate.
- The Trust had a number of capital schemes in progress, noting that the Trust was successful in bidding for national funding when it became available, but that this funding was not always in alignment with the Trust's immediate priorities.
- The performance improvement trajectory was felt to be good, with the Trust managing a challenging winter, building works and EPR implementation. A deep dive into Trauma and Orthopaedics had taken place.
- The meeting had noted that the Trust was on track to deliver its financial plan at the end of the financial year, however it would enter the new financial year with a difficult underlying position due to a number of factors.

The Board received and noted the Committee Chair's report.

29/03/26 Operational Performance Report

The Board received the Operational Performance Report, circulated with the agenda pack. The following was discussed:

- No changes to the assurance ratings in the paper had been made since the last meeting.
- In terms of national benchmarking, the Trust had improved in three areas and deteriorated in four. These included RTT 18 week waits, where it was still in the top 20 Trusts for performance in the country; and 4 and 12 hour urgent and emergency care waits (UEC), noting, however the significant improvements made since the same time last year.
- **Urgent and Emergency Care**
 - o The Trust had not met the 4 hour trajectory or national target in January, but the position was still an improvement compared to the same time last year. Growth continued to be experienced in Type 1 and ambulance activity. The improvements made over the last year were against a backdrop of increased attendances.
 - o A sprint programme of work was in place to further improve performance by the end of the financial year.
 - o A query was raised around the need to ensure any work that was undertaken as part of the UEC sprint was sustainable. The Deputy Chief Operating Officer explained that the actions that were being

taken had been identified as ones that could be sustained in the longer term.

- o Ambulance handover times had deteriorated in January, but had improved in February.
- o The national standard of fewer than 10% of patients spending more than 12 hours in the Emergency Department had not been met, however performance in February had improved back to national standards.

- **Elective Care – Referral to Treatment (RTT)**

- o The Trust had met RTT standards up to September 2025, but then performance had plateaued. A sprint was currently taking place aimed at all patients waiting a first outpatient appointment over 40 weeks and patients awaiting an elective day case procedure.
- o There continued to be a number of 65-week breaches, with the main area impacted being Orthopaedics with some issues being due to short notice absence. Several actions were being taken to improve the February and March positions including mutual aid.
- o Only two procedures had been cancelled due to the lack of supply of bone cement, with work taking place to rebook those patients.
- o The Trust was still on schedule to meet its elective recovery fund standards.

- **Cancer**

- o The core 28 day faster diagnostic and 62 day cancer targets were met in December. Due to the improvements in performance the Trust had exited the Tier 2 monitoring programme.
- o Short notice absence in Dermatology during December had caused a backlog in January, with work taking place to clear the backlog and return to the 28 day faster diagnostic standard in February.

- **Diagnostics**

- o Diagnostics remained an area of challenge for the Trust, in particular in the following areas: non-obstetric ultrasound, DEXA and flexi cystoscopy. An improvement plan was in place, with outstanding issues for non-obstetric ultrasound being addressed by a re-profiling of the Community Diagnostic Centre capacity.
- o A query was raised around the profile of the Trust's waiting list and if any elements of the Trust's patients were waiting longer than others. It was noted that there had been evidence that carers were at risk of waiting longer than others. A review of this data would take place and be shared with the Board. **Action: SWS**
- o In addition to potential inequities on the Trust's waiting lists, there was evidence that patients who lived in deprived areas of the Trust's footprint presented later than others with conditions and were in crisis. A report would be provided to the Board on this issue. **Action: ST**
- o Assurance was provided that waiting lists were regularly reviewed to ensure patients were not coming to harm whilst waiting for treatment.

- o The issue of trauma cases impacting on orthopaedic work was discussed. It was noted that a deep dive on the data had been undertaken which showed that there might be some issues around coding, however it was recognised more work needed to be undertaken in respect of prevention, for example a fracture liaison service. The data also suggested the Trust understood trauma work that should be undertaken by University Hospitals Plymouth.

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

30/03/26 **Monthly Finance Report**

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

- The Trust was reporting a year to date deficit of £21m against a plan of £10.7m. The variance was due to the withholding of £10.3m of deficit support funding.
- A request for additional cash and been supported so the Trust's cash position was positive.
- Work continued to ensure the Trust's capital allocation was spent by the end of the financial year, noting that some national monies had not been received until late in the year. This work included working with suppliers and contractors to ensure they were able to deliver by the end of the financial year.
- The need to ensure the Trust had business cases ready and aligned to the Trust's estates plan when late notice requests for bids were received was acknowledged.

The Board AGREED the overall assurance level relating to the financial position of the Trust as SATISFACTORY assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce. The Board also noted:

- **The Trust's financial performance was off plan by £10.3m year to date due to withholding of deficit support funding (DSF).**
- **Forecast Outturn to 31st January 2026 was £14.4m adverse to plan, reflecting withholding of Quarter 3 and Quarter 4 deficit support funding £15.4m, partially offset with £1.0m of additional dental income. The Trust expected applications of Public Dividend Capital Revenue Support to mitigate the cash impact of the loss of DSF.**

31/03/26 **Quality and People Committee**

The Board was briefed as follows:

- The meetings had very full agendas following the combining of the quality and workforce agendas, however this had allowed for linkages to be made across the two portfolios.
- Trusts' maternity services continued to be under intense scrutiny, however the Trust was performing well given the size of its team.
- As previously reported, there had been four neonatal deaths which were being reviewed through the standard national process and local reviews.

- The Trust's neonatal workforce was fragile.
- Analysis showed that the Trust had a shortage of 3.81 whole time equivalent midwives.
- Mandatory training targets were being met, but areas of concern were Information Governance and Manual Handling.
- Neurodiversity waiting lists were long with a need for a paediatric assessment limiting progress. Other models were in the process of being explored to improve the waiting list position. The Chief Strategy and Planning Officer reported that work had already taken place, with the support of the ICB and Universities Hospitals Plymouth (UHP), to reduce the waiting list and a 25% reduction had already been achieved. Further detail on this work would be provided to the QPC Chair. **Action: ST**
- The impact of corridor care had been noted by the Committee.
- The Committee had discussed the impact of the national exercise to review Band 5 registered nurses. It was noted that for those trusts that had already undertaken this exercise, it had not resulted in a rebanding for a significant number of nurses. Assurance was provided that national funding had been provided to support any uplifts, but it was not yet known if it would be adequate.
- Mortality score card data continued to improve with Hospital Standardised Mortality Ratio in the expected range. Two areas of higher mortality highlighted by the Summary Hospital-level Mortality Indicator were GI bleed and congested cardiac failure. Both areas were being monitored. It was noted, however, that the Trust's footprint included areas of high deprivation and liver failure bleeds due to alcohol were more likely to result in death than an ulcer, for example. It was also known that the Trust had a high number of alcohol-related admissions. It was also possible some of the issues were due to inaccurate coding, which would be resolved with the new EPR.
- The complaints backlog and delay in responding to complaints was noted, but there was an improving trajectory.
- A deep dive had been undertaken on the Trust's stroke service as the Trust was a national outlier in terms of performance. A number of improvement actions were being implemented including the ringfencing of stroke beds. It was noted that stroke had been one of the Peninsula Acute Sustainable Programme (PASP) priorities and since the standing down of the PASP, the work on stroke was being led by the Chief Medical Officer at UHP.

The Board received and noted the Committee Chair's report.

32/03/26

Perinatal Quality and Safety Report

The Board received the Perinatal Quality and Safety Report, circulated with the agenda pack. The following was discussed:

- The report had previously been received and considered by the Quality and People Committee.
- The Board noted the contents of the report, in particular the targeted work taking place as part of the Maternity Safety Improvement Programme in respect of leadership, culture and governance.

- Following the publication of the interim report as part of the National Maternity and Neonatal Investigation, work would take place to review the recommendations to ensure any that were not already being addressed were added to the Trust's Maternity Improvement Plan.
- The gaps in the Trust's maternity workforce was discussed noting there was a plan in place to fill those gaps.
- There was a period recently where the Trust had needed to close the neonatal unit for 24 hours due to a lack of trained staff. Alternative arrangements had been put in place and work would be taking place with the ICB and region to consider how any risks could be mitigated in future. It was suggested the Devon maternity network was not as strong as it could be – for example a nurse could have been sent to the Trust from another Trust so that the unit did not have to be closed for a period of time. The Chief Nurse said that she understood other Trusts also had a fragile service, but she would investigate further. **Action: NM**

The Board noted and agreed the assurance recommendations and confirmed that this executive oversight report was sufficient to enable assurance of key issues that are described in full in the supplementary report. The Board also:

- **Noted actions to strengthen midwifery workforce sustainability, including progressing the Birthrate Plus-identified uplift of 1.11–3.81 whole time equivalent through the business planning process.**
- **Acknowledged neonatal workforce risks and support recruitment, QIS training expansion, and structural review to meet British Association of Perinatal Medicine medical and nursing standards.**
- **Supported ongoing culture and wellbeing initiatives, including listening events, psychological support, and embedding SCORE (safety, culture, operational risk, resilience/burnout and engagement) survey actions into the perinatal improvement plan.**

33/03/26

Safer Staffing Review

The Board received the Safer Staffing Review report circulated with the agenda pack. The following was discussed:

- The Safer Staffing Review was a national tool that ensured the correct staffing establishment was provided based on patient acuity and dependence; patients and staff outcomes; and the use of an evidence-based tool.
- The report stated the Trust met all of the requirements, apart from the need for an effective workforce plan that was updated annually, where partial compliance was reported.
- There was, however, a variance between the suggested staffing numbers and the Trust's current establishment (a variance of 81.8 whole time equivalent posts).
- It was noted that this tool could not be used in isolation, and professional judgement and complexity of care being provided needed to be taken into account. A further review had therefore been undertaken to test the robustness of the findings and the review had highlighted the following:

- o The test period had recorded 3% of empty beds across the Trust, however beds would have been occupied alongside the workload associated with caring for those patients;
- o Only bed-based patients were captured, not additional patients over and above established beds; and
- o The tool did not capture patients waiting in the Emergency Department longer than four hours and did not recognise anyone who did not deliver hands on care.
- The Chief Nurse stated, based on the information provided, in her professional judgment the Trust had the correct number of nurses to provide care to its patients.
- It was noted that the Finance and Operations Committee had discussed productivity and the use of Model Hospitals and GIRFT data to support sustainability and to deliver financial savings. The Deputy Chief Operating Officer said that a system-wide approach was being taken in respect, for example, no criteria to reside, and the Trust needed to ensure it actioned what was in its gift to change and work with system partners on those areas that would require system support. This would include a review of nursing establishments to ensure they were sustainable.
- It was recognised that more work was needed to take place in areas such as rostering practices and policy; and an understanding of the Trust's nursing requirements and improved training pathways, to support a reduction in the use of temporary staffing.
- Other factors that affected nursing numbers were the opening of escalation capacity, higher acuity patients, and the need to support mental health patients
- The ratio between qualified and non-qualified nurse was queried. It was noted the Trust's ratio was 60:40 which was considered to be appropriate, but which might increase in areas of high dependency such as the Intensive Care Unit.
- A query was raised around when the 2026/27 Workforce Plan would be finalised. It was noted that there was more work that needed to be completed, however a draft version could be presented to the meeting being held on the 18th March. **Action JP**

The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. The Board also took satisfactory assurance that 2024/25 Safer Nursing care Tool outcomes had been reviewed in conjunction with professional judgement to ensure the nursing bed base workforce was fit for purpose and actions were being taken to continue to drive down costs that fall outside of the set establishments. This was based on satisfactory assurance given noting the risks identified and the work being undertaken to mitigate these.

FOR INFORMATION

34/03/26 Legal/Regulatory Report

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

CLOSING MATTERS

35/03/26 Any Other Business and Review of Meeting

As it was his last public meeting, the Board wished to place on record its thanks to Chris Balch for his contribution to the Trust as Chair for the last two years.

36/03/26 Board Assurance Framework (matters for review or escalation)

It was agreed the following areas might require review to ensure they were properly reflected in the BAF:

- Financial targets and any stretch did not compromise safety
- Estates risks
- Workforce
- Need for improved system working

Action: JC/AJ/JP/ST

19/03/26 Board Workplan

The Board received and noted the Board Workplan.

19/03/26 Date and Time of Next Meeting:

The next Board meeting in public is scheduled to take place at 12.30 pm on Thursday 7th May 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
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: deep dives for both this and the action below were in the process of being prepared. A request was made for a deep dive to be added to the QPC workplan on corridor care.	Closed
12/01/26	Operational Performance Report – discharge deep dive to be presented to Quality and People Committee.	AJ	See above	Closed
23/03/26	Chairman's Report – response to corridor care key areas of focus to be shared with the Board.	SWS	May Update: request this is scheduled for June. Data currently being analysed.	Open
24/03/26	Chief Executive's Report – further update on Pathology to be provided in next report.	JT		Open
29/03/26	Operational Performance Report – review of equity of waiting lists to be undertaken.	SWS	May Update: will be addressed through work with the CSPO/CNO in line with action below.	Closed
29/03/26	Operational Performance Report – report to be provided discussing patients from deprived areas who presented late to the Trust with conditions and who were often in crisis.	ST		Open
31/03/26	Quality and People Committee – detail on work to reduce neurodiversity waiting list to be provided to QPC Chair.	ST	May Update: detail sent to QPC Chair on 26 March. Propose close.	Open
32/02/36	Perinatal Quality and Safety Report – investigate support provided by the Devon maternity network.	NM	May Update: Raised at the regional /system perinatal quality meeting in March- see below . Clarity was provided that decisions might be different based on other risk factors. The ODN have reviewed the Trust's decision making and were supportive of the decision to divert. However , it was recognised that	Open

			system communications and working needs strengthening – this is being facilitated by a system working party that the ICB are chairing along with an updated version of the regional maternity OPEL that is being released towards end of April Safety led escalation is supported Neonatal and maternity diversions taken on clear safety grounds (e.g. SCBU capacity) were explicitly supported by the ODN, recognising geography, acuity, and local scrutiny context. I had raised the challenge we had around closure from system partners. Propose close	
33/03/26	Safer Staffing Review – present draft workforce plan to extraordinary Board meeting being held on 18 th March.	JP	May Update: presented to Board on 18th March. Propose close.	Open
36/03/26	Board Assurance Framework – ensure BAF properly reflected the following: • Financial targets and any stretch did not compromise safety • Estates risks • Workforce • Need for improved system working	JC/AJ/JP/ST		Open



Torbay and South Devon
NHS Foundation Trust

**MINUTES OF THE TORBAY AND SOUTH
DEVON NHS FOUNDATION TRUST
EXTRAORDINARY PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM AND MS TEAMS
AT 5.00 PM ON THURSDAY 26TH MARCH 2026**

Present:	Prof. C Balch	Chairman
	Mr J Teape	Chief Executive
	Dr M Beaman	Non-Executive Director
	Mr J Corrigan	Chief Finance Officer
	Mrs L Edwards-Smith	Non-Executive Director
	Mr A Ghadiali	Non-Executive Director
	Ms A Jones	Deputy Chief Executive/Chief Operating Officer
	Dr C Lissett	Chief Medical Officer
	Mr P Richards	Non-Executive Director
	Mr C Saxby	Non-Executive Director
	Mr S Tapley	Chief Strategy and Planning Officer
	Mr R Williams	Non-Executive Director
In Attendance:	Ms A Coles	Director of Adults and Community Services
	Mr D Cawley	Governor
	Ms L Densham	Deputy Lead Governor
	Cllr H Foster	Councillor, Torbay Council
	Mrs S Fox	Corporate Governance Manager
	Cllr C Lewis	Deputy Leader, Torbay Council
	Cllr S Long	Councillor, Torbay Council
	Mr A Stilliard	Governor
	Cllr D Thomas	Leader of Torbay Council
	Mr S Wadham-Sharpe	Deputy Chief Operating Officer

WELCOME AND INTRODUCTIONS

- 39/03/26 The Chairman welcomed those in attendance at the Trust's Extraordinary Public Board meeting. He explained the Board was meeting outside of its normal meeting cycle to make a decision on the future arrangements for the delivery of adult social care services under the current Section 75 agreement with Torbay Council. This decision could not be delayed until the next scheduled Public Board meeting in May.
- The Trust had received several requests for individuals to speak at this meeting. Those present were reminded that this was a Board meeting held in public, not a public meeting, in accordance with the Trust's Standing Orders in respect of the conduct of the Board. Individuals were therefore not able to speak at the meeting.
- It was noted that in person attendance in the Boardroom was limited to Governors and Torbay Council colleagues. Members of the public had been invited to either attend in the Trust's TREC to watch the meeting or view it via a livestream video link.

PRELIMINARY MATTERS

40/03/26 Apologies for Absence, Quoracy and Declarations of Interest

Apologies for absence were received from Mark Greaves, Non-Executive Director, Nicola McMinn, Chief Nurse, and Emily Long, Director of Corporate Governance and Trust Secretary.

No declarations of interest were received, and the Chair confirmed the meeting as quorate.

FOR APPROVAL

41/03/26 Future Arrangements for Delivery of Adult Social Care Services for Torbay Council Residents

The Board received the Future Arrangements for Delivery of Adult Social Care Services for Torbay Council Residents report, circulated with the agenda pack.

The following was discussed:

- In June 2025, the Board set a clear framework and set of principles to guide the work that had taken place. The paper being considered at this meeting had been developed within that framework.
- Letters from several local community partnerships and from individual members of the public had been received and had been shared with Board members.
- The level of engagement across the system as part of the preparation for this meeting was acknowledged.
- The Leader of Torbay Council, the Council's Chief Executive and the Director of Adult Social Services attended a private Board meeting on 8 January 2026, where they set out their position and engaged in a detailed discussion with us.
- Over recent months, the Chairs and Chief Executives of the Integrated Care Board, Torbay Council and the Trust - including the Leader of Torbay Council - have held regular meetings to explore all feasible options.
- Board members also attended Torbay Council's [Adult Social Care and Health Overview and Scrutiny Sub-Board](#) on 4 February 2026 and the public meeting held in Torquay on 8 January 2026.
- Questions from the public had been invited in advance of this meeting. Fifteen public questions had been received from five sources: two adult social care colleagues (one asking a single question and one asking six), one from a public governor, five from Healthwatch Torbay, and two from Councillor David Thomas on behalf of Torbay Council.
- The full questions and the Trust's written responses would be made available on the Trust's website after the meeting.

The Chief Executive then briefed the meeting on the key points that needed to be considered before making a decision:

- The report presented to the Board represented the bringing together of several months of detailed work to understand the position of the adult social care services delivered by the Trust on behalf of Torbay Council under the current Section 75 agreement.
- Clarity was provided that:

- o This was not about stepping back from integrated working or withdrawing NHS support from the people of Torbay. The Trust's commitment to partnership was unchanged, and joint working would continue as we look forward; and
 - o This was about whether the current contractual and financial framework that underpinned that partnership was still sustainable, safe and lawful for the Trust as an NHS organisation. The evidence showed that the current arrangements could no longer provide the footing required by the Trust.
- The Board paper summarised detailed work across 2025 and 2026, including:
 - o An independent financial review;
 - o A case-file audit of residents that receive services from the Trust and Adult Social Care;
 - o Comparisons with other systems; and
 - o Extensive discussions with Torbay Council and Devon Integrated Care Board to explore all feasible options.
- From that work, four central points had become clear:
 - o The financial deficit linked to adult social care had grown to a level the Trust could not safely carry without affecting NHS services in Torbay;
 - o The model needed to evolve to deliver the strengths-based, outcomes-focused approach the Trust wanted to deliver for its people, especially adults of working age and to align with the wider ambition for neighbourhood health;
 - o Despite constructive discussions, the Trust had not been able to reach a sustainable shared risk-share arrangement. At present all the financial risk sat with the Trust; and
 - o Without change, the Trust would ultimately need to reduce NHS services to subsidise adult social care. That was not a position that could be allowed to develop.
- The Trust had been open to every option that could support safe, integrated working. This had included detailed discussions with Torbay Council's Leader and Chief Executive in a private Board session on 8 January 2026 and continued engagement since with both the Council and the Integrated Care Board.
- Whatever the Board decided today, reassurance was provided that there would be no immediate changes to the care currently provided.
- If notice were served, it would begin a 12-month transition period during which:
 - o Care would continue;
 - o NHS responsibilities would remain unchanged, and
 - o The Trust, Torbay Council and the Integrated Care Board would work together to design a revised service model and a new contractual framework for April 2027.
- The choice before the Board today was therefore a clear one:

- o Whether it could continue under an agreement that had no risk-share and was not financially sustainable; or
- o Whether a reset was required — not to end joint working, but to put it on a fair, deliverable and sustainable footing for the future.
- The report presented to the Board sets out the recommendations and rationale for those recommendations.
- The report also outlined the Trust's intent: to use any notice period constructively, with partners, to design a model that was sustainable, strengths-based and aligned to statutory responsibilities.

The following questions from Board members were then raised as follows:

Q: Support for Staff through Change: *This decision affects colleagues who have worked within these arrangements for a long time. How are we supporting our people through this period of uncertainty?"*

A: This decision is about the contract, not the commitment or professionalism of our staff. We have spent time over the past few months with adult social care colleagues through a series of staff meetings led by the Chief Executive and the Chief Planning and Strategy Officer, with staff-side colleagues invited to join. We have committed to a further session this week with the Director of Adult Social Services so people can continue the conversation and ask further questions. We have created space for ongoing dialogue through manager briefings, drop-ins, staff-side engagement and a dedicated mailbox. We will continue to signpost the best routes for colleagues to raise concerns and to access support. This recommendation is about the contractual arrangements, not about our people or their professionalism. Any changes affecting our social care colleagues would follow a robust organisational process and would not take effect before April 2027.

Q: Transition arrangements and Board oversight: *If notice is served, what transition arrangements will be put in place, and how will the Board be kept sighted on progress and risk?*

A: If the Board agrees to serve notice today, we will establish a formal joint transition group with Torbay Council and Devon Integrated Care Board. It will have clear terms of reference and cover service, workforce, finance and equalities. This Group will report to the existing Section 75 Board which includes senior representatives from all the of parties – Trust, Council, Integrated Care Board. The Board will receive regular public updates during the 12-month notice period through the Chief Executive's report, so you retain full oversight of progress, risks and mitigations.

Q: Assurance on our commitment to pay NHS costs: *Can you give assurance about our ongoing commitment to meet NHS costs appropriately, both during transition and in the future?*

A: Yes. We will continue to meet our NHS financial responsibilities in full. Serving notice does not change that. In fact, the purpose of resetting the agreement is to ensure clear and fair alignment between delivery and financial responsibility going forward - NHS costs with the NHS; social care costs with the Council. We have already jointly agreed a budget for 2026/27 and agreed how as finance teams we will work together going forward.

Q: Neighbourhoods and integration: *Some people may worry this signals a step back from neighbourhood working or integration. Can you reassure us on our direction of travel?" and is not the case.*

A: Yes — this does not change our commitment to neighbourhoods or integrated working. Today's decision is about the contractual framework, not the care model. Integrated working can take different forms and what matters is ensuring a model that is sustainable, legally clear and delivers the best outcomes for people for all services we provide. This change is about putting those arrangements on more sustainable ground, not stepping away from them. We already have long-standing integrated arrangements in South Devon with Devon County Council, including joint leadership roles and a memorandum of understanding that supports shared work. We expect to continue working in integrated ways where it genuinely benefits people and supports safe, high-quality care across our neighbourhoods.

Q: Equality Impact Assessment (EQIA): *Can you explain how equalities have been considered so far, and how we'll manage impacts as the future model develops?*

A: The Stage 1 Equality and Quality Impact Assessment presented today relates specifically to the decision before the Board, which is whether to give notice on the Section 75 agreement. This is a governance decision. It does not change the services people receive, how those services are delivered, or how people access care. For that reason, the Stage 1 EQIA focuses on whether the act of giving notice itself creates any impact on people. The conclusion is that it does not result in any change to access, delivery or experience of services at this stage. A Stage 2 EQIA relates to the design and implementation of any future model. At this point, that model has not yet been developed, so it would not be possible to undertake a meaningful or evidence-based assessment. What we have done is begin to scope the areas that would need to be considered, and that work will be developed further in partnership with the Torbay Council and the Integrated Care Board as proposals emerge. Because there is currently no proposed future service model to assess, any attempt to undertake a detailed impact assessment now would be speculative and not evidence-based. In summary: Stage 1 shows no impact from the governance decision. Stage 2 will follow when a future model exists and any service change will be fully assessed and brought back to the Board.

Q: Commitment to ongoing engagement: *How will we continue to engage openly with staff, partners and our communities over the next year?*

A: If notice is served, we will continue to communicate openly and consistently. We will publish a transition timetable so people know when key updates and opportunities to contribute will take place, and we will keep providing regular Board updates and written responses to advance questions. The joint formal transition group will play a central role in shaping and assuring our engagement approach over the coming year. We will agree together how and when we involve people, so that engagement is coordinated, timely and meaningful. Alongside this, we will keep creating space for open conversations with adult social care colleagues, managers and governors, supported by clear routes for people to raise questions or concerns. Our aim is to keep the process straightforward, visible and inclusive.

Q: Assurance re robust options appraisal: *Have we genuinely exhausted alternatives?*

A: Yes. The alternatives were explored thoroughly and in good faith with all partners. To make Option 2 viable, we needed a three-way approach to

sharing the overall deficit between the Council, the Integrated Care Board and the Trust. This would have allowed the current contractual arrangement to continue while distributing the financial risk more fairly. For Option 2 to work, all three partners would have needed to agree to a shared financial model that was both affordable and sustainable over time. Despite constructive discussions, those conditions were not met. The Council, supported by benchmarking, felt they were already contributing at the upper end for adult social care, and neither the Council nor the Integrated Care Board were in a position to take on the level of additional cost required. Given this, and after exploring the alternatives fully, the only responsible option is to recommend issuing notice and moving towards a clearer and more sustainable arrangement.

Q: Feasibility of delivering the change: *Do we have the capacity to deliver this transition safely and realistically within 12 months?*

A: Yes. The recommended 12-month period is designed to be achievable and to give partners enough time to plan the transition safely. The joint formal transition group will oversee the timetable and agree the prioritisation of work so that effort is focused where it matters most. We recognise that any programme of this scale carries risk, which is why milestones will be monitored closely. If delivery risks emerge or timescales need to adjust, the transition group will escalate these promptly and recommend the right course of action. We have considered not just the direction of travel but the feasibility of delivering it – we believe that with clear governance and partner alignment this transition can be managed safely and effectively.

Q: Issuing Notice and Sustainable Partnership: *How does issuing notice create the reset we need to agree a clearer and more sustainable partnership and accountability model for April 2027?*

A: Issuing notice enables the reset required to put the partnership on a clearer and more sustainable footing. We already work successfully within a different integration model - our long-standing arrangements with Devon County Council - which shows there is more than one way to deliver joined-up care. Ending the current Section 75 allows all partners to step back, look honestly at what works, and shape a future model where accountability sits with the right statutory body while retaining the elements of integration that genuinely benefit people. This reset gives us the space for a shared, forward-looking conversation about what the partnership should be from April 2027, with clearer roles, clearer responsibilities and a renewed focus on what matters most for our communities.

Q: Legality of Approach: *Are we confident our approach is lawful, proportionate and defensible?*

A: Yes. We recognise that there are differing views about the best way forward, and we have taken those into account. We have sought and followed appropriate legal and procedural advice throughout, and the recommendation we are bringing to the Board is grounded in that advice. We are satisfied that the approach is lawful, proportionate to the issues we are addressing, and defensible in terms of governance and accountability. Whatever the Board decides today, we remain committed to engaging openly with staff, partners and elected members as the work progresses.

The Board was then provided with a summary of the public questions submitted in advance, noting that full questions and responses would be published on the Trust's

website following this meeting. All Board members had seen the full questions and the Trust's responses.

The questions from adult social care colleagues focused on two areas: pensions and impact of uncertainty on colleagues and care.

- The Board was informed that in terms of pensions there would be no immediate changes for staff. Pension benefits already earned in the NHS or Local Government schemes would remain protected. If, in future, any colleagues were to move to the Council, they would join the Local Government Pension Scheme from that point; there was an option to transfer NHS pension benefits and the Trust would advise taking independent financial advice.
- In respect of wellbeing and safety: the Trust's equality impact assessment showed that the proposal itself did not change staffing levels, pathways or access to services. It was recognised that uncertainty brought pressure, so regular briefings have been put in place, alongside visible leadership, and access to wellbeing and Occupational Health support. If notice were served, the Trust would complete a second-stage assessment before any future changes were proposed.

A public governor question had been received about whether continuing to carry a large unfunded shortfall in adult social care would be compatible with the Trust's responsibilities as an NHS Foundation Trust.

- Under the Section 75 arrangement, adult social care remained the statutory responsibility of Torbay Council, even though delivery was delegated to the Trust. The Trust had a duty to ensure that NHS resources were used for NHS purposes and that it broke-even over time. The work undertaken with partners showed a significant and recurring gap between the cost of delivering adult social care and the funding available. Continuing to absorb a large, unfunded shortfall of this kind was not compatible with the Trust's duties as an NHS Foundation Trust, which was why the Board was considering whether the current contractual framework remained workable for all partners.

Questions from Councillor David Thomas and Torbay Council had been received in respect of community services and safeguarding.

- Resetting the agreement was not stepping back from joint working. The Trust's commitment to partnership and preventative, community-based care remained. There would be no immediate changes to people's day-to-day care. If notice were served, any future changes would be planned with the Council and the Integrated Care Board and communicated clearly and well in advance. A more detailed equality impact assessment would be completed before any change to delivery arrangements.

Healthwatch Torbay submitted a question asking about continuity of care, access, complex needs and communication.

- There would be no immediate changes to care. During the 12-month period, care teams, social workers and integrated neighbourhood teams would continue their work. Any future changes would be carefully planned and clearly communicated. Safeguards—joint oversight, clear escalation routes, and stable safeguarding and mental-health pathways—would remain in place. Communication would be a priority through the Trust's website, direct updates, and voluntary, community and social enterprise partners so people

understood what would change, what would be staying the same, and who to contact.

Finally, questions from an adult social care colleague concerning the legal duty to consult, protected characteristics, and digital programmes had been received.

- The duty to consult applied when NHS services changed. The discussion at this meeting did not propose changes to NHS services. There were no immediate changes; any future changes would be planned and communicated in good time.
- The Trust's equality analysis identified no disproportionate impact on protected groups at this stage.
- In respect of digital programmes, essential work continued; any future adjustments would be planned jointly and communicated ahead of time.

The Chair then took the Board through each of the recommendations detailed below to understand if there were any concerns or dissent in respect of each one. Following that process the Board was asked to make its decision in respect of each recommendation:

- **Reaffirmed its commitment to ongoing partnership working with Torbay Council and Devon Integrated Care Board to deliver high quality, affordable, joined-up care for local people;**
- **Considered the assessment against the previously agreed options for addressing the challenges within the current Section 75 agreement;**
- **Discussed and agreed that all efforts had been made to find a financial solution that would allow the current arrangements to continue without ongoing and further detriment to the Trust;**
- **Noted that the timing and detail of the final decision would need to be aligned to the requirement to submit a three-year financial plan to NHS England for approval before the end of March that demonstrated a clear route to financial sustainability for the Trust;**
- **Agreed that in the context of the above, the Trust had no viable alternative than to take the decision, to serve notice on the current Section 75 agreement;**
- **Agreed that the Trust would urgently work with Torbay Council and Devon Integrated Care Board to establish a Transition Programme, reporting to the Section 75 Partnership Board, to plan and manage the change process through to April 2027;**
- **Agreed that through the transition programme, the opportunity to establish new and strengthened partnership and accountability arrangements with Torbay Council and Devon Integrated Care Board should be maximised;**
- **Agreed that the Trust would continue to work with Torbay Council and Devon Integrated Care Board to ensure that the current EQIA was updated to reflect the revised service model that would be developed during the transition period and that this would be brought back to the Board for assurance on appropriate mitigations before the end of March 2027;**

- **Agreed that, irrespective of the nature of future partnership arrangements, the Trust would commit to delivering continuity of health input to joint packages of care in the community; and**
- **Noted that as a minimum, future provision of integrated out-of-hospital care to residents of Torbay Council would be aligned to that currently provided by the Trust to residents of South Devon.**

The Board accepted and approved each of the recommendations and agreed to serve notice to Torbay Council regarding the current Section 75 agreement by 31 March 2026.

In terms of reassurance the following was stated:

- There would be no immediate changes for anyone receiving care.
- A 12-month transition period would commence once notice had been served during which the Trust, Torbay Council and Devon Integrated Care Board would work together on a revised service model and new contractual framework for April 2027.
- The NHS elements of people's packages of care would continue unchanged.
- Written responses to public questions would be published on the Trust's website.
- Updates would continue to be provided through future public Board meetings.

CLOSING MATTERS

42/03/26 Any Other Business and Review of Meeting

No further business was discussed.

43/03/26 Date and Time of Next Meeting:

The next Board meeting in public is scheduled to take place at 12.30 pm on Thursday 7th May 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.

Board of Directors

Chief Executive's report

Date of meeting	Date report produced
07.05.2026	28.04.2026

Author(s)		Report approved by	
Name and title:	Jane Harris, Associate Director of Communications and Partnerships; Laura Patrick, Head of Communications and Engagement	Name and title:	Joe Teape, Chief Executive

Date: 30.04.2026

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

N/A

Executive summary

This report 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

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

N/A

Key recommendations and actions requested

The report seeks to highlight key issues not covered in other reports and which need to be brought to the attention of the Board.

These are structured into four sections:

- Leadership, engagement and service visits
- Priority areas – planning, strategy and people
- National, regional and local issues and topics of interest
- Local media update

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

How does this report further our strategy?

This report provides the Board of Directors with narrative information on key corporate matters as well as local, system and national initiatives and developments that contribute to our vision and purpose.

How does the report support the Triple Aim

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

Impact on BAF Objectives

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

Risk

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risks

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

Chief Executive's report

Leadership, engagement and service visits

Engagement with our staff and partners

1. I have continued to visit as many areas of the wider organisation as I can, and it continues to be extremely valuable for me to listen to all of our teams and their views of our services and what it is like to work here. The feedback from my visits is being used to inform our planning going forward and the detail of actions we will take will be included in our plan for better care.
2. During my visits over recent months, a consistent theme has continued to come through: the pride colleagues feel in the care they provide, their commitment to our communities, and the practical ideas they have for how services could be improved or enhanced.
3. At the same time, some colleagues continue to describe frustration in their day-to-day experience of working in the organisation, which is also reflected in our staff survey and other feedback. Closing the gap between the pride people feel in their work and the reality of how it can feel to work here remains an important challenge for us.
4. Two messages stand out as we take forward the implementation of our organisational strategy. First, effective local leadership and line management play a critical role in shaping staff experience. Our clinical leaders and managers are closest to both the opportunities and the pressures within services, and we need to ensure they are supported, developed and clear about expectations so they can enable their teams to thrive.
5. Second, colleagues consistently tell us about the importance of autonomy, trust and the freedom to act in the best interests of patients. Many of the most effective improvements we see are driven locally, by teams who are empowered to identify problems and implement solutions. As an organisation, we need to strike the right balance between appropriate oversight and creating the conditions in which innovation and improvement can flourish.
6. My twice-monthly Meet Joe sessions continue to provide a valuable opportunity to hear directly from colleagues and in the past two months I appreciated being able to hear directly from colleagues at Kings Ash House and Newton Abbot Community Hospital. I also joined, participated in and/or hosted our corporate induction and Trust Talk in the past two months.
7. Since my March report I have spent time with our breast care team, special care baby unit, hydrotherapy service, cardiology colleagues and joined in with our nutrition and hydration week tea parties. I was privileged to join colleagues at Castle Circus Health Centre to celebrate its 50th birthday and to spend time with the Chairs of our Leagues of Friends at our quarterly meeting.
8. It has been particularly important to me to meet regularly with colleagues from adult social care since January to listen to their concerns and hopes as we reviewed our current Section 75 partnership agreement. I am grateful to all our

adult social care colleagues for their engagement, their constructive challenge and our shared continuing commitment to the people that we serve.

9. I have also been meeting regularly with pathology colleagues, along with fellow executives and senior leaders, over the past few months including meetings with blood science and microbiology colleagues as well as fortnightly meetings with histopathology (cellular pathology) colleagues as we progress a long-term solution for our routine histopathology service.
10. 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.
11. I continue to meet regularly with our local MPs, Steve Darling, Caroline Voaden and Martin Wrigley.

Leadership update

12. Last month was the final Board meeting of our former Chair, Professor Chris Balch. I would like to take this opportunity on behalf of the Executive team and the wider organisation to publicly thank Chris for his incredible dedication, work and support to us all over the last two years. This has been one of the most challenging periods in our organisation's history and Chris has always challenged us to do better for our staff and population and importantly has provided leadership and support to some very difficult decisions.
13. On a personal level I cannot thank Chris enough for his support to me during the last year. We wish him well for the future.
14. This is our new Chair, Martin Beaman's, first Board meeting in public as our Chair and I look forward to working under his leadership. Martin is a familiar and respected figure within Torbay and South Devon, having served as a Non-Executive Director since 2023 and as Vice Chair since 2024. As a non-executive Director, he has chaired our Quality Assurance Board Committee and has played a key role in supporting the organisation's strategic priorities.
15. I welcome Martin's background as a Consultant Physician and Nephrologist, alongside his leadership in postgraduate medical education across the South West Region, which brings a strong clinical perspective to the Board. He is widely recognised for his commitment to patient safety, workforce development and collaborative working.
16. Today is the last Board meeting for Robert Williams, who has been one of our Non-Executive Directors for the past few years. Robert leaves us to take up a role as Non-Executive Director on the South West Peninsula Board.
17. During his time with us, we have greatly benefited from Robert's expertise and his passion for partnership working, addressing inequalities and for his championship and support for our Torbay and South Devon NHS Charity.
18. We are delighted that Robert is staying within the Devon health and care system and we look forward to working in partnership with him as he steps into his new role on the South West Peninsula Board.

19. Adel Jones, Chief Operating Officer and Deputy Chief Executive, left us on 04 May 2026 to take up the role of Chief Operating Officer at University Hospitals Plymouth NHS Trust.
20. I want to place on record my sincere thanks to Adel for the commitment, leadership and care she brought to Torbay and South Devon over 6.5 years in a range of senior roles, most recently as Chief Operating Officer. Her contribution has had a lasting impact on the organisation, including her leadership of the implementation of our Epic electronic patient record, which went live on 03 April 2026.
21. I know the Board joins me in extending our very best wishes to Adel in her new role and recognises that we will continue to work with her through our shared system partnerships across Devon.
22. I am delighted to welcome Sam Wadham-Sharpe to his first Board meeting as our interim Chief Operating Officer and as a non-voting Board member. Sam (who was our Deputy Chief Operating Officer) has made a fantastic impact since he joined us and I have confidence he will continue to be successful in this interim role.
23. Our Non-Executive Director Nominations and Remunerations Committee have approved an in-house managed national recruitment campaign for our substantive Chief Operating Officer, aiming to conclude with a selection day in May 2026.
24. I am delighted to share that we have appointed Jess Piper as our substantive Chief People Officer, following an interview process. She brings a combination of frontline experience, deep organisational knowledge and strong values-led leadership. Jess understands what it takes to support our people well and she has already had a positive impact during her time in the interim role. I'm confident she will continue to play a vital role in shaping our culture and supporting colleagues across our organisation
25. Jess has spent her whole career working in health and care, beginning on the frontline in social care and going on to roles across community and acute hospital services. She joined us in 2005 and has held a range of operational and corporate roles during that time, giving her a deep understanding of the organisation, our people and the communities we serve.
26. I can confirm that, following a restructuring of our executive and senior management arrangements, Emily Long, Director of Corporate Governance and Trust Secretary, will be leaving us on 30 June 2026 to pursue new opportunities. I know the Board will join me in thanking Emily for her work and commitment during her time with us and for her valued contribution as a Board member and wishing her well for the future.

Planning for 2026/27

27. The Board approved a revised plan in March 2026 which included a Cost Improvement Programme (CIP) of £50m and a deficit plan of £62m.

28. Since this time, we have been granted £58m of deficit support funding on the condition our plan returns to break even. This means our CIP has increased to £54m.

29. The Board will know that this will be a significant challenge for us to deliver and we are refocussing our budget setting approach and governance and we will need to move at pace on the changes that will be required.

Voluntary redundancy scheme

30. Like NHS organisations across Devon and the country, we are operating in a very challenging financial environment as outlined above. We have been open with our colleagues, governors and the public about the significant financial pressures facing Devon's NHS and the difficult decisions required to live within the funding available while continuing to provide safe, high-quality care.

31. Over the past three years, we have taken substantial steps to improve efficiency and reduce costs while protecting patient care. This includes working collaboratively with partners to share services and reduce duplication, introducing new ways of working, improving urgent and emergency care and investing in technology such as our new electronic patient record. Despite this progress, further savings are required to return to financial balance.

32. As with other NHS trusts, the majority of our funding is spent on staffing. For this reason, our Board has agreed to open a time limited voluntary redundancy (VR) scheme, in common with other providers locally and nationally.

33. The scheme is entirely voluntary, has been approved by NHS England and is designed to offer choice where it is safe and practical for roles to reduce or change. There is no obligation for anyone to apply, and we are not setting targets for numbers of people to leave. Applying for voluntary redundancy does not automatically mean a request will be agreed and applying does not commit either the individual or the organisation to completing the process.

34. Each application is carefully assessed on a case-by-case basis. No application will be approved if it would create an unmanageable risk to patient safety or service delivery or compromise the care we provide to our communities. Patient safety and quality of care remain our absolute priorities.

35. We recognise that decisions about voluntary redundancy are deeply personal and may feel unsettling. Support is available to all colleagues, including access to line managers, trade union representatives, wellbeing services and the Employee Assistance Programme and colleagues are encouraged to take time and seek advice before making any decisions.

36. The voluntary redundancy scheme is one part of a wider programme of work to ensure we are financially sustainable and able to continue providing safe, compassionate hospital, community and adult social care services across Torbay and South Devon. The scheme does not change our commitment to maintaining essential local services, now and in the future.

Torbay public governor vacancies

37. We are sorry that two people who were recently returned as public governors for the Torbay constituency have decided not to take up their roles and we are disappointed that they felt unable to continue at this early stage.
38. We recognise how strongly people in Torbay and across South Devon care about their local NHS services – and about Torbay Hospital in particular. Hearing local voices matters and we will continue to listen and engage openly, especially when decisions are difficult.
39. Public governors have an important role in representing the interests of members and the public and in holding our non-executive directors to account for the performance and leadership of our organisation. Torbay Hospital is a vital part of our organisation, and we also provide hospital and community services across Torbay and South Devon and adult social care services in Torbay.
40. In this instance, the two individuals were returned unopposed in the Torbay public governor election. Their decision not to take up the roles was made before the standard onboarding steps for new governors were completed (including induction, signing the governors' code of conduct, declaring interests and completing mandatory training). They had not yet attended a meeting of the Council of Governors.
41. Our Constitution sets out how vacancies among elected governors may be handled and it is for the Council of Governors to decide how to proceed. This includes options to run an election within three months, to invite the next highest polling candidate from the most recent election to become a governor (if there is one), or – depending on the circumstances – to leave seats vacant until the next elections are held.
42. We will support the Council of Governors to follow this process, and we encourage anyone interested in becoming a public governor to consider standing when nominations open. Public governors help ensure local views are heard and play an important part in good, constructive governance.

Segmentation and league table publication

43. The Quarter 3 NHS Oversight Framework (NOF) segmentation data was published online on Wednesday 18 March.
44. We remain in Segment 3, and our position in the league table has improved to joint 83rd, an uplift of four places from Quarter 2.
45. Our system partners (DPT, RDUH and UHP) have also seen largely unchanged positions.

Provider capability ratings published

46. NHS England has now published initial provider capability ratings, which assess organisational capability and leadership rather than the quality of care provided to patients.
47. We completed our self-assessment in October 2025 and assessed itself as partially compliant across areas including strategy, leadership, finance, access to services, people and culture, and compliant in relation to quality of care. The

published Amber/Red rating reflects that self-assessment and the ongoing operational and financial pressures we face.

48. Since October 2025, further work has continued to address the areas identified. We remain focused on sustained improvement while continuing to provide safe, high-quality care for the population we serve.

Recovery Support Programme

49. As Board are aware, we have been supported through the NHS England Recovery Support Programme, reflecting the scale of the operational and financial challenges we face.
50. We have worked closely with NHS England to stabilise performance, strengthen grip and put in place clearer plans for improvement.
51. As a result of this progress and with continued oversight through established regional and system arrangements, we have received confirmation that we have moved out of the Recovery Support Programme.
52. This does not mark the end of our challenges, but it does reflect greater confidence in our direction, leadership and plans.
53. We remain realistic about the work still to do and will continue to focus on sustained improvement, financial recovery and delivery of safe, high-quality care for our population.

Capital investment programme

54. We concluded the purchase of land at the Edginswell Business Park site from Torbay Council last month.
55. The site was identified as the preferred option for future expansion, offering good accessibility, strong development potential and positive stakeholder support.
56. Securing the site has given us essential capacity to relocate key support services - such as medical electronics, patient transport, logistics and estates functions - and provide immediate relief through additional staff parking, while unlocking space on the main hospital campus for future redevelopment.
57. Phase Two of the Emergency Department redevelopment has now been completed and opened to patients and colleagues. This milestone delivers a new ambulatory care area designed to support timely assessment and treatment for people who can be safely managed without admission. The dedicated space is already helping to improve flow, decision making and the overall experience for people requiring urgent assessment.
58. This follows the successful completion of Phase One in December 2025, which provided a new reception and waiting area, additional triage rooms and improved staff facilities. Feedback from patients and colleagues on these earlier improvements has been positive, with the new environment described as calmer and more supportive.
59. Delivering Phase Two in a live Emergency Department has required careful planning and close coordination between clinical teams, estates colleagues and

our construction partners. Their work has enabled continuity of services throughout the build period and minimised disruption to patients.

60. The programme is now in Phase Three – the final stage of the redevelopment – due to complete in early summer 2026. Phase Three will provide further enhancements to supporting spaces, enabling colleagues to work more efficiently and improving the resilience of the department.
61. A significant crane lift to support the theatres redevelopment at Torbay Hospital was completed successfully at the end of March. As part of these works, Car Park A was closed for three days to allow safe installation and lifting of the new theatre modules.
62. To minimise disruption, Car Park D was reassigned for patient and public parking, supported by shuttle buses and traffic marshals throughout the works. These lifts formed part of our broader theatre refurbishment programme and the expansion of our OMFS department, enabled by recently secured capital funding.

Resident doctor industrial action

63. The most recent period of industrial action by resident doctors came at an especially demanding time for our organisation, immediately following our Epic go-live and over the Easter weekend. This combination created additional operational pressure, and it is a real credit to colleagues across our organisation that services continued to run safely and professionally throughout.
64. As planned, we put in place our established arrangements to protect patients, with senior clinical and operational leaders on site, clear oversight of risk and a continued focus on urgent and emergency care and time-critical services.
65. Locally, around 65% of resident doctors took part this period of industrial action and there were 229 appointments that needed to be rescheduled across elective ordinary, day-case, inpatient and outpatient services.
66. Direct comparison with previous rounds of industrial action is not relevant, as this period coincided with the go-live of our electronic patient record (EPR). The EPR implementation required a different operational approach to managing activity and cancellations, and significant outpatient activity had already been reduced in advance of go-live.
67. As a result, the distribution of cancelled activity across services in this round reflects the specific operational context rather than a like-for-like change in impact compared with earlier industrial action.
68. Five patients on open cancer pathways had outpatient appointments rescheduled during this period; all were rebooked within national timeframes.
69. Despite the disruption, essential services continued to operate safely and there were no significant patient safety incidents.
70. Colleagues have worked with flexibility, professionalism and care to minimise the impact on patients, often at short notice and under pressure. I want to recognise the collective effort across clinical, managerial and support teams during this period.

71. NHS England has shared a letter from Sir Jim Mackey, Chief Executive of NHS England, thanking staff across the NHS for their commitment and leadership during industrial action and acknowledging the efforts made locally to keep services running safely. This has been shared with colleagues.

72. Industrial action is unsettling for people and colleagues alike and we recognise the disruption it causes while also respecting the rights of individuals to take action. We continue to support respectful dialogue at national level and hope to see a swift resolution between the Government and the British Medical Association.

Electronic patient record go-live

73. Our new electronic patient record (EPR) is now live across our services, marking a significant milestone for both ourselves and for the wider Devon health system.

74. The new system replaces more than 100 separate clinical systems and what was the oldest patient administration system in England. It is a once in a lifetime transformation programme for our colleagues.

75. This go-live represents the culmination of many years of sustained work, planning and collaboration involving clinical teams, operational colleagues, digital and IT specialists, programme teams and system partners. It reflects a shared commitment across organisations to modernise how we deliver care and how information is used to support patients and colleagues.

76. The Devon EPR brings together patient information in a single digital record, including medications, allergies, test results, imaging, care plans and observations, enabling safer and more joined up care across different settings. The system is being implemented across three NHS Trusts:

- Royal Devon University Healthcare NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust
- University Hospitals Plymouth NHS Trust (scheduled to go live in July 2026)

77. Introducing the EPR at scale has required extraordinary effort from colleagues across all parts of the organisation, both in the lead-up to go-live and during the transition period itself. Many teams have gone above and beyond to support colleagues, adapt to new ways of working and ensure that patient safety has remained paramount throughout.

78. The EPR also enables patients to access information about their hospital and specialist community care through MY CARE, complementing the NHS App and supporting greater transparency and involvement in care. People can access MY CARE online using a tablet or via a mobile phone app from the Apple App Store or Google Play by searching for MyChart and searching for Torbay and South Devon NHS Foundation Trust. Select MY CARE to complete sign-up. From a computer, people can sign up online at mycare.exe.nhs.uk/MYCARE and follow the instructions.

79. As we move beyond go-live, our focus is firmly on stabilisation, learning and continuous improvement. We will continue to support teams, listen to feedback and ensure the system delivers the benefits intended for patients, colleagues and the wider system.

80. I want to acknowledge and thank everyone who has contributed to this programme over many years. This achievement reflects a true collective effort and a shared determination to improve care for the people we serve.

Successes – our people and teams

UNICEF Baby Friendly Initiative reaccreditation

81. I am pleased to report that our maternity services have been successfully reaccredited at Level 3 of the UNICEF UK Baby Friendly Initiative following an independent external assessment.
82. This reaccreditation confirms that our services continue to meet UNICEF's Baby Friendly standards, which focus on how well maternity services support infant feeding, early parent–baby relationships and parents' confidence during pregnancy and the early days of life.
83. As part of the assessment, UNICEF assessors spoke directly with parents and staff and observed care in practice across maternity and neonatal services. The assessors' report recognised the strong culture within our services in supporting parent–baby relationships and highlighted the consistently high quality of breastfeeding and infant feeding support provided to families.
84. The UNICEF UK Baby Friendly Initiative is widely recognised as a benchmark for evidence-based maternity care that supports babies' health and development while respecting parents' choices and circumstances. This reaccreditation provides independent reassurance to families in our communities about the quality of care they can expect.
85. We are proud of the professionalism, compassion and commitment of our maternity and neonatal teams in sustaining these standards and we will continue to build on this strong foundation as we look ahead to further improvement.

Surgical hub at Torbay Hospital achieves national accreditation

86. The elective surgical hub at Torbay Hospital has been formally accredited through the national Getting It Right First Time (GIRFT) Surgical Hub Accreditation Scheme, recognising that it meets a defined set of high clinical and operational standards for planned surgery.
87. The accreditation, delivered by NHS England in partnership with the Royal College of Surgeons of England and supported by the Royal College of Anaesthetists, provides independent assurance that the hub is operating safely and effectively across the whole elective pathway, including patient flow, staffing and training, clinical governance, use of facilities and theatre productivity.
88. This recognition reflects sustained effort by day-case theatres and Ophthalmology teams during a period of significant pressure. Torbay's day-case theatres are among the strongest performers in the South West for theatre productivity, enabling more patients to receive planned surgery safely and on time while making efficient use of NHS resources.
89. Accreditation aligns with our wider elective recovery work, including increasing day-case surgery, maximising theatre utilisation and creating additional

appointments, all of which support ongoing reductions in waiting times for planned care.

90. Torbay Hospital is one of 69 surgical hubs nationally to have achieved accreditation to date. While participation in the scheme is not mandatory, the national ambition is for all elective hubs to be accredited over time.

Chief Allied Health Professional Officer's Gold Award for Excellence

91. I to recognise the outstanding national achievement of Angela Abbott, one of our podiatrists, who has been awarded the Chief Allied Health Professional Officer's Gold Award for Excellence.
92. This is one of the highest honours for Allied Health Professionals and reflects Angela's long-standing contribution to improving foot health services, developing the podiatry workforce and shaping practice well beyond our organisation.
93. It is a fantastic recognition of Angela's leadership, commitment to patients and the impact of her work locally, regionally and nationally.
94. Formal presentation of the award will take place in due course through the national process.

Professional achievement in our mortuary team

95. I want to recognise an important professional achievement within our mortuary team. Mark O'Brien has been awarded Registered Scientist status by the Science Council, and Emma Acton has been awarded Registered Science Technician status.
96. Professional registration is a significant milestone. It reflects the high standards, expertise and professionalism that Mark and Emma bring to their roles and highlights the vital contribution made by the Anatomical Pathology Technology profession to the safe, compassionate and high-quality care we provide.
97. Both registrations were achieved through sustained commitment and hard work and I am particularly pleased that Mark and Emma are the first colleagues within our mortuary department to achieve these respective registrations. Their achievements also support the continued development and recognition of their profession more widely.
98. I would like to offer my congratulations to Mark and Emma and thank them for the professionalism, expertise and care they bring to their work every day.

Royal Garden party

99. I am delighted to share with the Board that Dr Carl Edwards, Consultant Musculoskeletal (MSK) Physiotherapist, has received an invitation to attend a Royal Garden Party this month, representing the NHS in Torbay and South Devon.
100. Dr Edwards is an Allied Health Professional and holds a PhD. He was put forward for an invitation in recognition of the work he has led to improve MSK services locally, particularly through introducing new digital ways for patients to access care more easily and for services to work more effectively. This has

helped people get the right support sooner and contributed to improving the experience of MSK care across Torbay and South Devon.

101. Invitations to Royal Garden Parties are rare and are regarded as a national recognition of public service. I am pleased that Dr Edwards' contribution has been recognised in this way, which also reflects the wider commitment, skill and innovation shown by colleagues across our organisation.

Torbay community nurse honoured with prestigious Queen's Nurse title

102. A much loved community nurse who has dedicated four decades to caring for people in Torbay and South Devon has been recognised nationally with a Royal stamp of approval.

103. Jenny Piedot, a Community Epilepsy Specialist Nurse, was just 18 when she first put on her nurse's uniform. Now, 40 years later, she has received the prestigious Queen's Nurse award for her services to community nursing.

104. During the past 40 years, Jenny has supported hundreds of local families and children, often from early childhood into adulthood.

105. Jenny has spent the past 12 years working as a Community Epilepsy Specialist Nurse and prescriber in Torbay and previously worked as a community nurse for people with learning disabilities. In 1992 she set up the popular Saturday Club at a family centre in Newton Abbot offering respite care for children with complex care needs aged four to 18. It continues to run today.

106. The Queen's Award is awarded to nurses who demonstrate consistently high standards of patient care, leadership and a commitment to learning and recipients join a national community benefiting from workshops, bursaries, and professional support.

Celebrating 50 years of Castle Circus Health Centre

107. I had great pleasure joining colleagues at Castle Circus Health Centre last month to celebrating 50 years of caring for the people of Torbay and South Devon, marking the anniversary of its opening on 31 March 1976. The centre was formally opened by the Worshipful the Mayor of Torbay, Councillor John Farrell OBE, and has been a trusted and familiar part of the town ever since. For half a century, it has supported generations of local people at every stage of their lives, evolving continually to meet changing health needs.

108. In its early years, the centre supported services such as mother and baby clinics, offering vital support to young families. Over time, the range of care delivered from Castle Circus has grown significantly.

109. Today, the building is home to a wide mix of essential community and outpatient services, including Neuropsychology, Children's Speech and Language Therapy, the Blue Badge Service, Podiatry and Orthotics, Community Dental Services and Sexual Health Services. Clinics also run for Lower Limb Therapy Services, Abdominal Aortic Aneurysm (AAA) screening, adult and paediatric Bladder and Bowel Services, foot clinics and Drug and Alcohol Services. Bringing so many services together under one roof helps ensure joined up, accessible care for people across Torbay and South Devon.

Priority areas

Cardiology

110. NHS Devon has confirmed that the cardiology work will now be taken forward within the wider Devon Health and Care Strategy, rather than as a standalone specialty review. This means the case for change for cardiology and cardiovascular services will be incorporated into the system's five-year commissioning plan and the developing neighbourhood health model. There are no proposed changes to the location or configuration of cardiology services at Torbay - or anywhere else in Devon - arising from this programme.
111. NHS Devon has emphasised that the strengthened prevention and early intervention work already underway, coupled with the publication of the Devon Health and Care Strategy (2025) and the new five-year commissioning plan, now provides a clear system wide direction for how acute and community services should evolve. Cardiology will therefore be considered as part of a future whole system acute reconfiguration programme, to be clinically led and aligned with the NHS Long Term Plan.
112. NHS Devon has committed to keeping local people, stakeholders and communities informed as the broader programme develops. People can find out more about the plan and sign up for a new lived experience group on the One Devon website: [Cardiovascular and heart services](#)

Development of Gadeon House for the long-term provision of Cellular Pathology Services

113. Cellular Pathology is one part of our wider pathology services, which also include Blood Sciences and Microbiology. While Blood Sciences and Microbiology focus on tests such as blood analysis and the identification of infections, Cellular Pathology involves the examination of tissue and cell samples to support diagnosis and treatment, including the diagnosis of cancer and other serious diseases. These services are safety-critical and rely on specialist laboratory facilities and workforce.
114. Over several years, we have sought national support to address significant estates safety risks associated with the life-expired temporary building at Torbay Hospital, from which Cellular Pathology services have been provided. These risks include ventilation and formalin exposure and cannot be safely mitigated over the longer term. Earlier plans to address this through the creation of a new on-site asset as part of enabling works linked to the New Hospitals Programme did not progress in 2024, leaving us with an urgent requirement to secure a safe and sustainable solution.
115. In parallel, we have worked with the Peninsula Pathology Network to explore options for a more resilient and sustainable regional pathology model, including the potential for consolidated laboratory provision across the peninsula, while maintaining appropriate local service delivery.
116. In January 2026, we were advised that capital funding from NHS England was available, subject to a requirement that an affordable and deliverable solution could be implemented within the financial year, with all expenditure completed by 31 March 2026. This created a time-limited opportunity to address the longstanding safety risks associated with the current accommodation.

117. An options appraisal was presented to Executive Committee on 19 March 2026, which identified a preferred option to establish a consolidated Cellular Pathology laboratory at Gadeon House, Exeter. This includes an initial relocation of Cytology services to Royal Devon University Healthcare NHS Foundation Trust to release capacity on the Torbay site, enabling immediate mitigation of safety risks, followed by a planned move into the fully fitted laboratory at Gadeon House within an estimated 12–18 months.
118. To deliver this option, it was necessary to agree a lease arrangement and commit funding for design and fit-out works within a short timescale. A detailed business case was therefore brought to Executive Committee on 25 March 2026. Given the time-critical nature of the funding opportunity, the Chief Executive and Chair approved the proposal under our urgent decision-making arrangements on 26 March 2026, in line with our governance arrangements and standing financial instructions.
119. Appropriate due diligence was undertaken alongside executive engagement with cellular pathology colleagues and the rationale for urgency, the financial arrangements and the expected benefits were fully documented. The approach, including the landlord paying fit-out invoices directly, was agreed as a proportionate and financially compliant route to delivery, with design and cost risk remaining with us.
120. Approval was given for £4.6m of national NHS England capital funding, secured through a time-limited estates safety funding programme, to support the development of Cellular Pathology services at Gadeon House, Exeter. This funding is ring-fenced capital and cannot be used for day-to-day operational or staffing costs. The investment covers lease costs, design development and professional fees, and the fit-out of the laboratory space to create fit-for-purpose facilities. We have entered into a 15-year lease with Torbay Council, who are the freeholder of the building, with a Trust break option at 10 years.
121. Throughout the transition, maintaining service quality, turnaround times and clinical support for patients remains a core requirement. Urgent and time-critical pathology services will continue to be delivered safely from Torbay Hospital through an Acute Service Laboratory, while routine elements of the service transition in a phased and managed way. Clinical leaders are closely involved in the design and implementation of the model and risks associated with transition are being actively managed.
122. The new accommodation will provide long-term, fit-for-purpose laboratory facilities, improving staff safety, wellbeing and retention and enhancing service resilience through standardised reporting, improved workforce productivity and the use of digital pathology.
123. Equality and workforce impacts will continue to be considered as part of detailed implementation planning, with mitigations developed where required. Progress and risk will be reported through our established governance arrangements, including to the Board of Directors in public.

Maternity Incentive Scheme – Year 7

124. NHS Resolution has formally confirmed that, following external verification and consideration by the national Collaborative Advisory Group, we have met all

ten safety actions for Year 7 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.

125. This confirmation reflects the continued work of our maternity, neonatal, governance and corporate teams to embed national safety standards, demonstrate strong clinical governance, and maintain a clear focus on learning and improvement.
126. The Maternity Incentive Scheme is designed to support safer care for women, babies and families, and meeting all ten actions provides assurance that our systems, processes and leadership arrangements meet national expectations.
127. While this is a positive milestone, it does not signal an endpoint. We continue to treat maternity and neonatal safety as a priority area, with an ongoing emphasis on listening to families, supporting our colleagues and strengthening learning across the service.

Corridor Care action plan

128. Following the national corridor care event in London and receipt of the new GIRFT corridor care improvement materials, we have completed an initial review of our current arrangements and developed a consolidated action plan.
129. A dedicated multidisciplinary group - spanning operational, medical, nursing and allied health professional (AHP) leadership - has been convened to align our local actions with the enhanced GIRFT expectations, ahead of our participation in the first tranche of the national GIRFT programme, with our initial meeting scheduled for 07 April.
130. The work focuses on strengthening leadership oversight; improving staff, patient and carer experience and driving more consistent operational and clinical practice across escalation spaces. This includes updating our definitions of escalation areas, building improved reporting and audit capability into Epic, enhancing near real-time feedback mechanisms, reinforcing staffing reviews and debriefing arrangements and sharpening discharge, frailty and admission avoidance pathways.
131. This programme forms part of our Q1 2026/27 priorities and will be overseen by the Executive Committee, with assurance through the Quality and People Committee and onward to the Trust Board

Adult Social Care in Torbay

132. Following the Board decision to serve notice on the Section 75 agreement with Torbay Council we are working jointly with the Devon Integrated Care Board and Torbay Council through a Transitions Board to establish a revised partnership and manage the transition carefully. This work is being led by the Chief Strategy and Planning Officer and will be reported through Our Plan for Better Care.
133. I want to be very clear with our communities: this step does not change the care people receive. Services continue exactly as they are today, and people do not need to do anything differently. We will keep integrated working where it best serves people and align responsibilities to the appropriate statutory bodies.

Throughout, we will maintain continuity of our health input to joint packages of care.

134. Serving notice allows us to take a careful and considered look at how our partnership arrangements are governed in the future. Throughout this period, our absolute focus is on maintaining safe, high-quality services and supporting our staff to continue delivering excellent care for local people. We will keep colleagues, partners and the public informed as work progresses.

135. Any future changes would be subject to appropriate planning and engagement and there will be no sudden or unplanned changes to services.

136. We recognise these arrangements have been in place for close to 20 years. Change brings uncertainty as well as opportunity. We will support our people and engage openly as plans develop and we'll update our Equality Impact Assessment as the future model takes shape.

Children and Family Health Devon (CFHD)

137. The transfer of Children and Family Health Devon (CFHD) to Devon Partnership NHS Trust took place on 01 April 2026, following the completion of the work required to ensure a safe and orderly handover of clinical, operational and governance responsibilities. Oversight of the transition has been led through the Executive Operations Group, with particular focus on workforce arrangements, commissioning alignment and clinical governance to ensure continuity of care for children, young people and families across Devon.

138. Colleagues across both organisations have worked closely together to manage the requirements of the transfer, including pathway review, activity planning and financial reconciliation. Communication with teams has been ongoing throughout and we remain grateful to colleagues for their professionalism and commitment during a period of significant change.

139. The transfer provides an opportunity to strengthen the delivery of neurodevelopmental, community paediatrics, mental health and associated services through a single specialist provider, with the intention of improving access, reducing variation and enabling a more coherent model of care for children and families.

140. We will continue to monitor transition risks through existing assurance routes and maintain close partnership working with Devon Partnership NHS Trust and the ICB as the new arrangements embed.

National, regional and local issues and topics of interest

Local Government Review – organisational response to consultation

141. We have submitted our formal response to the Local Government Review consultation, reflecting our role as a key system partner across Torbay, Devon, Teignbridge and South Hams. In the letter, I emphasised the strength of our existing place based relationships, highlighting that our most effective work is grounded in neighbourhood level collaboration, Local Care Partnerships and wider system connections. This approach, I noted, would continue to underpin how we work with any newly formed authority.

142. Our response also underlines the importance of future arrangements being able to respond to local circumstances, including health inequalities, deprivation, and the specific challenges of rural and coastal communities. We reiterated the vital role that local government plays in supporting employment and good work, given their significance as determinants of health.

143. While none of the proposed options are coterminous with our NHS footprint, I confirmed that this is already something we manage effectively in practice. As an organisation, we did not express a preference for any specific model but made clear our commitment to working positively and constructively with whichever authority is established, in the best interests of local people and services.

South West Peninsula Cluster Integrated Care Board – Executive Appointments Update

144. The Board notes recent senior leadership appointments across NHS Cornwall and Isles of Scilly and NHS Devon, reflecting the formal establishment of the South West Peninsula cluster and ongoing preparation for a potential merger of the two Integrated Care Boards (ICBs) next year.

145. Following a period of engagement and consultation to align leadership arrangements, Mark Hackett was appointed as Interim Cluster Chief Executive from 16 March 2026 for an initial 12-month period. Mark will lead both ICBs as a single cluster during this phase of increased alignment. He brings extensive experience of senior leadership across the NHS and wider health system, most recently as Interim Chief Executive of University Hospitals Plymouth NHS Trust, and previously as Chief Executive of Swansea Bay University Health Board and other NHS organisations.

146. In parallel, and following a robust recruitment process, appointments have been confirmed to the new cluster ICB executive team, which brings together leadership capacity from both organisations. From 01 April 2026, the cluster executive roles are:

- Chief Finance Officer – Simon Gittoes-Davies
- Chief People Officer – Patrick Weir
- Chief Place and Transformation Officer (Chief Medical Officer) – Chris Reid
- Chief Clinical Officer (Chief Nursing Officer) - Susan Bracefield
- Chief Population Health Officer – Peter Collins
- Chief Strategic Planning and Commissioning Officer – Libby Ryan-Davies
- Company Secretary – Philippa Harding

147. From April 2026, the team will begin working with partners across the cluster to deliver shared priorities, including improving population health, tackling inequalities, supporting the workforce and transforming services.

Five year commissioning plan for Devon (One Plan)

148. At the South West Peninsula Board on 26 March 2026, the One Plan for Devon, the five-year commissioning plan was agreed. Information about the One Plan including frequently asked questions is available on the One Devon website: [One Plan for Devon](#)

Changes to clinical referral guideline model for Long COVID

149. Changes have been made to the way people with symptoms of Long Covid are referred for treatment to ensure they receive the right care as quickly and safely as possible.
150. Clinicians will continue to assess each patient individually and based on their main symptoms, refer them to the service best suited to their needs. These changes are also being made by all NHS trust providers in Devon due to changes in commissioning arrangements.
151. There is no change to how people seek specialist care for Long COVID symptoms. This change is designed to improve how patients are directed through the system so they can be seen in the right place first time, while GPs continue to use their clinical judgement to make the best decisions for their patients.

Community blood testing (phlebotomy) arrangements

152. People who have been advised by a clinician that they require a blood test can book appointments at the outpatient departments at Torbay Hospital, Brixham Hospital and Paignton Health and Wellbeing Centre.
153. Bookable appointments are available:
- Torbay Hospital: Monday to Friday, 8.30am–5.00pm
 - Brixham Hospital: Tuesdays and Fridays, 9.00am–1.20pm
 - Paignton Health and Wellbeing Centre: Wednesdays, 8.30am–3.40pm
154. Appointments are booked via the phlebotomy team on 01803 655544.
155. While some GP practices continue to offer blood testing directly, patients registered with the following practices are advised to access phlebotomy services at Torbay Hospital, Brixham Hospital or Paignton Health and Wellbeing Centre (where appropriate to their location):
- Albany Surgery
 - Chilcote Surgery
 - Corner Place Surgery
 - Croft Hall Medical Practice
 - Compass House Medical Centre
 - Mayfield Medical Centre (all practices)
156. The Community Diagnostic Centre in Market Street, Torquay, run by InHealth, no longer provides a walk-in phlebotomy service.

NHS Excellence Awards

157. The South West have been named regional champions in the inaugural NHS Excellence Awards, celebrating outstanding contributions to patients, communities and staff.
158. The awards recognise the very best of the NHS – from innovation and quality improvement to partnership working and leadership. While most categories celebrate teams, the Leadership award recognises exceptional individual impact. Regional champions will now progress to the national shortlist, with winners announced at NHS ConfedExpo in Manchester in June 2026.
159. Congratulations to all winners and runners-up

160. South West regional champions:

Digital innovation – NHS 111 Online Self-Referral for Breast Cancer Diagnostics, NHS 111 Online and Somerset NHS Foundation Trust
Delivering value – Drugless CT Coronary Angiography, University Hospitals Plymouth NHS Trust
Sustainable healthcare – Pee-In-Pot (PiP), Somerset NHS Foundation Trust
Valuing our people – Reasonable Adjustments Project, Devon Partnership Trust
Patient involvement and choice – Isaac's Story, NHS Cornwall and Isles of Scilly ICB
Leadership – Dr Scott Grier, Retrieve Adult Critical Care Transport Service (hosted by UHBW)
Working in partnership – Compassionate End-of-Life Care, University Hospitals Plymouth NHS Trust
Improving health outcomes – The Market Health Hub, Coast and Country PCN
Neighbourhood health – Cornwall and Isles of Scilly Neighbourhood Health, Cornwall Partnership NHS Foundation Trust
Quality improvement – Acute Medical Admission Pathways, University Hospitals Plymouth NHS Trust

161. The regional runners-up are.

Digital innovation

2nd place: Digital Medicines Team, Somerset NHS Foundation Trust
 3rd place: Silent Hospital Project, Royal Cornwall Hospitals NHS Trust

Delivering value

2nd place: Neonatal Oral Antibiotics at Home (NOAH), NIHR Applied Research Collaboration South West Peninsula
 3rd place: The X-ray Car Team, Royal Cornwall Hospitals NHS Trust

Sustainable healthcare

2nd place: Nightingale Hospital, Royal Devon University Healthcare NHS Foundation Trust
 3rd place: The Reusable Curtains Project, University Hospitals Plymouth NHS Trust

Valuing our people

2nd place: People & Communications, Salisbury NHS Foundation Trust
 3rd place: 'Never OK' staff abuse and violence prevention programme, Great Western Hospitals NHS Foundation Trust

Patient involvement and choice

2nd place: The Young Persons Patient Council: Putting Youth Voice at the Heart of Care, University Hospitals Plymouth NHS Trust
 3rd place: Health Connect Coaching, Torbay and South Devon NHS Foundation Trust

Leadership

2nd place: Jon Aning, SWAG Cancer Alliance, hosted by Southmead Hospital
 3rd place: Kandarp Thakkar, University Hospitals Plymouth NHS Trust

Working in partnership

2nd place: Community Appointment Days (with partners), NHS Cornwall and Isles

of Scilly Integrated Care Board

3rd place: Dorset Intelligence and Insight Service (DiiS), NHS Dorset Integrated Care Board

Improving health outcomes

2nd place: Frequent Use Support and Empowerment (FUSE), Livewell South West

3rd place: Dorset Respiratory Network, Dorset County Hospital NHS Foundation Trust

Neighbourhood health

2nd place: Right by You Wessex (delivering to Dorset residents) – A neighbourhood model of cancer and complex care support, Wessex Cancer Alliance

3rd place: Neighbourhood health work in partnership with VCSE partners, VCSE partners, Cornwall Council and others, NHS Cornwall and Isles of Scilly ICB

Quality improvement

2nd place: Revolutionary digital diagnostic pathway for new glaucoma patients, Centre of Excellence for Eyes, Nightingale, Exeter

3rd place: PreCiSSlon, implementation of digital surveillance and a care bundle to prevent surgical site infection following Caesarean Birth across the West of England, Health Innovation West of England

Local media update

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

Key media releases and responses

[Voting now open to celebrate Torbay and South Devon NHS Foundation Trust's brilliant teams](#)

[Our maternity services reaffirm their commitment to giving babies the best start in life Phase Two of Torbay Hospital Emergency Department multi-million pound redevelopment now open](#)

[Community generosity supports Torbay Hospital's baby loss garden](#)

[Voting now open to celebrate Torbay and South Devon NHS Foundation Trust's brilliant people](#)

[Our new electronic patient record has launched](#)

[Reassurance for local communities following notice served on Section 75 arrangements in Torbay](#)

[Celebrating 50 years of Castle Circus Health Centre](#)

[Chloe's preparing for the race of her life](#)

[Torbay community nurse honoured with prestigious Queen's Nurse title](#)

[Board decision on the Section 75 arrangements for Adult Social Care](#)

[New electronic patient record goes live across Torbay and South Devon NHS Foundation Trust](#)

[Torbay Hospital League of Friends funds new road sweeper for hospital site](#)

[Board of Directors meeting in public – Thursday 26 March 2026, 5pm](#)

[Join us at our Medicine for Members event to learn about the power of involving people in decisions about their care](#)

[Baby loss charity expands its services to Torbay and South Devon](#)

[Sponsors announced for our annual celebration event](#)

[Section 75: update following partner discussions](#)

Coverage

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



Torbay and South Devon
NHS Foundation Trust

Trust Board of Directors

Board Assurance Framework

Date of meeting	Date report produced
7 May 2026	28 April 2026

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	Name and title:	Cath Parnell Chief of Staff
		Date:	30/04/2026

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 and Organisational Risk Map (ORM), for the Board's review. The full Board Assurance Framework is available in the Information Pack available on Diligent.

The Board will note that, due to the transition from the legacy Datix system to DCIQ, it has not been possible to produce the DRR report this month. Assurance is provided that, as the transition to DCIQ takes place all risk owners and risk handlers continue to be able to access the legacy Datix system. From 30th April 2026 all new risks will be added to DCIQ. Risk Group is continuing to meet during this period to oversee any emerging risks and to validate those risks scoring 15+ to be added or removed from the Corporate Risk Register.

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

Whilst the Board has delegated detailed review of a number of risks to Board Sub-Committees, it remains 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 with the Organisational Risk Map (ORM) (providing oversight of the overarching risk position of the Trust, adjusted for inherent and residual risk).

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

Appendices

Board Assurance Highlight Report
Board Assurance Framework (in items for information pack)
Organisational Risk Map

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 & Remuneration	Satisfactory
	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 the 10 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	Green
	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) – April 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 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.	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 1 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, ,	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 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, 2348, 2179, 3922, 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 13 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 EPR Go Live happened 2 nd April full risk assessment on going as minor issues are resolved	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 &	3804, 2542, 3519, ,2307, 1069, 3485, 2429, 4020	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 risks scoring above 13 currently recorded.	Moderate - High

	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
	Stat/Mand reqts within allotted funding	3521, 2718, ,4201,4200, 4203, 4202, , 4197, 4236, 4222						The median scores are above the Trust's agreed risk tolerance score. - Digital and physical environments are not fit for purpose, significant back log maintenance infrastructure challenge (£120m+). - NHP potential investment moved out to mid 2030's. - In line with the above, the fragility of our estate combined with a limited financial envelope for capital increases the risk of business interruption but also infection control, as we predominantly have wards (which do not contain infection as well as single rooms); though this is managed as well as possible.	Which is above the Trust's agreed risk appetite
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 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	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
								scored above 13 is also 0, with 0 risks scoring above 13 currently recorded.	
Communication & reputational Risk:	3557: Potential for Negative Publicity, Public Perception or Uncontrollable Events that may Impact on the Trust's Reputation	4178,	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 1 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

Board of Directors

Risk Management Framework

Approval of Core Documents and Migration to DCIQ

Date of meeting	Date report produced
7 May 2026	30/04/2026

Author(s)		Report approved by	
Name and title:	Kaajal Kotecha-Chotai, Risk Consultant Cath Parnell, Chief of Staff	Name and title:	Joe Teape, Chief Executive Officer
		Date:	30/04/2026

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

N/A

Executive summary

This paper presents the updated Risk Management Framework for Board of Directors approval. The framework has been developed in response to the Trust's migration from Datix Web to Datix DCIQ as its strategic risk management system, the requirements of the CQC Well-Led framework, and the need to align TSDFT's risk management approach with the NHS Devon Integrated Care System (ICS) Board Assurance Framework for 2026/27.

The framework comprises four substantive documents for Board consideration: the Risk Management Strategy (Part A), Risk Management Policy (Part B), Risk Appetite Statement, and a proposed BAF domain structure aligned to the Trust's strategy and five signature moves.

Executive Committee considered the full suite of papers on 16 April 2026 and approved them for onward submission. A Board development session on 24 April 2026 provided Board members with early sight of the documents and an opportunity to discuss the framework in detail, with particular focus on risk appetite, risk culture and the practical steps required to ensure adoption of the new framework. Audit and Risk Committee considered the final suite of papers on 30 April 2026 and recommended them onward to the Board for approval.

A transitional reporting note is also included. During May and June 2026, standard Datix DCIQ and Yellowfin assurance reporting will be limited while the system is being configured, data is being migrated, and dashboards are being built. During this period, the Organisational Risk Overview will serve as the interim Board and committee risk summary. Full dashboard reporting is expected from July 2026.

The framework is designed to create a clearer line of sight from operational risk to executive oversight and Board assurance. It establishes DCIQ as the single source of truth for risk information, aligns escalation and appetite thresholds to a consistent Trust-wide methodology, and supports a strengthened BAF linked to the Trust's strategy and signature moves.

The success of this framework will be judged by demonstrable improvements in risk quality, decision-making and escalation over the next 6–12 months, alongside evidence of culture change across the organisation.

Appendices

- Appendix A — Draft Risk Management Strategy
- Appendix B — Draft Risk Management Policy
- Appendix C — Draft Risk Appetite Statement
- Appendix D — Draft BAF and Trust Strategy Alignment Documents

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

- Risk Group (December 2025): agreed the TSDFT risk category list then in use, approved the NPSA-aligned consequence and likelihood matrices, and agreed the principle of migrating from Datix Web to Datix DCIQ.
- Risk Group / Working Group consultation (2026): the DCIQ Risk Type Taxonomy has been shared with the Risk Management and System Improvement Working Group for comment, with further refinement to follow through the agreed governance route before final implementation.
- Risk Group Chair's action (April 2026): following cancellation of the scheduled Risk Group meeting on 7 April 2026, papers were shared for review via Chair's action to maintain governance oversight within the available timescales.
- Executive Committee (16 April 2026): approved the Strategy, Policy and Risk Appetite Statement for onward submission, noted the proposed BAF domain structure and endorsed the approach, and noted the transitional reporting arrangements.
- Board development session (24 April 2026): Board members had early sight of the core documents and discussed risk appetite, implementation, cultural adoption and the importance of embedding the new framework in day-to-day decision-making and escalation behaviours.
- Audit and Risk Committee (30 April 2026): recommended approval of the Strategy, Policy, Risk Appetite Statement, BAF domain structure and migration to DCIQ, and noted the associated implementation, reporting and taxonomy papers.

Key recommendations and actions requested

The Board of Directors is asked to:

- 1. Approve the Risk Management Strategy (Appendix A).
- 2. Approve the Risk Management Policy (Appendix B).
- 3. Approve the Risk Appetite Statement (Appendix C).
- 4. Approve the proposed BAF domain structure and its alignment to the Trust's strategy and five signature moves (Appendix D).
- 5. Note the transitional reporting arrangements for May and June 2026, including the use of the Organisational Risk Overview as the interim risk summary while DCIQ is configured and Yellowfin dashboards are being built.

How does this report further our Trust strategy?

This report supports the Trust's strategy by strengthening the foundations for safe, high-quality and sustainable care across Torbay and South Devon. By improving the consistency, quality and use of risk information, embedding DCIQ as the Trust's strategic risk system, and strengthening governance and assurance, the programme will support better clinical and operational decision-making, stronger grip on delivery and recovery priorities, and greater confidence in the Board Assurance Framework. This directly supports the Trust's objectives around quality, safety, workforce resilience and sustainable services. It also supports decision-making in the context of the Trust's financial position, recognising that delivery of financial recovery will require managed risk-taking, particularly in relation to transformation and service change.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	A robust, transparent risk management framework supports earlier identification and mitigation of systemic risks that may disproportionately affect vulnerable populations. The inclusion of Health Inequalities and Population Health as a dedicated BAF domain (as proposed by this paper) ensures this risk area receives Board-level visibility and explicit appetite setting.
Quality of services provided	Aligning risk categories, appetite thresholds and BAF domains to the Trust's strategic objectives strengthens the link between operational risk management and the delivery of safe, high-quality care. The framework establishes clear escalation routes so that no patient safety risk is managed at service level without appropriate clinical oversight.
Sustainable and efficient use of resources	A consistent, well-governed risk management framework reduces duplication, improves risk record quality and enables more efficient prioritisation of mitigation activity and resources. Migration to Datix DCIQ provides a single source of risk data aligned to the Trust's reporting and governance architecture.

BAF Objective	Impact
Quality, Safety, and Patient Experience	This programme of work strengthens the Trust's ability to identify, describe, escalate and oversee risks to clinical quality, patient safety and patient experience in a more consistent way. By improving the quality of risk records, standardising scoring and escalation, and creating a clearer link between operational risk and Board assurance, it supports earlier visibility of emerging concerns and stronger committee oversight.
Leadership and Governance	This programme of work materially strengthens the Trust's governance framework by establishing clearer risk architecture, defined ownership and escalation routes, and a more coherent relationship between risk registers, the BAF and Board assurance. It supports greater consistency, transparency and defensibility in how risk is governed and led across the organisation.
Performance	This programme of work improves the Trust's ability to identify and escalate risks that may affect delivery of constitutional standards, operational flow and service performance. By introducing a more structured approach to risk recording, review and oversight, it supports earlier intervention and better grip on delivery risk.
People and Culture	This programme of work strengthens oversight of workforce-related risks by improving consistency in how risks relating to staffing, capability, culture and inclusion are identified, scored and escalated. It supports a clearer line of sight from operational workforce pressures to committee and Board-level assurance. Successful implementation will, however, require explicit cultural adoption, not just new documents and system design.
Strategy and Business	This programme of work provides a stronger framework for managing risks associated with transformation, business continuity, environmental sustainability and wider organisational change. By aligning the BAF more clearly to the Trust's strategy and signature moves, it improves the Board's ability to oversee whether strategic risks are being managed in support of delivery. Transition risks are actively managed within defined tolerance boundaries.
Finance	This programme of work improves the quality and consistency of risk information relating to financial sustainability, resource pressures and delivery risk. This supports clearer escalation, more structured oversight, and better alignment between financial risk, operational pressures and strategic decision-making. The framework will need to demonstrate in practice how financial; clinical and workforce risks are brought together rather than considered in silos.

Risk

This programme of work improves the quality and consistency of risk information relating to financial sustainability, resource pressures and delivery risk. This supports clearer escalation, more structured oversight, and better alignment between financial risk, operational pressures and strategic decision-making. The framework will need to demonstrate in practice how financial, clinical and workforce risks are brought together rather than considered in silos.

Risks lodged on Datix:

A live Datix reference is not yet assigned to this programme-level framework paper. Relevant implementation and migration risks are being managed through the programme governance arrangements (Risk Management and System Improvement Working Group) and will transfer into the new DCIQ structure as configuration is finalised.

External Standards affected by this report and associated risks

This report supports the Trust's alignment with external governance and assurance standards, including CQC and NHS England expectations and the ICB risk management framework. The proposed approach strengthens the consistency and reliability of risk management arrangements and assurance reporting. If not progressed, there is a risk that variability in practice and data quality continues, reducing the effectiveness of oversight and assurance.

Risk Management Framework – Approval of Core Documents and Migration to DCIQ

1. Introduction and background

Torbay and South Devon NHS Foundation Trust is committed to robust, transparent and proportionate risk management. Effective risk management is a core component of the Trust's Well-Led obligations, its NHS England provider oversight requirements, and its ability to deliver safe, high-quality services to the people of Torbay and South Devon.

This paper presents the Trust's updated Risk Management Framework for Board of Directors approval. The framework has been developed to address three significant drivers of change:

- The migration from Datix Web to Datix DCIQ as the Trust's primary risk management system, requiring a new taxonomy, configuration and governance architecture
- The requirements of the CQC Well-Led framework and NHS England provider oversight, which require a Board-approved risk management framework with clear appetite, escalation and assurance arrangements
- The need to align TSDFT's risk management approach with the NHS Devon ICS Board Assurance Framework for 2026/27

The framework has been developed by the Corporate Governance Team in consultation with the Risk Management and System Improvement Working Group, the Risk Group, and relevant system partner representative(s), particularly RDUH.

While the framework has been designed to align with the NHS Devon ICS and South West Peninsula Board approach wherever appropriate, some elements reflect deliberate local adaptation to TSDFT's provider context, direct patient-facing responsibilities, and current organisational risk profile. Future iterations should also continue to consider wider system relationships, including Cornwall and, as neighbourhood models develop, other system partners such as DPT.

2. Purpose of report

The Risk Management Manual comprises three parts. Parts A (Strategy) and B (Policy), together with the supporting Risk Appetite Statement, are submitted for Board approval in May 2026. Part C is the operating manual which will be completed when Board approval for Parts A and B is received.

The purpose of this report is to:

- Provide the Board of Directors with the updated drafts of the Risk Management Strategy, Risk Management Policy and Risk Appetite Statement, following Executive Committee approval in principle and Audit and Risk Committee recommendation, for formal approval in May 2026
- Present the proposed BAF domain structure aligned to the Trust's strategy and five signature moves for Board approval in May 2026
- Summarise progress to date, next steps, dependencies and transitional reporting arrangements, highlight the current assurance position and principal implementation risks, and set out how Executive Committee, Audit Chair and Board development session feedback has been reflected through the framework and implementation actions

3. The Risk Management Framework: what is being presented

The Risk Management Manual comprises three parts. Parts A and B, together with the supporting Risk Appetite Statement, are submitted for Board approval through the formal governance route. Part C will be completed when Board approval for Parts A and B is received.

Part A – Risk Management Strategy (Appendix A)

The Strategy sets out the Trust's strategic approach to risk management, including alignment to the NHS Devon ICS, system partner arrangements (RDUH, UHP), the regulatory framework, and the proposed BAF structure. It describes the target operating model for risk management under DCIQ, including the register structure, governance architecture and the three-lines-of-defence model.

The Risk Management Strategy is presented for Board approval.

Part B – Risk Management Policy (Appendix B)

The Policy sets out the mandatory requirements for risk management across the Trust, including risk recording, scoring, escalation, review frequency and roles and responsibilities. It incorporates the NPSA-aligned 5×5 consequence and likelihood matrices agreed by the Risk Group in December 2025 and defines the escalation thresholds consistent with the Risk Appetite Statement.

The Risk Management Policy is presented for Board approval.

Risk Appetite Statement (Appendix C)

The Risk Appetite Statement sets out the Board's appetite for risk across 17 categories in total, comprising 13 previously (Risk Group) agreed categories and 4 proposed additions. It uses the Trust's NPSA-aligned scoring bands and includes an overarching position statement, category-level appetite and tolerance thresholds, BAF domain alignment, and governance oversight arrangements. It is the reference point against which risk scores are interpreted, and escalation decisions are made across the organisation.

The Trust's overall risk position can be stated as follows: the Trust has the lowest tolerance for risks that could harm patients, staff or the public, and a higher tolerance for the risks that come with transforming the way it delivers care. Everything else sits between those two poles, calibrated by category.

The Risk Appetite Statement is presented for Board approval.

4. Supporting documents:

BAF and Trust Strategy Alignment Documents (Appendix D)

This document sets out how the Trust's risk framework aligns to its strategic objectives and five signature moves. It shows the mapping from signature move to BAF domain, risk category, appetite and committee, and explains how the framework works in practice from risk identification through to Board assurance. Five of the ten BAF domains are directly anchored to a signature move.

The proposed BAF domain structure is presented to the Board for approval. The wider alignment pack is provided to support understanding, scrutiny and implementation planning.

5. Key decisions made in developing the framework

The following material decisions were made during the development of the framework and are highlighted for Board awareness:

- **Scoring bands:** the Trust uses NPSA-aligned scoring bands: Very Low 1-3, Low 4-6, Moderate 8-12, High 15-25. The ICS score bands have not been adopted operationally; the Trust aligns with the ICS framework at the qualitative appetite level only.
- **Strategy and Transformation appetite:** High. This reflects the Trust's current context given the Trust's financial context and the scale of transformation required.
- **Business Continuity appetite:** Low (proposed appetite). This reflects the immediate post-Epic go-live context and the importance of maintaining a cautious position on business continuity risk.
- **BAF domains:** six domains are established and four additional domains are proposed as part of the revised structure, with final committee oversight arrangements to be confirmed through the Trust's governance process.
- **Risk categories in DCIQ:** 13 categories were previously agreed through the existing governance route(s). Four additional categories are now proposed, giving 17 categories in total.
- **Target scores:** these are not set out in the Risk Appetite Statement at this stage. They will be configured through reporting arrangements once the DCIQ and Yellowfin build is sufficiently mature. A final deadline for this configuration should be confirmed as part of the July 2026 readiness checkpoint.

6. Transitional reporting arrangements – May & June 2026

The Trust is undertaking a significant risk management transition during May and June 2026. Datix DCIQ is being configured as the Trust's primary risk system, data is being migrated from Datix Web, risk registers are being cleansed with Care Groups and corporate areas, and Yellowfin dashboards are being built. As a result, standard assurance reporting will be limited during this period and the Board is asked to note this.

During this transitional period, the Organisational Risk Overview will serve as the interim Board-level and committee-level risk summary. This document will use the new 17-category DCIQ taxonomy, aligned to BAF domains, and will include the Trust's agreed risk appetite thresholds from the Risk Appetite Statement. It will provide a consistent interim view of the Trust's principal risk position until DCIQ and Yellowfin dashboard reporting are fully operational.

7. Approval route and next steps

Following Executive Committee approval on 16 April 2026, Board development discussion on 24 April 2026, and Audit and Risk Committee recommendation on 30 April 2026, the following approval route applies:

Stage	Forum	Date
Draft paper issued	Executive Committee	13 April 2026
Review and approval in principle	Executive Committee	16 April 2026
Board development session	Board of Directors	24 April 2026
Independent scrutiny and recommendation onward	Audit and Risk Committee	30 April 2026
Formal approval	Board of Directors	7 May 2026

Following Board approval, the Trust will continue DCIQ implementation, finalise the Operating Manual through its separate approval route, and continue implementation of the updated ORM taxonomy and reporting model. A formal post-implementation review of the framework will be undertaken once DCIQ is embedded and brought back through Audit and Risk Committee, with reporting onward to Board as required.

8. Delivery approach, phasing and dependencies

Delivery is phased to ensure safety and control, focusing first on governance, design, data quality and capability before migration. Care Groups will be supported through facilitated sessions to improve the quality of risks, build capability, and prepare for transition.

Key dependencies and risks include Care Group capacity and engagement, timely decision-making through agreed governance routes, baseline variability in data quality, and the availability of key staff to support training and embedment. These will be actively managed through the programme governance arrangements. Success will also depend on explicit culture change, not only on new documents and system design.

The 24 April Board development session included a focused discussion on how the Trust embeds risk management culture change across all levels of the organisation, with particular emphasis on risk appetite, executive behaviours, and ensuring the new framework is adopted in practice rather than existing only as a set of documents.

9. Progress to date

Several streams of work have been managed via the weekly meeting of the Risk Management and System Improvement Working Group. The purpose of the Group has been to ensure timely development and delivery of the Risk Management module in DCIQ, devise a cutover strategy from Datix Web to DCIQ, oversee the development of associated documentation, and support organisational transition to the new system in terms of engagement and capability.

Key progress as part of the work of the Risk Management and System Improvement Working Group includes:

- Completion of a Trust-wide review of Datix Web risk data quality
- Design and testing of DCIQ risk forms in the test environment and development of a cutover strategy to new system
- Agreement of governance arrangements and Terms of Reference
- Approval of the data cleansing and Care Group enablement approach
- Approval of the framework, strategy and policy refresh approach
- Drafting of risk management strategy and policy documents, risk appetite statement, refreshed risk taxonomy for the entirety of the risk management framework, as well as the supporting operating manual
- New draft BAF developed for the executive team for consideration
- Draft BAF alignment to new strategy and signature moves for the executive team for consideration
- Process mapping of current and proposed risk management systems to ensure alignment and use to educate and inform colleagues when undertaking the Care Group risk sessions.

10. Next steps

The next phase is focused on (and all are currently in progress):

- Building and configuring the live DCIQ environment –cutover to the new system is undertaken 30th April 2026
- Completing User Acceptance Testing – underway
- Finalising and approving the Strategy and Policy – through this paper and the Board approval route
- Care Group data cleansing and enablement – underway
- Preparing for phased migration from Datix Web – this is near completion, alongside implementation, communications and practical support materials so that the framework is translated into day-to-day behaviours, not only documented standards.

11. Assurance recommendations and summary

This report includes the following assurance assessment:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Governance and delivery control	Significant	Improvement
Policy, strategy and framework	Significant	Improvement
DCIQ implementation	Satisfactory	Improvement
Data quality and migration	Limited (Improving)	Improvement
Overall programme	Satisfactory (Improving)	Improvement

12. Recommendations

The Board of Directors is asked to:

1. Approve the Risk Management Strategy (Appendix A).
2. Approve the Risk Management Policy (Appendix B).
3. Approve the Risk Appetite Statement (Appendix C).
4. Approve the proposed BAF domain structure and its alignment to the Trust's strategy and five signature moves (Appendix D).
5. Note the transitional reporting arrangements for May and June 2026, including the use of the Organisational Risk Overview as the interim risk summary while DCIQ is configured and Yellowfin dashboards are being built.



Torbay and South Devon
NHS Foundation Trust

Board of Directors

Planning 2026/27 – April Update

Date of meeting	Date report produced
Thursday 7 th May	Monday 27 th April

Author(s)		Report approved by	
Name and title:	Andrea Wright, Director of Operational Finance	Name and title:	Simon Tapley, Chief Planning and Strategy Officer
	Alan Welch, Business Director for Planning and Productivity		

Date: Monday 27th April

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

Executive summary

The Trust has submitted a compliant financial plan (breakeven including £57.8m of Deficit Support Funding (DSF) and £54.4m Cost Improvement Target)), supported by cash, capital, workforce plans that are triangulated and budgets set for funding and establishment that are aligned with these plans. The Trust and Devon ICS await confirmation from NHSE that the plan has been accepted.

The Board is requested to agree SATISFACTORY assurance on finance plan submission, alignment of all components of the plan and Trust budgets.

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
Finance Plan Submission	Satisfactory	No change

Appendices

Appendix A – Planning Update Paper presented at March Board Meeting
Appendix B – Finance Plan Update Slide deck presented to Finance & Operations Committee

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

Previous Plan submissions have been reported to executive Committee, Board and Finance and Operations Committee.

Key recommendations and actions requested

Board is requested to AGREE the overall assurance level relating to the financial plan submission of TSDFT as SATISFACTORY, noting that work continues to reduce plan delivery risk relating to CIP maturity.

How does this report further our Trust strategy?

The delivery of the Trust strategy is included in the transformation plan

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	The plan development is incorporating strategic shifts towards prevention, integrated neighbourhood teams and community-based frailty models, directly supporting population health objectives.
Quality of services provided	Delivering quality services is built on good planning. Triangulation across finance, activity, and workforce maintains quality as a central planning principle.
Sustainable and efficient use of resources	Planning is fundamental to delivering Trust strategy. The establishment of stringent financial principles and high efficiency targets is key to achieving financial sustainability, efficiency and delivering best value services from limited funding

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	
Leadership and Governance	
Performance	The Operating Plan, refined through Care Group Demand & Capacity modelling and triangulation checkpoints, will describe how challenging performance standards will be met.
People and Culture	
Strategy and Business Intelligence	The Operating Plan will translate the new Trust strategy into deliverable, quantified operational plans.
Finance	Planning is fundamental to delivering Trust strategy. The implementation of a two-stage financial planning process, focusing on baseline clarity and aggressive CIP targets is central to achieving financial sustainability and ensuring efficient use of the Trust resources
Risk	
Risks lodged on Datix:	
N/A	
External Standards affected by this report and associated risks	
A robust plan will support delivery of performance targets and quality standards.	
No issues relevant to External Standards raised in this report.	

1. Introduction and background

The approach to Business Planning has been reported to Executive Committee, FPC/FOC and Board since August 2025. This update follows the full report provided to the Board meeting on 17th March 2026 and summarises the additional submission completed since that report.

The Medium-Term Plan submitted as part of Business Planning triangulates data from the Activity, Finance and Workforce Plans. All three templates were updated as part of the third submission on 18th March 2026 to which Appendix A relates. In response to feedback received a fourth submission was made 31st March containing changes to the Finance Plan which is the focus of this report based on the slides presented to Finance & Operations Committee (Appendix B).

2. Progress Update

The Trust submitted a finance plan in March for 2026-27 of Breakeven (£57.8m deficit excluding DSF) reflecting:

- Underlying deficit exiting from 2025-26 of £99.5m
- In-year cost pressure (costs of delivery exceeding funding) of £12.7m
- Non-recurrent Deficit Support Funding (DSF) of £57.8mm
- Cost Improvement Plans (CIP) of £54.4m

This is an improvement on the previous submission of £62.2m deficit plan, reflecting additional NHSE funding of £57.8m DSF and a commitment to increased CIP of £4.4m.

Bridge Analysis

Updated bridge with movements to previous submission are included in the following table:

		1st March Submission		Adjustment		Final March Submission	
		Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)
		£M	£M	£M	£M	£M	£M
2025-26 Planned Deficit		(8.0)	(8.0)	0.0		(8.0)	(8.0)
Loss of Non-Recurrent Funding	DSF	(30.8)				(30.8)	
Loss of Non-Recurrent Funding	Regional Surplus Redistribution	(18.9)				(18.9)	
Loss of Non-Recurrent Funding	System Flex	(8.4)				(8.4)	
Loss of Non-Recurrent Funding	System Support	(4.5)				(4.5)	
Loss of Non-Recurrent Funding	Other NR Income	(2.4)				(2.4)	
Loss of Non-Recurrent Funding	Loss of Non-Recurrent Funding Total		(65.0)		0.0		(65.0)
Efficiency	Planned Non-Recurrent CIP	(8.8)	(8.8)		0.0	(8.8)	(8.8)
2025-26 Planned Recurrent Deficit		(81.8)	(81.8)	0.0	0.0	(81.8)	(81.8)
Efficiency	Recurrent efficiency under delivery	(10.1)	(10.1)		0.0	(10.1)	(10.1)
In-Year Cost Pressures	Pay Cost Pressures Incl Pay Award	(1.3)				(1.3)	
In-Year Cost Pressures	Adult Social Care Cost Pressure	(3.5)				(3.5)	
In-Year Cost Pressures	UEC Demand Growth/ Escalation	(1.0)				(1.0)	
In-Year Cost Pressures	Other FYE Cost Pressures	(1.8)				(1.8)	
In-Year Cost Pressures	In-Year Cost Pressures Total		(7.6)		0.0		(7.6)
2025-26 Forecast Recurrent Underlying Deficit		(99.5)	(99.5)	0.0	0.0	(99.5)	(99.5)
Inflation	Adult Social Care and Continuing Healthcare Costs above funding	(1.4)				(1.4)	
Inflation	Other inflationary impacts above funding	(1.7)				(1.7)	
Inflation	Inflation Total		(3.1)		0.0		(3.1)
Demand	Demand Growth - Unfunded Adult Social Care & Continuing Healthcare	(4.7)				(4.7)	
Demand	Demand Growth - Other funding growth, cost pressures and investments	1.1				1.1	
Demand	Reduced Activity Growth Expectations to DALY	0.9				0.9	
Demand	Reduced Activity Funding Growth to DALY	(0.9)				(0.9)	
Demand	Reduced Activity on Commissioning Intentions	2.4				2.4	
Demand	Reduced Funding on Commissioning Intentions	(2.4)				(2.4)	
Demand	Demand Total		(3.6)		0.0		(3.6)
PDC Dividend Change	Impact PDC Capital Allocations and PDC Revenue Support	(3.2)	(3.2)		0.0	(3.2)	(3.2)
Funding Adjustments	Funding Adjustments - Efficiency in tariff	(10.1)				(10.1)	
Funding Adjustments	Funding Adjustments - ICB Surplus and Other Allocations	7.3				7.3	
Funding Adjustments	Funding Adjustments - Deficit Support Funding			57.8		57.8	
Funding Adjustments	Total Funding Adjustments		(2.8)		57.8		55.0
Other	Provision for Redundancy	(2.5)				(2.5)	
Other	Non-recurrent funding	2.5				2.5	
Other	Total Other		0.0		0.0		0.0
2026-27 Pre-Efficiency Planned Deficit		(112.2)	(112.2)	57.8	57.8	(54.4)	(54.4)
Efficiency	Initial Efficiency of £40m	40.0				40.0	
Efficiency	Efficiency - Additional Stretch	10.0		4.4		14.4	
Efficiency	Efficiency Total		50.0		4.4		54.4
2026-27 Planned Deficit		(62.2)	(62.2)	62.2	62.2	0.0	0.0

Key Risks and Mitigations

The Trust reported plan delivery risks of £25.8m (£45.8m gross risk offset with £20.0m mitigation) of which:

- CIP Risk is £23.9m* (£32.4m gross risk on all low and medium maturity plans offset with an expectation that all medium maturity plans (£8.5m) would reach delivery quickly)
- Application of freeze dates for SUS submissions is £0m (gross risk on uncoded backlog is c£5.0m, offset with £5.0m mitigation that Trust is investing in coding staff and will negotiate contract terms to avoid application of non-payment rules).
- EPR Implementation risk of £1.9m (unmitigated risk reflecting potential for loss of productivity in EPR implementation phase)
- Resident Doctor Strikes risk of £0m (gross risk of £1.5m reflecting a continuation of impact recognised in 2025-26, offset with a mitigation of £1.5m assuming additional national funding to meet costs).
- Band 5 Nurse Job Profiles risk of £0m (gross risk of £5m relating to change in profiles and banding, offset with a mitigation of £5m assuming additional national funding to meet these costs).

*It should be noted this risk assessment was based on CIP maturity at the point of plan submission on 31st March, the Trust is rapidly progressing CIP maturity with the target of achieving 75% Green delivery.

Assumptions

Financial Plan underlying assumptions are unchanged from previous plan submission, except DSF, which has been included at an uplifted value to latest NHSE offer.

Recurrent underlying position (ULP) is based on month 6 forecast outturn adjusted for material non recurrent items (Non recurrent CIP and deficit support funding) and full year effects of recurrent CIP delivery and investments started in 2025/26.

The recurrent cost base includes the recurrent running costs of EPR, with an additional non-recurrent cost provision of £0.5m, reflecting that cost reductions will be part year due to timing of legacy contracts end dates and other factors. Income has been set per ICB allocation schedule except for income disputes totalling £8.7m, against which a risk provision of £3.8m has been maintained in the plan, consistent with the initial proposal for a convergence deduction, which was subsequently withdrawn.

CFHD has been removed from cost and income base in Year 1, due to transfer to DPT, all other services have been treated as continuing services, with the exception of ASC which is shown as a service divestment in Year 2 of the plan.

Income Growth:

- Income CUF 2.03% - per ICB schedule
- Income Efficiency (2.00%) - per ICB schedule
- Activity growth - £8.6m
- Convergence deduction – -£3.8m (maintained in plan as a risk provision, although this was subsequently withdrawn and replaced by the ICB with a proposal to remove £8.1m contract income as Commissioning Intentions).
- Other operating income - inflation applied at 2%, almost CUF (2.03%)
- Council income increased to £70.7m - per S75 (£68.165m + £2.55m) plus £1m ASC client contributions
- CHC – (2.81% - demographic growth)

Expenditure Growth:

- ASC - £8m (£4m activity & £4m inflation) & CHC £4m
- Spec Comm inflation / growth estimated/matched based on 2627 M6 ULP
- Inflation: Pay +2.10%, Non Pay +2.20%, High cost / PTP Drugs +5.90% (matched to income inflation), Cost of capital +1.66%, Unallocated CNST +0.52%
- Business cases included: SCBU Safer Staffing £47k, Biosimilars (Rheum) £251k, Finance restructure £262k
- Demand Growth has been provided for at £4.3m (c50% of demand funding growth)
- RTT - added in £4,940k income and expenditure to meet RTT
- DSF has been included at latest NHSE offer value of £57.8m
- Bank and agency plan set at cap limits (£17,014k and £4,053k respectively for 26/27).

Medium Term Update

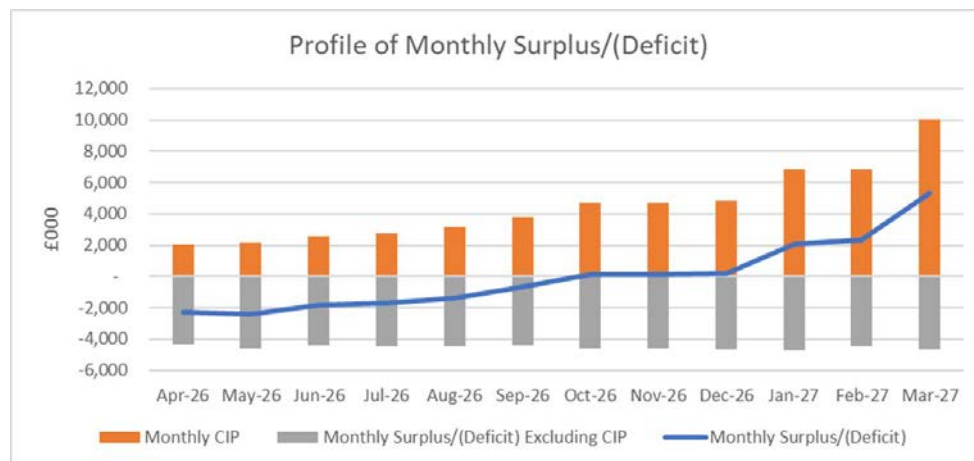
The Trust has made assumptions for Year 2 and 3 of the financial plan consistent with expectations in Year 1

Amended Submission		
	Year 2	Year 3
	£M	£M
ULP	(66)	(22)
Inflation Funding	9	9
Inflation Costs	(13)	(14)
Demand Growth Funding	8	8
Demand Growth Costs	(8)	(8)
RTT Funding	5	5
RTT Costs	(5)	(5)
Efficiency in Tariff	(9)	(9)
ASC Service Transfer	21	
Funding Adjustment	7	7
Non-Recurrent Costs of Transformation		(10)
Non-Recurrent DSF	22	10
Pre-CIP Plan	(29)	(29)
Recurrent CIP	29	29
Non-Recurrent CIP		
Draft Surplus/(Deficit)	(0)	0
Draft Recurrent Surplus/(Deficit)	(22)	0

- Inflation pressure largely relates mainly to expectations of CHC costs rising above general inflationary trends, assumed at 2% pa on costs and income, 6% on high cost drugs (fully funded), contributes net £4-5m deficit pa.
- Demand growth on key points of delivery expected to continue at the same rates modelled for Year 1, between 1-3% dependent on point of delivery, with costs of meeting demand equivalent to the investment (neutral to plan) with opportunities to meet demand growth at less than full cost included in CIP.
- Plan assumes that the RTT trajectory for years 1 and 2 is consistent with Year 1 and that gross cost investment matches tariff funding. Net £0m impact pa. Opportunities to meet demand growth at less than full cost included in CIP.
- 2% efficiency topslice assumed each year from contract, contributing £9m loss.
- Withdrawal from ASC assumed for Year 2, improving position by £21m.
- The Trust assumes that the contract underfunding position will be resolved over the 3 year plan horizon, improving the bottom line by £7m pa.
- Provision for £10m Non-recurrent cost to implement transformational change in Year 3.
- Non-recurrent DSF included at value proposed by NHSE in Years 2 and 3.
- £29m CIP assumed in each year in recurrent savings to meet in year and breakeven and recurrent breakeven by end of Year 3.

Revenue Plan Phasing

The Trust plan reflects a breakeven plan including DSF, £57.8m deficit excluding DSF. The plan reflects an expectation of £6.5m deficit in Q1, £3.7m deficit in Q2, £0.4m surplus in Q3 and £9.8m surplus in Q4.



The phasing of the revenue plan reflects an expectation of average deficit of £4.5m per month, with increasing CIP delivery from £2.0m in Month 1 to £6.8m in Month 11. The final step up to CIP delivery in Month 12 of £10.0m reflects £2.9m Non-recurrent CIP delivery associated with technical balance sheet releases

Cash Plan

The plan includes an assumption that the Trust will require Revenue PDC support of £10m to support the monthly deficits in Q1-2, which will be repaid in Q4 as the Trust moves into surplus.

The Trust cash plan assumes full achievement of the revenue plan and reflects a closing cash balance that does not fall below £18m in Q1-2, therefore the Trust should be able to maintain cash balances without drawing on PDC Revenue support.

The Trust will closely monitor cash position and forecast to avoid any unnecessary PDC Revenue support and minimise impacts on PDC Dividends.

Capital Programme

The Trust plan submission includes total capital expenditure of £24.0m, of which £23.7m is classed as CDEL spend.

This includes spend on major service development schemes:

- Theatres (£2m),
- Aseptic Suite (£2.3m)
- Cardiac Cath Lab (£1.2m)

The plan includes ongoing commitment to IM&T, estates backlog and medical equipment programmes as well as final phases of EPR.

Capital CDEL Limits

The Trust plan has a total CDEL limit of £23.7m, of which £0.9m is from nationally funded PDC schemes, £0.5m relates to PFI capital charges and £22.7m relates to Trust-funded capital spend.

It is likely that additional national PDC funding will be awarded during the year for specific schemes.

Capital Cash Sources

The Trust capital programme of £24m is mainly funded by depreciation cover of £25.3m, but has a net shortfall of cash sources of £1.1m (reflecting the extent that capital repayments exceed depreciation cover and new lease funding). The Trust will need to submit a request for Capital Support PDC to cover the cash shortfall to meet spend up to approved CDEL Limits. If Capital Support PDC is not approved the Trust will need to consider reducing the capital programme or maximising leasing acquisitions to maintain cash balances.

CIP Target Allocation (including WTE)

The Trust has planned CIP of £54.4m, of which:

- £33.4m are supported by Care Group plans detailed down to a cost centre level
- £21m relate to opportunities that have been assessed at a Trust-level but do not have cost centre level delivery (this includes a major workforce schemes for voluntary redundancy).

The full target (in financial and WTE terms) has been allocated to Care Groups and Exec Directorates in budgets to identify the full CIP requirement at the outset of the financial year, based on influenceable spend.

The Trust has planned CIP WTE reduction of 311 (consistent with the workforce plan), of which:

- 162 are supported by Care Group plans detailed down to a cost centre level
- 150 relate to opportunities that have been assessed at a Trust-level but do not have cost centre level delivery (this includes a major workforce schemes for voluntary redundancy).
- The full target (in WTE terms) has been allocated to Care Groups and Exec Directorates in budgets to identify the full CIP requirement at the outset of the financial year.

Workforce

The Trust has submitted a workforce plan with closing workforce WTEs of 6,237 WTEs, including 311 WTE reduction relating to CIP.

This is triangulated with the finance plan and establishment budgets have been set at a corresponding level, including a target reduction relating to unallocated CIP target (as per previous section).

3. Next Steps

Income protection actions to be implemented, including maintaining SUS submission timeliness and progressing contract discussions intended to avoid the application of non-payment rules.

Productivity through the EPR implementation phase will be monitored and any emerging impact escalated through the appropriate operational and financial governance routes.

Cash performance will be monitored against the in-year phasing to minimise reliance on Revenue Public Dividend Capital support and manage any associated dividend impacts.

A request for Capital Support Public Dividend Capital will be prepared and submitted to deliver the approved CDEL programme, with spend reprofiled and leasing options maintained as mitigations if capital support is not approved.

Shifting focus back to the wider Business Planning Process progress updates and escalations relating to transformational schemes will report to the “Our Plan for Better Care” Oversight Group.

Care Groups will be updated on actual achievement against activity, workforce and financial trajectories via Business-as-Usual reporting and governance.

A review of 2026/27 Business Planning will take place in June and agreed adjustments to templates and process will be implemented ahead of commencing the 2027/28 cycle in September.

4. Summary

The Trust submitted a 2026/27 breakeven finance plan including £57.8m non-recurrent Deficit Support Funding. The plan represents a £57.8m deficit excluding Deficit Support Funding.

The position reflects an underlying deficit exiting 2025/26 of £99.5m and in-year cost pressures of £12.7m and includes Cost Improvement Plans of £54.4m.

This is an improvement on the previous position of a £62.2m deficit plan. The improvement reflects the latest NHSE Deficit Support Funding offer and a £4.4m increase in the Cost Improvement Plan commitment.

Plan delivery risks total £25.8m net. This comprises £45.8m gross risk offset by £20.0m mitigation. Principal risk remains Cost Improvement Plan delivery at £23.9m net. The risk assessment reflects Cost Improvement Plan maturity at 31 March 2026 and work is taking place to progress maturity with an ambition to achieve 75% “Green” delivery confidence.

Other risks include potential productivity impacts during EPR implementation of £1.9m with no mitigation currently assumed. Risks relating to SUS submission freeze dates are mitigated through additional coding capacity and contract discussions intended to avoid non-payment rules.

Revenue phasing assumes an average deficit of £4.5m per month with increasing Cost Improvement Plan delivery through the year. The profile assumes a £6.5m deficit in Q1 and £3.7m deficit in Q2, followed by a £0.4m surplus in Q3 and a £9.8m surplus in Q4.

The cash plan assumes full delivery of the revenue plan. A potential requirement for £10m Revenue Public Dividend Capital support is shown for Q1–Q2, but the forecast cash balance does not fall below £18m, indicating that support may be avoidable with close monitoring.

The capital programme totals £24.0m, of which £23.7m is classed as CDEL spend. This includes major schemes for Theatres (£2.0m), Aseptic Suite (£2.3m), and

Cardiac Cath Lab (£1.2m), alongside IM&T, Estates backlog, medical equipment programmes and final phases of EPR. The programme is reliant on approval of £1.1m Capital PDC Support to make up a capital cash shortfall, the Trust will need to apply for this funding and a decision is not expected before September.

The workforce plan shows a closing position of 6,237 WTE. This includes a planned reduction of 311 WTE aligned to Cost Improvement Plan delivery and establishment budgets.

Board of Directors

Strategy Report

Date of meeting	Date report produced
07.05.2026	30.04. 2026

Author(s)		Report approved by	
Name and title:	Simon Tapley, Chief Strategy and Planning Officer; Jane Harris, Associate Director of Communications and Partnership	Name and title:	Joe Teape, Chief Executive

Date: 30 April 2026

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

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Executive summary

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

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
ALL	Satisfactory	No change

Appendices

Draft strategy (March version)
AI assessment of our draft strategy (January version)

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

Iterations of the draft strategy have been circulated and discussed through Trust Board development sessions.

Key recommendations and actions requested

The Board are asked to approve the strategy.

How does this report further our Trust strategy?

The Strategy is built on the Joint Strategic Needs Analysis of the population and seeks to provide a vision to support.

How does the report support the Triple Aim

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

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

Several risks will be identified at programme level. Overall resource to support the material changes will be added to the risk register at macro level.

Risks lodged on Datix:

Overall risks to the achievement of our strategy will be reflected in a redesigned BAF for 2026/27

External Standards affected by this report and associated risks

Care Quality Commission, Terms of authorisation, NHS England licence and regulations, 10-year plan.

Trust Strategy

1. Introduction and background

We are asking the Board to approve our organisational strategy for 2026–31. The strategy sets a clear and realistic direction for how we respond to the challenges we face locally and nationally, while protecting what matters most for the communities we serve.

This refresh was commissioned in 2025/26 and developed using the Three Horizons model, informed by structured engagement with colleagues, communities and partners. It responds to a materially changed operating environment, including significant and sustained financial challenge, the delay to our New Hospital Programme main build to 2034–35, the condition of our estate, and the statutory duty to collaborate within the Devon system.

The Board reviewed an early draft in private in March 2026. This public paper presents the final version for approval, taking account of Board feedback and further engagement.

If approved today, we will move into delivery and mobilisation. A year one delivery plan is already in development as part of our 2026/27 operational planning, supported by continued engagement with partners and communities as implementation progresses.

Our draft strategy has been cross-checked against:

- the NHS Long Term Plan.
- Cornwall and Isles of Scilly Strategy.
- NHS Devon commissioning intentions.
- Recently published NHSE strategic commissioning priorities.

2. Purpose of this paper

This paper:

- sets out why we need a refreshed organisational strategy now
- summarises how the strategy has been developed and informed by engagement
- confirms alignment with national and local direction
- sets out the proposed approach to mobilisation and delivery following approval
- recommends approval of the strategy and notes next steps.

Engagement undertaken to date has focused on shaping overall strategic direction, informed by colleagues, community insight and system intelligence. The strategy intentionally does not set out detailed service changes. Any future service changes will be developed through structured engagement with partners and communities and in line with best practice.

3. Why we need a refreshed strategy now

We are operating in a materially changed environment.

The national review of the New Hospital Programme confirmed that our main construction timetable has moved to between 2033 and 2035. This extends the

period over which we must manage significant estate risk at Torbay Hospital, where some of our estate is among the oldest in the NHS, and requires a different and more explicit approach to bridging investment, productivity and service sustainability.

At the same time, we continue to face significant financial challenge, including a material underlying deficit, and the requirement to deliver sustained cost improvement while maintaining high standards of care and safety.

Our system context has also shifted. The Health and Care Act 2022 placed Integrated Care Systems on a statutory footing and created a legal duty on NHS organisations to collaborate in pursuit of the triple aim: improving population health and outcomes, improving quality and experience of care, and achieving value for money. These duties now shape decision-making and priorities across the system.

Together, these factors mean we need a strategy that is explicit about:

- how we respond to constraint and uncertainty
- how we work with partners to deliver the best outcomes for our population
- how we make choices, sequence delivery and focus effort over the next five years.

This strategy:

- sets direction and priorities
- establishes principles for decision-making
- identifies where partnership working is essential.

This strategy does not:

- prescribe specific service relocations
- pre-determine access points or sites
- replace statutory consultation or local engagement.

4. How we developed our strategy

4.1 Strategy development approach

During 2025/26 we commissioned a refresh of our organisational strategy. This was driven by our financial position, our entry into the National Oversight Framework, the appointment of a new Chief Executive, and the need for clearer and more consistent organisational direction.

To strengthen strategic capability, our Chief Strategy and Planning Officer engaged external strategic support and adopted the Three Horizons model, focusing on:

- our current position and constraints
- where we aim to be by 2031
- the practical steps required to bridge the gap in a realistic and deliverable way.

4.2 Board input and revision

The strategy development process included Board workshops and development sessions, followed by iterative drafting. In March 2026, the Board reviewed a draft strategy in private session. This paper reflects those discussions and brings forward the final strategy for approval in public.

5. What we heard – how real voices shaped this strategy

We have been clear throughout: this strategy must be grounded in the realities experienced by our colleagues and communities.

5.1 Listening activity

In summer 2025 we undertook engagement with colleagues and the public to inform our future direction. This included:

- staff and public surveys
- workshops and focus groups with colleagues
- review of themes from complaints, concerns, Freedom to Speak Up, staff survey and patient survey feedback
- insights from local Healthwatch reports
- themes from the Devon 10-year plan engagement undertaken between November 2024 and March 2025.

5.2 What colleagues told us

Colleagues consistently described:

- pressure created by staffing shortages and workload
- the cumulative impact of post-pandemic demand and fatigue
- frustration with inconsistent systems and process friction
- a desire for clearer priorities and a stronger sense of organisational direction.

Alongside challenge, colleagues were explicit about what they value and want us to protect: compassion, teamwork, community connection, patient focus and our track record of innovation.

5.3 What we heard from our communities

Community engagement highlighted:

- delays and poor flow across pathways
- anxiety about losing local services and the importance of transparency and early engagement
- fragmented communication and lack of co-ordination
- barriers to access and inclusion, including estates and digital access
- consistent gratitude for staff compassion as the human constant people trust.

5.4 What this means for the strategy

These themes directly shaped the strategy, particularly our focus on:

- simplifying how decisions are made
- visible and inclusive leadership
- better flow and integrated pathways
- protecting compassion as a defining organisational strength.

6. The strategy being presented for approval

The strategy proposes a focused set of strategic priorities for 2026–31, designed to be deliverable within the constraints we face. In summary, the strategy commits the us to:

- stabilising and strengthening our foundations, including financial sustainability, workforce wellbeing, safety and essential estate resilience
- improving flow and experience across pathways, working with partners to reduce fragmentation and delay
- delivering more care in neighbourhoods, supporting prevention, independence and equity of access where this improves outcomes and value
- making our organisation easier to work in and with, simplifying systems, clarifying accountability and reducing avoidable bureaucracy
- acting as a responsible system partner, meeting our statutory duty to collaborate and contributing to population health improvement across Devon.

The strategy is intentionally selective. It requires difficult choices and clear sequencing and recognises that not all ambitions can be progressed at the same pace. Some developments will need to be deferred or delivered differently to ensure focus, affordability and sustainability.

7. Partner engagement (April 2026)

In April 2026, a high-level summary of the draft strategy was shared with system partners, governors and key stakeholders to sense-check direction of travel ahead of public consideration:

- our people and our governors (who also received access to the full draft strategy)
- Chief Executives of Torbay Council, Plymouth City Council, Devon County Council
- Chief Executives, Deputy Chief Executives and Directors of Strategy at Devon Partnership NHS Trust, University Hospitals Plymouth NHS Trust, Royal Devon University Healthcare NHS Foundation Trust, LiveWell SouthWest, Devon Integrated Care Board
- The Chair of the GP Collaborative Board
- Local MPs – Steve Darling, Caroline Voaden, Martin Wrigley and Mel Stride
- Directors of Adult Services (DAS), Children’s Services (DCS) and Public Health (DPH) at Torbay Council, Devon County Council and Plymouth Council
- The Chair and Chief Executive of Healthwatch Devon, Torbay and Plymouth
- Practice Managers of GP practices in Torbay and South Devon
- Chairs of Torbay and Devon Health and Wellbeing Boards
- Chief Executives of Torbay Communities and Teignbridge CVS (key VCSE partners)

The focused engagement on the draft strategy has generated a broad and constructive response. Taken together, the feedback provides strong assurance that the strategic direction is understood and broadly supported, while also offering valuable insight into the conditions required for successful delivery.

There is clear alignment around the intent and ambition of the strategy. Feedback recognises the realism of the challenges set out and the need for change, particularly in relation to sustainability, neighbourhood-based care and improving flow. One colleague reflected this balance clearly, noting that the strategy *“recognise[s] the need to make some tough decisions on our services”* while still setting a coherent direction for our organisation.

Alongside this support, engagement has surfaced a strong desire for confidence in how change will be delivered. Several colleagues described a tension between agreeing with the direction and feeling uncertain about our capacity to navigate change alongside current pressures. As one member of colleague put it, *“I feel challenged by how our Trust will navigate this change”*. This has reinforced the importance of realism, sequencing and visible leadership in the delivery plan.

Feedback has also been clear on the need for clarity of scope as the strategy moves into implementation. Stakeholders stressed the importance of avoiding misinterpretation of the strategy as pre-determining service changes. This was echoed by partners and representatives seeking reassurance that conversations about delivery will be staged, transparent and grounded in evidence rather than assumption.

There has been a consistent emphasis on access, equity and local impact, particularly from community and partner perspectives. Points raised about rurality, transport and digital access are not being addressed through changes to the strategy document itself, but are informing how delivery planning and future impact assessments will be approached.

Finally, feedback highlights strong appetite for continuing joint working. Partners, Healthwatch and system colleagues have expressed willingness to engage constructively in the next phase, with a clear expectation of ongoing engagement, clarity about roles and shared ownership of delivery.

The table below summarises the key themes from this engagement and shows how feedback is shaping delivery planning and community conversations, rather than resulting in material change to the strategy itself.

What we heard	What it means for delivery	Illustrative feedback (distinct voices)
Strong alignment with the strategic direction and case for change, including sustainability, neighbourhood	Gives confidence to proceed to delivery planning within the agreed strategic framework.	<i>"I agree with the principles laid out in this document, which align with national priorities and patient needs."</i>
Concern that the strategy could be misunderstood as signalling fixed service decisions.	Requires clear framing during delivery that the strategy sets direction, with detailed service proposals developed separately through appropriate processes and engagement.	<i>"I'm concerned it could be interpreted as decisions already being made."</i>
Support for the direction, paired with concern about deliverability under current pressures.	Delivery planning must prioritise pacing, sequence and capacity, with explicit recognition of operational realities.	<i>"What I lack confidence in is how we will navigate this change alongside everything else."</i>
Expectation that engagement must continue beyond strategy approval.	Delivery plan will include structured, ongoing engagement with staff, communities, governors and partners focused on implementation and impact.	<i>"I would welcome the opportunity to meet and talk through how we work constructively together through the next stage."</i>
Concerns about access, rurality, transport and digital inclusion.	These issues will inform delivery planning and impact assessments as proposals develop, rather than being set at strategy level.	<i>"Access and transport need to be thought through carefully as plans are developed."</i>
Frustration where information is perceived as fragmented or hard to access.	Engagement and communications during delivery must prioritise clarity, consistency and ease of access.	<i>"The various communication avenues don't always join up and it can be hard to access information."</i>

Opportunities for stronger joint working with partners and system colleagues.	Strategy provides a shared framework for aligned delivery and joint problem-solving where roles and timelines are clear.	<i>“Happy to catch up and work through this constructively.</i>

Taken together, the feedback provides assurance that the strategy is well aligned with national and local directions, while clearly shaping our approach to delivery, engagement and joint working as we move into implementation.

8. If approved today: engagement and mobilisation (summer 2026)

Subject to approval, we will move into delivery planning and continued engagement.

Over summer 2026 we will hold community conversations across our five neighbourhoods, using a mix of:

- targeted sessions with partners such as primary care and VCSE organisations
- open sessions for people who wish to attend
- proactive engagement with groups whose voices are less often heard, including people with serious mental illness, autistic people, people with learning disabilities, working-age men and young families, with a focus on health inequalities.

Subject to Membership Committee approval, we will also plan our annual members’ meeting in September as a health event with partners and communities, using workshops and focus groups to continue the conversation.

9. Delivery planning and assurance

A year one delivery plan is already in development and will form part of our 2026/27 operational improvement planning. We are also establishing a transformation unit by pooling existing resources to support delivery at pace and scale.

As delivery plans are developed, we will explicitly consider access impacts, including transport and digital connectivity, particularly for rural communities and work with partners to mitigate unintended barriers.

Progress against the strategy will be monitored through existing Board reporting and assurance mechanisms. The delivery plan will be treated as a living document, responding to learning, engagement and changes in the external environment.

10. Risks and mitigations

Key risks associated with the strategy include:

- extended estate risk resulting from the New Hospital Programme delay and constrained capital
- the scale of the financial challenge and requirement for sustained improvement
- system dependencies and the need for effective partnership working under the statutory duty to collaborate.

The strategy reflects a managed approach to risk aligned with our risk appetite and will be overseen through existing governance and reporting arrangements.

11. Recommendations

The Board is asked to:

1. Approve our organisational strategy for 2026–31.
2. Note that the strategy has been shaped through structured engagement with colleagues, communities and partners.
3. Note the proposed approach to mobilisation, delivery planning and ongoing engagement following approval.

12. Assurance recommendations and summary

The Board are asked to NOTE the progress and APPROVE the final draft strategy with final sign off at the public Board in May 2026.

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
ALL	Satisfactory	No Change

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

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

Board of Directors

Our Plan for Better Care

Date of meeting	Date report produced
7 th May 2026	24 th April 2026

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

Date:

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 a summary of the Trust's delivery of Our Plan for Better Care at the end of year one and outlines the organisation's transition into year two.

During 2025/26, the Trust focused on stabilisation, re-establishing operational grip, restoring confidence and strengthening organisational resilience across the five core improvement domains: leadership, strategy, performance, finance and workforce. Significant progress has been made across all improvement domains, supporting the Trust's successful exit from NOF4 and establishing a more stable platform for future delivery.

In 2026/27, the Trust will move from stabilisation and foundational improvement into strategic transformation. This phase is structured around the signature moves and enablers described in the new Trust strategy and reflect the transformation changes required to deliver the first phase of the strategy.

As this transformation programme evolves the detailed work to be completed becomes increasingly complex and the nature of the programme oversight and management needs to also evolve. Further improvements will be made to our Programmatic approach in order to streamline governance, manage the increasingly complex interdependencies and improve reporting.

Resource requirements to support the work are also becoming more challenging and the Trust is looking to establish greater capacity and capability to support transformation work. This is essential to the Programmes success and is likely to include use of external expertise.

The transformation work to be delivered in this programme is important and fundamentally linked to the delivery of the Trust's Operational Plan for 2026/27 and

beyond. The operational plan targets around finance and CIP, workforce and performance are all reliant on successful delivery of Our Plan for Better Care.

This report follows the Board Development discussion in March 2026 and subsequent discussion with the Executive Team. It summarises the achievements of year one, reflects on key learning, and sets out the priority deliverables for year two.

Appendices

(Items for Information)

Annex 1: Our Plan for Better Care Summary of Year 1 and Transition into Year 2

Annex 2: IA Report – Our Plan for Better Care Part 1: Governance

Annex 3: IA Report – Our Plan for Better Care Part 2: Performance Assurance

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

Our Plan for Better Care Oversight Group.

Key recommendations and actions requested

The Board is asked to:

- **Note** the progress made in stabilising leadership, governance, performance, finance and workforce domains, and the learning taken from year one with the Board of Directors invited to **Discuss**.
- **Take assurance** that appropriate foundations are now in place to support delivery in year 2
- **Support** the transition into Year2, recognising the shift from foundational improvement to strategic transformation aligned to the Trust strategy

How does this report further our Trust strategy?

Our Plan for Better Care supports the Trust's purpose to help the people of Torbay and South Devon live well by strengthening the sustainability, safety and quality of services.

Year 1 improvements across leadership, governance, performance, finance and workforce domains have enhanced the Trusts ability to deliver safe, effective, sustainable services and has contributed to the Trusts successful exit of NOF4.

Year 2 is aligned to the transformation required to deliver phase 1 of the Trust strategy. As such the plan is intentionally structured around the five signature moves & enablers set out in the Trust strategy ensuring alignment between transformational delivery and strategic ambition.

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 safety and quality is interwoven through all workstreams
Sustainable and efficient use of resources	Tighter prioritisation and clear alignment between transformation, productivity and CIP delivery.

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Embeds quality and safety into pathway redesign, neighbourhood care models, clinical service reviews and digital delivery, improving continuity, safety and patient experience.
Leadership and Governance	Clear SRO accountability, strengthened programme governance and robust PMO assurance provide effective oversight of strategic transformation and RAID management.
Performance	Service redesign, productivity programmes, service line reporting and expanded out-of-hospital models drive sustainable improvements in access, flow and operational performance.
People and Culture	Focused investment in leadership, wellbeing, skills and culture supports workforce sustainability, engagement and delivery of transformed services.
Strategy and Business Intelligence	Delivery of the Trust's signature moves, supported by improved intelligence and benefits tracking, strengthens strategic grip and evidence-based decision-making.
Finance	Financial sustainability is supported through productivity, service redesign and disciplined CIP governance.

Risk: Risk ID (as appropriate)

Not applicable

Risks lodged on Datix:

Not applicable

External Standards affected by this report and associated risks

Not applicable

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

1. Introduction and background

- 1.1 At the outset of *Our Plan for Better Care*, the Trust was operating in a highly challenged context. It had been subject to prolonged scrutiny having been placed in the highest level of National Oversight Framework (Segment 4) for several years, alongside a significant financial deficit and savings requirement. Operational performance was fragile, with persistent challenges in meeting national access and quality standards across key services and increasing pressure on frontline teams. This was compounded by low staff morale and limited leadership stability, creating an urgent need to re-establish operational grip, restore confidence and strengthen organisational resilience.
- 1.2 During Year 1, the Trust worked collaboratively and successfully with NHS England's Recovery Support Programme to develop a clear, integrated improvement plan that built the structure, discipline and leadership required for sustainable change. This shift moved the Trust from fragmented improvement activity to a single, coherent improvement programme.
- 1.3 The plan was intentionally branded *Our Plan for Better Care* to promote a clear and consistent message across the organisation. Programmes were aligned to executive portfolios to reinforce ownership and accountability. A robust governance and oversight framework was established through the Our Plan for Better Care Oversight Group. Senior leaders were supported through targeted coaching to strengthen accountability and improve the quality and consistency of reporting.
- 1.4 This report follows the Board Development discussion in March 2026 and subsequent discussions with the Executive Team. It summarises the achievements of Year 1, reflects on key learning, and sets out the deliverables for year 2.

2. Year 1 Achievements

- 2.1 During Year 1, the Trust made material improvements across leadership, strategy, performance, finance and people domains. Further detail is shared in Annex 1 and summarised below.
- 2.2 Through the leadership domain, governance and assurance arrangement have been strengthened through a redesigned committee structure, standardised reporting and an updated Board Assurance Framework. The externally commissioned Well-Led review was completed and its recommendations fully integrated into improvement activity. Executive leadership stability has been improved through key substantive appointments, and a structured Board and Executive development programme has commenced.
- 2.3 Strategically, a three-to-five-year Trust Strategy has been developed providing clear organisational direction, to be approved by Public Board in May. Key workstreams such as EPIC, Adult Social Care, Continuing Health Care and Child and Family Health Devon have progressed key milestones, reducing delivery risk and improved readiness for future transformation.

- 2.4 The performance domain delivered clear operational improvements across elective care, flow, frailty and maternity safety. Approved digital and theatre transformation initiatives improved patient engagement, increased theatre utilisation, and reduced cancellations to support RTT recovery. Ambulance handover delays improved and effective frailty services are diverting patients away from emergency pathways. Maternity services achieved full CNST compliance, significantly strengthening safety assurance.
- 2.5 Through the finance domain, the Trust has made measurable progress in strengthening financial governance, stabilising delivery performance, improving finance capability. Progress has been made in developing system-level finance functions with One Devon Shared Procurement Services now established and advancing work with One Devon Shared Finance services.
- 2.6 Collectively, these improvements have delivered measurable improvements in core KPI's, making a significant contribution to the Trusts successful exit from segmentation 5

Table 1:

	April 2025	Target March 2026	March 2026
Substantive executive leadership posts filled by 30th March 2025	75%	100%	100%
RTT 18 week wait	61.8%	66.8%	65.4% (M12 unvalidated)
RTT 52 week wait	2.6%	0.9% of waiting list	1.8% (M12 unvalidated)
Cancer FDS	75.1%	80%	80% (M12 unvalidated)
Cancer 62 day wait	68%	75%	75.1% (M12 unvalidated)
Diagnostic wait over 6 weeks	32.4%	5%	37% (M12 unvalidated)
UEC 4 hour wait	72.8%	78%	66.2% (M12 unvalidated)
UEC 12 hour wait	5.7%	6.1%	10.1% (M12 unvalidated)
Total CIP target (£) vs. delivered	£41.5m	£41.5m	M12 Delivered: £41.5m
Achieve Month 12 Workforce Plan of Total Workforce (WTE)	6815	Original target: 6363 Revised target: 6556	M12: 6710
Reduction in Agency spend by 30%	£10.1m	£7.1m (30% reduction)	M12 Final Year End: 6.2m
Reduction in Bank spend by 10%	£21.1m	£19m (10% reduction)	M12 Final Year End: £20.2m
Staff Feedback: National Staff Survey	39%	45%	35.55%
Staff Feedback: Pulse Survey Response Rate	1.96%	45%	2.58%

- 2.7 While not all targets have yet been fully achieved, most have improved. The strengthened grip and control processes now in place provide a solid foundation and are expected to continue delivering positive impact throughout 2026/27.

3 Learning from Year 1

- 3.1 The move to a single, integrated improvement plan has materially strengthened prioritisation, clarity and accountability across the organisation. Clearer governance and reporting arrangements have enabled leadership to focus improvement activity on those initiatives with the greatest impact and urgency. As these controls have matured, a growing proportion of activity originally managed through Our Plan for Better Care is now transitioning into business-as-usual arrangements, enabling the Year 2 programme to concentrate more explicitly on strategic transformation.
- 3.2 Aligning effort, budgets and staff time within one plan has maximised impact and reduced duplication. Delivery experience in Year 1 has reinforced the importance of tightly controlling the number of active workstreams to avoid organisational

over-stretch, alongside the need for realistic and credible delivery timescales to support sustainable outcomes.

- 3.3 Increased emphasis on cross-functional working and shared accountability has begun to reduce silos between services and teams. However, Year 1 has also demonstrated the need for earlier identification and more dynamic management of interdependencies to minimise delay and unintended consequences.
- 3.4 The adoption of a standardised programme management methodology has strengthened oversight of delivery, risks and issues at Executive and Board level. As the programme transitions into Year 2, there will be a stronger focus on evidencing delivery and benefits realisation to enhance assurance. Together with the introduction of RAID (Risks, Assumptions, Issues and Dependencies) management processes.
- 3.5 Building upon the communication of Our Plan for Better Care will remain a priority in Year 2 to ensure that the purpose, priorities and progress of the transformation programme are well understood and actively supported across all staff groups.

4 Year 2 Transition

- 4.1 Most of the Year 1 workstreams have now formally closed, either having delivered their agreed objectives in full or with remaining actions transitioned into established business-as-usual arrangements. Where workstreams have moved into BAU, associated risks have been appropriately transferred to relevant departmental risk registers to ensure ongoing ownership and oversight. In a small number of instances, workstreams have ceased where progress was no longer viable. A defined subset of workstreams will continue into Year 2, as illustrated in the visual below.

Table 2:

Senior Responsible Owner:	 CEO	 CPSO	 COO	 CFO	 CPO
Programme:	1. Leadership	2. Strategy	3. Performance	4. Finance	5. People
Workstream:	1.1 Governance & assurance 1.2 Well-Led 1.3 Board & Executive Development	2.1 3-5 Year Strategy Establishment 2.2 EPIC 2.3 PASP 2.4 Adult Social Care/Continuing Health Care 2.5 Child & Family Health Devon	3.1 Planned Care Improvement 3.2 UEC Flow 3.3 Community Services Redesign - Frailty 3.4 Maternity Safety Programme 3.5 Managing our Estate	4.1 Cost Improvement & Control Programme 4.2 Financial Capability & Capacity 4.3 Managed Services & Subsidiary Company Arrangements 4.4 One Devon Shared Services – Finance & procurement	5.1 Delivering Workforce Plan 5.2 Workforce Capability & Capacity 5.3 Organisational Development & Learning
	Successful completion of all deliverables Outstanding deliverables transitioning to BAU		No longer progressing Transitioning into year 2		

- 4.2 Year 2 marks a transition from improvement into strategic transformation and is structured around the Trusts five signature moves and enablers. Following the Board development session in March 2006, the programme has critically reviewed each workstream to ensure the deliverables are transformation in content. Improvement deliverables have been removed and will progress as part of business-as-usual governance. This has streamlined the number of workstreams within the programme.

- 4.3 With support from PMO, each workstream lead has developed a plan on a page (PoP) This is a concise version of a full delivery project plan that contains objectives, high-level deliverables, risks, assumptions, dependencies and defines the workstreams success measures. The plans on pages been approved by the SRO and OPFBC Oversight group and are shared with the Board of Directors for noting.
- 4.4 For ease of reference the transformational deliverable for 26/27 are summarised below.

Living well in our Neighbourhoods

- Expand the Harbour, our community frailty hub
- Expand and invest in virtual wards, the Medical Admissions Avoidance Team (MAAT) and hospital-at-home services.
- Upgrade core IT systems for neighbourhood teams, enabling effective risk stratification
- Review our bed-based offer to ensure it supports reablement, promotes independence and delays unnecessary moves into long-term bed-based care.
- Undertake a community estate review & rationalisation
- Adult social care transition
- Establish an Innovation & Evaluation hub
- Strengthen partnerships
- *Addresses ICB Priorities – cardiovascular disease, respiratory, end of life & frailty*

Reimaging Acute & Specialist Care

- Undertake Clinical Service review for identified specialties against clear service viability criteria, including quality, safety, workforce sustainability and value for patients.
- Continue to progress legacy projects already underway to stabilise and strengthen fragile services.
- Roll out service line reporting across all specialties, using best practice and GIRFT standards to support consistent improvement.
- Implement a productivity programme focused on delivering a minimum 2% annual productivity improvement over the next 3 years.
- Co-design a network target operating model for Pathology
- *Addresses ICB priorities – orthopaedics, urology, ophthalmology, cardiology & dermatology*

Joined up care every step of the way

- Review priority pathways against best-practice evidence and make changes where care is not meeting that standard.
- Build prevention into pathways wherever possible, learning from successful models such as Joint School
- Expand advice and guidance pathways to support earlier decision-making and reduce unnecessary referrals

Smart use of technology for better care

- Implement our new acute and community electronic patient record, supporting safer, more joined-up care across settings and benefits realisation.
- Review the evidence and deploy AI-supported tools where appropriate, to support timely and effective decision making and efficient utilisation of resources
- Roll out MYCARE to support better communication, coordination and patient experience

Caring skilled people ready for tomorrow

- Introduce a strengthened health and wellbeing offer, supporting our people to stay well and helping reduce sickness absence while improving retention and performance.
- Co-design and launch a Learning Academy to attract and help people grow into future roles, including preventative, community-based and digital roles.
- Introduce a renewed leadership and management programme, equipping leaders with the skills to create positive working environments and support safe, effective care.
- Implement a Just & Learning culture approach and accountability framework, setting consistent expectations for leaders & managers
- Undertake organisational and management reviews to ensure the right workforce model to deliver strategic & operational priorities
- Delivering the People Digital Programme and developing a modern, efficient People Services model aligned with regional and system priorities

Strategic Enabler

- Implement a finance shared service across Devon to drive best value

- 4.3 Each transformation domain has an identified Executive Director as Senior Responsible Owner (SROs), who is accountable for overall delivery of the domain and the achievement of its intended outcomes and benefits.
- 4.4 Domain SROs have determined the governance arrangements for their respective programmes, reflected in Annex 1. For some workstreams this is the receipt of a monthly highlight report to which the SRO will apply a robust 'check and challenge' process. For others, the SRO will chair a programme group meeting and apply the 'check and challenge' process
- 4.5 Domain SROs will provide a consolidated monthly assurance report to Our Plan for Better Care Oversight Group, chaired by the Chief Executive (or nominated delegate). The Oversight Group will provide authoritative scrutiny of delivery, risks, issues, dependencies, and benefits realisation, and will report directly to the Board on progress and any areas requiring Board intervention or decision.

5 CIP Delivery

- 5.1 The transformation work to be delivered in this programme is important and fundamentally linked to the delivery of the Trust's Operational Plan for 2026/27 and beyond. The operational plan targets around finance and CIP, workforce and performance are all reliant on successful delivery of Our Plan for Better Care.
- 5.2 Each CIP scheme has been mapped to the appropriate OPFBC workstream, with delivery oversight reported through OPFBC. Overall assurance of CIP delivery is provided through Finance Delivery Group as reflected in the CIP governance in Annex 1.

6 Strengthening Programme Management

- 6.1 As this transformation programme evolves the detailed work to be completed becomes increasingly complex and the nature of the programme oversight and management needs to also evolve.
- 6.2 The Programme Management Office (PMO) continue to strengthen programme and project management capability and governance across OPFBC. This includes the development and publication of a clear OPFBC handbook and practical guidance to support consistent application of agreed methodologies. These resources reinforce robust governance expectations, including the systematic use of RAID (Risks, Assumptions, Issues and Dependencies), to improve delivery discipline, transparency, and assurance, and the development of a decision-making framework to reflect authority defined at workstream, SRO and oversight level.
- 6.2 The PMO has established a Programme RAID Register. The most significant risks relate to workforce capacity, both in terms of programme delivery support and the potential impact of voluntary redundancy on longer-term capacity & capability. Competing organisational priorities, including the EPIC implementation and wider organisational restructures, present additional pressures. Mitigating actions are underway, including the commissioning of short-term supplementary resource, alongside plans to establish a dedicated transformation team as the organisational redesign is completed.
- 6.3 OPFBC has received two internal audits, part 1: Governance Assurance and part 2: Performance Assurance. Both audits received *significant* assurance, with the former making four recommendations with management actions implemented as below and the latter with no recommendations.

Recommendation	Management Response
ToR for OPFBC Oversight to be amended to reflect current practice	Updated and published ToR
Evidence to be provided to PMO to support declared position of KPI's and deliverables	OPFBC Handbook developed & published, PMO training delivered
Document process for requesting & approving workstream closures	Detailed in OPFBC Handbook
Consider inclusion of agreed extensions to target dates within Board report	Head of PMO & Board report to include deliverables due to be completed in month but subject to date change, when delivery reporting recommences in May 2026

7 Assurance recommendations and summary

7.1 The Board of Directors are invited to:

- **Note** the progress made in stabilising leadership, governance, performance, finance and workforce domains, and the learning taken from year one with the Board of Directors invited to **Discuss**.
- **Take assurance** that appropriate foundations are now in place to support delivery in year 2
- **Support** the transition into Year2, recognising the shift to strategic transformation aligned to the Trust strategy.

7.2 Noting the above, the Board are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

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

Board of Directors

Committee Chairs' Report

Date of meeting	Date report produced
7 May 2026	30 April 2026

Author(s)		Report approved by	
Name and title:	Sophie Byrne PA to Chairman	Name and title:	Sarah Fox Corporate Governance Manager
		Date:	30 April 2026

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 – 28th April 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:

- M12 Integrated Workforce Performance Report & Workforce Plan progress 2025/26 – Limited/Satisfactory – To receive
- Workforce Strategies in the Plan 2026/27- Update – Satisfactory/Limited – To receive
- Cultural Insights Review Group - update for information – Satisfactory – To receive
- Freedom to Speak Up Bi-annual Report – Limited – To receive
- WRES, WDES, Equality Objectives and Action Plans – Satisfactory/Limited – To receive
- 2025 National Staff Survey Results Report – Satisfactory – To receive
- Health Inequalities Report – Limited – To receive
- Quality Report for Healthcare – Limited/Satisfactory – To receive
- Working Lives of Resident Doctors - Integrated Executive Summary – 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 ratings above and TAKE ASSURANCE as to those matters reviewed by the Committee NOTING the following risks, mitigations, actions and successes:

ALERT:

Committee was informed that discharge related incidents are increasing and have been escalated as a PSIRF priority.

GMC National Training Survey and GoSWH reports identify pressure points for trainee resident doctors relating to intensity of night work and access to senior clinical support out-of-hours

ADVISE:

25/26 workforce establishment closed 277.67 WTE above plan (£12.2m overspent). The overspend was driven mainly by substantive pay costs; the lack of funding support for a CR scheme contributed to non-delivery of recurrent workforce reduction.

26/27 workforce plan is challenging. It includes a 311 WTE workforce CIP (221 WTE confirmed schemes and 90 WTE

stretch). A Workforce Programme Group has been established to oversee all workforce activity contributing to the 26/27 plan. Clear workforce strategies were presented including improved and strengthened AfC e-rostering and the implementation of Medical e-rostering.

Committee noted the clear and recurring insights from the NHS Staff survey results (2025) and FTSU intelligence: sustained workload and capacity pressures, variability in psychological safety with inconsistent leadership behaviours, mixed wellbeing outcomes and persistent inequity of experience for some staff groups. Acknowledgement of early priority actions and challenge from the committee to see agreed timelines for delivery.

FTSU interim arrangements are being reviewed to strengthen transparency, independence and capacity.

Committee discussed the annual WRES/WDES report. Urgent action is needed to address the persistent and unacceptable bullying, harassment and abuse of Global Majority and Disabled staff by colleagues.

Progress was noted on the Trust's 'reducing health inequalities' reporting framework and the need to strengthen data quality, analytical capability and routine inequalities reporting.

Committee noted:

- variable effectiveness of care group clinical governance processes relating to low harm incident management, Duty of Candour and inconsistent oversight of actions, affect key learning opportunities. 3-month improvement programme noted.
- Deterioration in proportion of patients reaching the stroke unit in 4hrs (38%) which is below the national average. Improvement measures were noted.

Committee discussed the working lives of resident doctors, receiving an integrated executive summary update from the Resident Doctor Representative Committee Chair and Peer Lead:

- The Trust has met or is meeting the expectations outlined in the Ten Point Plan
- GoSWH exception reporting reforms have been implemented locally with a substantial increase in reporting volumes that highlight operational pressure and rota gaps

	• Recurrent late finishes are concentrated in specific medical wards for which targeted care group level reviews are planned to strengthen rota resilience and escalation arrangements. • GMC National Training Survey shows Torbay and South Devon continues to compare favourable overall, but triangulates with other reports highlighting pressure points for Torbay around the intensity of night work and access to senior clinical support out of hours.
ASSURE:	Mandatory training overall remains above target (in the context of the recent Epic implementation). ER performance is improving with reduced case completion times. Long-term sickness cases are reducing across all care groups. Focused line manager support is having a positive impact. Improvements in ambulance handover times have reduced risk of harm with no incidents of patient harm (moderate or above) associated with ambulance delay or corridor care have been raised this quarter. GMC National Training Survey continues to show Torbay and South Devon year-on-year improvements in clinical supervision, reporting systems, handover, educational governance and facilities.
RISK:	Emerging delivery risk to the People Digital programme concerning the technical readiness/functionality of the chosen 'Service Now' platform. Resultant delay of Wave 2 timeline whilst One Devon People Digital Programme Board decide next steps.
CELEBRATE OUTSTANDING:	EPIC implementation has been delivered safely with no significant patient safety incidents. A huge achievement for the organisation with strong clinical engagement and considerable effort across all teams. Committee commends the much-improved approach to triangulating data across multiple sources to identify and better understand key themes impacting on staff experience and safety. The Cultural Insights Review Group, which brings together people and patient safety, appears to be rapidly maturing in its approach.

Committee Chairs' Report – 29 April 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:

- Establishment of NHS tele-reporting company through TSD wholly-owned subsidiary: Business Case progress update – Satisfactory – To recommend for Board approval
- Month 12 Finance Report – Satisfactory/Limited – To receive
- Treasury Report – Satisfactory – To receive
- Capital Spend and Planning – 25/26 to 30/31 – Satisfactory – To receive
- Adult Social Care Debt Report – Satisfactory – To receive
- 2026/27 Finance Planning Update – Satisfactory – To receive
- Strategy into Action - Presentation
- Operational Performance Report – Limited/Satisfactory – To receive
- Robotic Assisted Surgery – To recommend to Board for approval
- Digital Update – Significant/Satisfactory/Limited
- Electronic Patient Record Progress Report – Satisfactory – To receive
- BAF – Satisfactory – 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:

ADVISE:

Received update presentation & discussed proposal for set up of NHS tele-reporting company through TSD wholly-owned subsidiary.
Key queries raised:

- Clarification of governance and operating model
- Resourcing model (Radiologist)
- Value/return to TSD vs overhead effort
- Potential future implications of AI

Recommendation to consider/incorporate feedback prior to submitting to Board for final approval.

	Confirmation of updated financial planning to include additions DSF for FY26/27 plus additional CIP target. - Clarification of improving maturity of CIP plans aligned with ICB/PWC approach; target 75% of CIP rated green by end next week No update provided at this meeting on Tower Risk mitigation activities or on estate maintenance activities (next due for May meeting); understand work on track as per plans but note risks remain. Escalation of delays & lack of progress in implementing system-wide TOM has created some movement, with DPT CEO taking senior level accountability & co-ordinating discussions across partners. However, finalisation & implementation of proposed approach realistically not anticipated for up to 12 months; recommendation for TSD to take/extend interim senior level IT leadership support. No significant changes to operational reporting performance since last month: - No activity reporting available yet post EPR go live; operational challenges escalated but managed during go-live due to combination of operational factors (not due to EPR) - Note Sir Jim Mackay enforced reporting 'holiday' during go live so nationally reported data remains as per March reporting until July - Initial indications suggest activity levels post EPR go live remain ok& under projected levels; 6 known problem areas; encouragingly however, Dermatology already back at full activity level after 2 weeks. Received & discussed business case to proceed with procurement of the Versius Surgical Robotic System from CMR Surgical: - Recommendation to take forward to Board for full approval.
ASSURE:	Finance Month 12 outturn delivered to plan (£1m ahead) excluding DSF; nb under delivery of recurrent CIPs impacting FY26/27 ULP Governance process & confidence in developing and qualifying CIPs significantly advanced since previous financial year (45% green at this time last year vs 70%+ this year) Received update on Our Plan for Better Care clarifying in detail the workstreams/programmes & Executive ownership to be delivered this FY Detailed Capital Plan submitted; despite ongoing risks & challenges with overall estate condition maintenance, a growing confidence in co-ordination & strategic oversight of development of future Torbay site; - Nb NHP planned visit in mid May Progress being made with implementing Cyber Security enhancement plan; remains Limited assurance until actions completed.

	Constructive Committee development session undertaken focused on setting up for success in FY26/27 including: - Exploring use of Copilot - Enhancing efficiency & effectiveness of Committee - Raising awareness & understanding in consistency of reporting WTEs - Key lines of enquiry in operational performance reporting
RISK:	Discussion on ASC debt provision; satisfactory reporting of process but concerns raised with managing the narrative & process carefully & proactively as part of ASC transition to Council. Torbay Data Centre migration remains complex & behind schedule & a risk to business continuity & resilience: - Discussed escalation approach & impact; assured appropriate efforts & mitigation actions in place but risks further delay to latest target completion date (July 2026)
CELEBRATE OUTSTANDING:	Recognition & appreciation extended to the EPR IMT and EPR programme teams for their outstanding achievement in managing EPR go-live (whilst also contending with industrial action). Feedback from EPI has been very complimentary. Recognition & appreciation also extended to RDUH and UHP colleagues for invaluable support for EPR go-live

Committee Chairs' Report

Audit and Risk Committee – 30 April 2026

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 • ASW Assurance Interim Report – n/a • Draft Strategic Audit and Assurance Plan – n/a • ASW Assurance Charter – n/a • Draft Head of Internal Audit Opinion - Satisfactory • Counter Fraud Interim Report – n/a • Counter Fraud Workplan – n/a • Cyber Security Update – Significant/Satisfactory/Limited • External Audit Plan – n/a • Risk Management Framework – n/a • End of Year Governance Items – Satisfactory/Limited • Information Governance Update – Satisfactory/Limited	• Raising Concerns/F2SU Annual Review – Satisfactory/Limited • Annual Finance Policy Update - Satisfactory • Grant Thornton Audit Contract - Satisfactory • SBS Implementation - Satisfactory • Devon Investment Policy - Satisfactory • EPRR Action Plan - Satisfactory • Waiver of Competition Report - Limited • Losses and Special Payments - Satisfactory • Committee Self-Assessment - Limited

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:

Cyber security continues to present a **significant organisational risk**. While technical controls have improved, evidence from phishing testing indicates ongoing vulnerability through staff behaviour, and recovery capability is not yet fully assured. It is important that the actions from the recent cyber investment business case are

	enacted as soon as possible, which should then help mitigate this risk. Freedom to Speak Up (FTSU) arrangements currently provide Limited assurance, reflecting reduced independence and sustainability following changes to the Guardian role, and this is being actively managed monitored by QPC. Information Governance statutory compliance, particularly FOI and Data Access & Disclosure, remains an area of heightened risk, with performance currently outside guidelines due to capacity issues. It was noted that there have recently been a number of FOI requests whose characteristics may be outside of FOI guidance, in terms of length, costs or confidentiality.
ADVISE:	The Board is advised that aspects of the annual planning and assurance cycle are currently out of sync with the recent significant changes to Board Assurance Framework and new risk management approach; transitional governance oversight will therefore remain important over the coming months. Internal audit and counter fraud annual plans were approved but may need to be revisited as the BAF and risk framework are finalised. Continued senior leadership focus is required to improve Declarations of Interest compliance, particularly among consultants, where non-submission undermines transparency and confidence.
ASSURE:	Internal Audit has made strong progress during the year, and the Committee supports the proposed move to an overall Satisfactory Head of Internal Audit Opinion, reflecting improved financial control, risk maturity and audit coverage. This improvement reflects good co-operation from the executive and employees. An external audit contract extension was agreed with Grant Thornton, with a price rise to £262k (6% up from £248k fixed for last three years).

	Counter fraud, finance policy updates, EPRR and core financial governance arrangements continue to provide Satisfactory assurance.
RISK:	There remains a delivery risk during transition to the new risk management framework, with some assurance plans and reporting structures still aligned to the previous BAF. Workforce-dependent risks (cyber awareness, IG compliance, declarations of interest) continue to feature across multiple assurance reports, indicating the need for stronger cultural and behavioural reinforcement.
CELEBRATE OUTSTANDING:	The Committee notes clear improvement in the quality, transparency and assurance discipline of reports to ARC coming forward this year. The Committee is assured that good progress is being made in implementing the new BAF and risk management framework, with a clearer line of sight between strategic objectives, risks and controls. Formal thanks have been passed to those responsible. Internal Audit delivery and engagement have notably improved, supporting more confident assurance to the Board and hopefully a Satisfactory Opinion



Torbay and South Devon
NHS Foundation Trust

Finance and Operations Committee Operational Performance Report

Date of meeting	Date report produced
29th April 2026	22nd April 2026

Author(s)		Report approved by	
Name and title:	Sam Wadham-Sharpe Deputy Chief Operating Officer	Name and title:	Sam Wadham-Sharpe Deputy Chief Operating Office
		Date:	22nd April 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 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 within the 25/26 operating plan. This report will cover performance detail on the progress on the exit measures for UEC performance and Elective performance.

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	Limited	Satisfactory
Cancer Performance	Limited	Satisfactory
Diagnostic Performance	Limited	No Change

Appendices

N/A

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

N/A

Key recommendations and actions requested

The Committee are asked to AGREE the recommended assurance 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	
Quality of services provided	All impacted by detail in this report
Sustainable and efficient use of resources	

Impact on BAF Objectives

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

Risk

Risk associated with RSP exit due to not meeting operational performance trajectories. This is explained in alternative reports

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risks

NHS Oversight Framework and national performance standards

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 Committee in respect of the key performance indicators measured that were required exit from the national RSP. As the Trust has received official confirmation of exit from RSP oversight, this report and the performance indicators reported to the committee will be reviewed as part of the committee development session in April. This report continues to report on the key areas of performance that are measured nationally as part of the 2025/2026 operating plan and the contract oversight processes overseen by NHS Devon ICB.
2. As part of the national sign off for the 'go live' of the new electronic patient record system which occurred on the 3rd April, the national team have mandated that elective performance will not be reported by the Trust for the months of April, May and June. National teams will continue to use the Trust numbers from our weekly submission on the 29th March with the Trust recommencing national reporting from the 15th July. As such, national benchmarking data for the period of April to June will not reflect the Trust current position. The performance team will be required to undertake a manual update for the committee and the Trust Board based on this.
3. It should be noted that there are a small number of reporting issues for some performance metrics such as 4-hour performance and RTT clock stops at present. These are currently being worked through with the Epic team with a requirement to resolve all UEC issues by the first week of May to enable submission of an accurate position. As such, it will not be possible to give an accurate forecast position for April on some areas of performance.

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 March 2026 in UEC, and February 2026 in all elective metrics.

3. National Benchmarking

3. The table below reflects latest published data (as at 16/04/26) 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 Feb 2026	Elective proportion waiting over 52 weeks Rank out of 118 Feb 2026	Cancer faster diagnosis Rank out of 119 Feb 2026	Cancer 62-day combined Rank out of 119 Feb 2026	Diagnostics proportion waiting over 6 weeks Rank out of 117 Feb 2026	A&E 4-hour performance Rank out of 118 Mar 2026	A&E 12-hour performance Rank out of 118 Mar 2026
Torbay And South Devon NHS Foundation Trust	66.8% 25	1.8% 77	79.7% 86	67.1% 71	30.6% 98	66.6% 98	10.6% 68

Metric	Previous available rank	Latest available rank	Improved/Worsened
RTT 18-week wait	22 (Jan 2026)	25 (Feb 2026)	Worsened
RTT 52-week wait	67 (Jan 2026)	77 (Feb 2026)	Worsened
Cancer FDS	110 (Jan 2026)*	86 (Feb 2026)*	Improved
Cancer 62-day wait	34 (Jan 2026)*	71 (Feb 2026)*	Worsened
Diagnostic wait over 6wks	92 (Jan 2026)**	98 (Feb 2026)**	Worsened
UEC – 4-hour wait	86 (Feb 2026)	98 (Mar 2026)	Worsened
UEC 12-hour wait	59 (Feb 2026)	68 (Mar 2026)	Worsened

*Rank out of 119

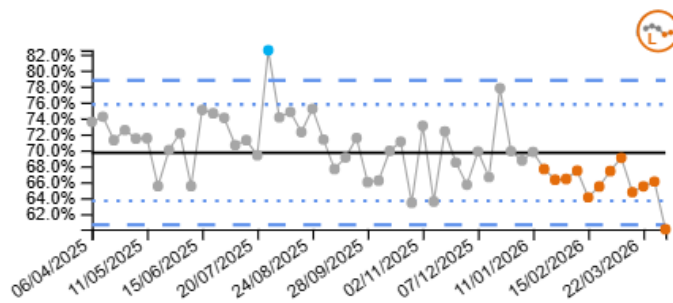
** Rank out of 117

4. Urgent and Emergency Care

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	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Oversight Framework														
Urgent and Emergency Care														
Ambulance handovers - time lost over 15 mins - Actual (hours)	1981		1268	839	1530	1159	725	943	1823	810	624	559	1283	621
Average handover time (mins)	45 mins		47	36	52	45	32	38	60	33	29	27	45	30
Total average time in ED (hours/minutes)			05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	06:10
ED attendances visit time over 12 hours (minor/major/spec/paed/s)	0		615	415	688	494	457	426	655	585	549	520	918	740
Percentage of patients waiting over 12 hours in ED	6.1%		9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.7%	7.4%	13.3%	11.5%
UEC 4-hour target (RAG against local trajectory to national target)	78%		70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	66.4%
% patient discharges pre-noon	33%		22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%

4-hour and 12-Hour Performance

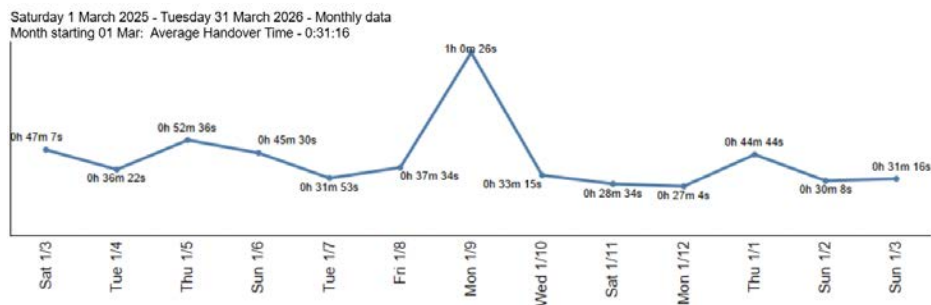
4. The Trust did not achieve the revised March trajectory and national target of 78.0% for 4-hour performance in March with performance for March 2026 at 66.6%. The ED leadership team are currently working through the plan which will identify how the capital investment in the department and the staffing investment agreed in 25/26 will enable an improvement in performance for 26/27. The team are expecting to enact improvements from 1st May and a first review of these plans is scheduled for the 23rd April. A verbal update on this review will be provided to the committee and it is recommended that the committee request a full review with the leadership team to enable assurance on the effective use of the investment agreed by the Trust.

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

5. In March 2026, the ICO managed 10759 all type UEC attendances. The Emergency Department recorded 7277 type 1 attendances which is a 3.3% accumulative increase on the previous year. The current all type UEC demand growth in FY25/26 is 5.3% against a planned increase of 2%.
6. The number of patients waiting longer than 12 hours for admission or discharge in the emergency department decreased to 10.1% of total attendances which has returned the Trust to close to national standard after the challenges seen in January and February.
7. As outlined in the March report, Urgent and Emergency care performance was affected by the Go Live. Processes within the Emergency Departments and across our wards and communities were be slower while teams learnt how to use the new systems. There was extensive supernumerary super-user support will be available round the clock to mitigate this, however there were impacts on waits to be see, triage times and times to transfer over the first week of go live.
8. As part of the planning for go live, extensive additional consultant and resident doctor resource was planned for the week leading up to go live, over the bank holiday weekend and through the first week of the new system implementation to mitigate any issues to flow and performance. The Trust also set itself the target of the achieving 90% occupancy at 3pm on the day prior to go live to ensure adequate capacity to support flow. The resident doctor industrial action which was announced for directly after the bank holiday significantly impacted the additional staffing that was planned to support flow with the requirement to safely staff the hospital over industrial action, particularly overnight. This reduced the additionality planned by over 60% of the shifts booked for this period.
9. The Trust did manage to exceed the planned reduction in bed occupancy by meeting 88% occupancy at 17:00 on the day before go live. Several learning opportunities form this process have been undertaken with a focus on management of expected date of discharge (EDD), robust reviews of complex discharge requests, robust oversight of therapy requests, and robust oversight of inpatient diagnostics.

Ambulance Handover Delays

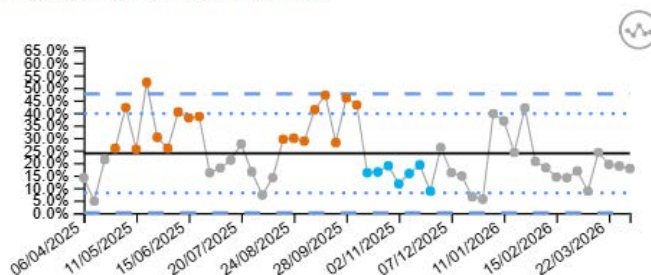
10. The total number of ambulance conveyances to the Trust in March 2026 was 2667 and a 14% increase on handovers from February 2025. This was the largest number of ambulances ever recorded by the Trust.



Ambulance handover dashboard: average handover time:

11. The Trust ambulance handover position improved through March to an average of 31 minutes and 16 seconds per handover. During this period there was an increase in the total delays over 45 minutes to 434 from 361 in February; the weekly trend in 45-minute breaches can be seen below.

Ambulance Delays >45mins



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. New national guidance on definitions and actions to address corridor care has been published by both the national UEC team and GIRFT.

11. The Committee 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.

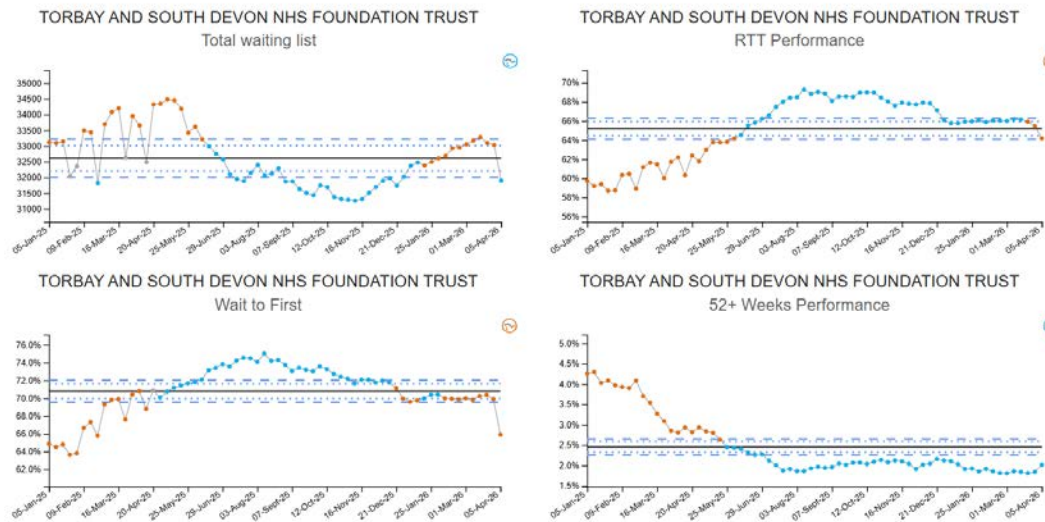
5. Elective Care - RTT

Torbay and South Devon NHS															
INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Oversight Framework															
Elective recovery															
RTT 78 week wait incomplete pathway	0		14	7	4	8	8	9	16	13	16	9	9	13	8
RTT 65 week wait incomplete pathway	0		215	141	145	126	95	97	105	110	109	84	94	83	76
RTT 52 week wait incomplete pathway	268		1209	931	914	805	740	615	618	615	647	607	663	604	607
RTT % incomplete pathways <18 wks	66.8%		62.2%	63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	66.1%	66.3%
RTT Wait for first appointment <18 weeks	70.3%		69.3%	70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		83.1%	79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	78.7%	60.6%	79.7%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		68.7%	74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	75.2%	67.1%
Cancer: No of patients waiting >62 days to start treatment	138		94	111	133	225	223	220	257	176	132	91	119	159	177
Cancer: % of patients > 62 days to start treatment	tbc		5.7%	6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	5.9%	7.6%	8.1%

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

March 2026. The charts below demonstrate the current progress against the key RSP exit criteria measures as reported regionally.

Waiting List Metrics: Torbay and South Devon NHS Foundation Trust



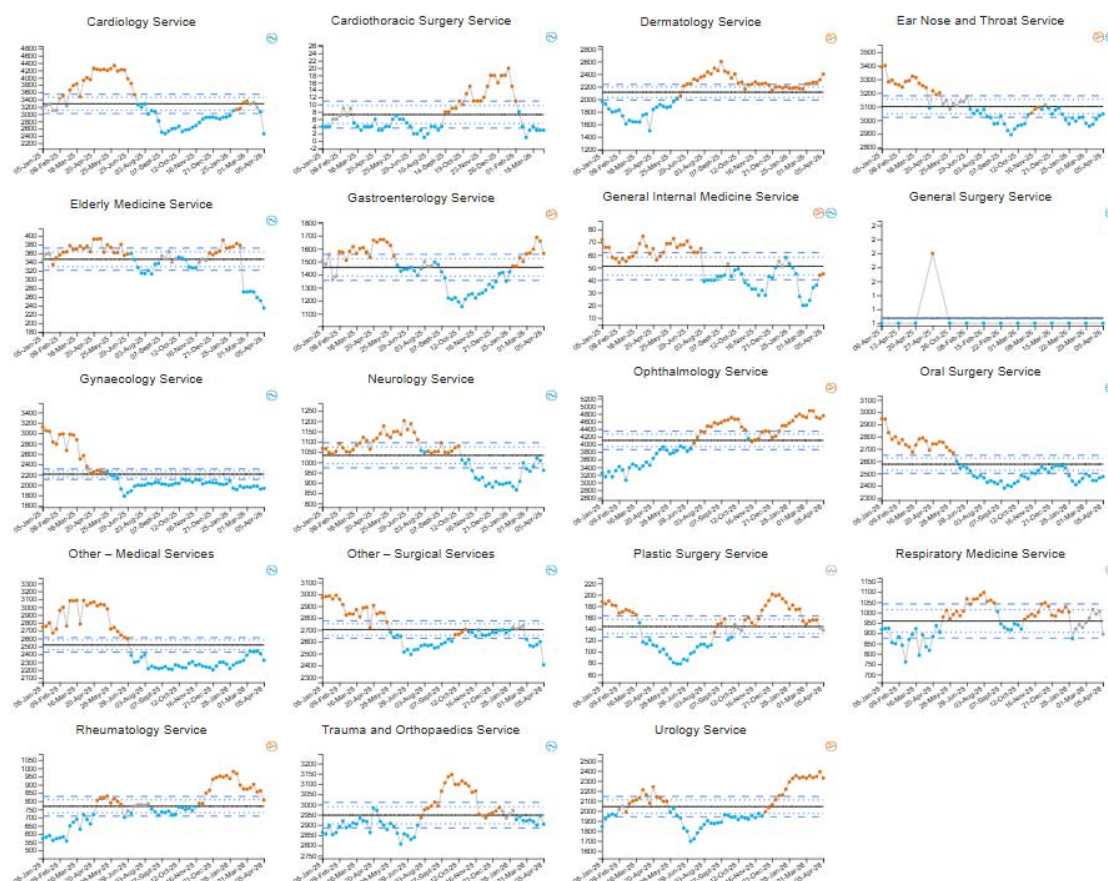
13. The charts detail the finalised February position and also the forecasted March position which has been submitted nationally as part of the required weekly submissions. It should be noted that while the Trust had achieved each of these standards in all months up to September, there was a clear plateau of the progress against each of these metrics heading into the autumn.
14. The Trust delivered an elective sprint through the month of which was 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. The Trust has demonstrated delivery of the majority of the additional activity required as part of the sprint, however the benefits of this activity has been offset by issues in other specialities meaning that improvements in the performance position have been small. It should be noted that without the delivery of the sprint activity, performance would have worsened and the Trust would have been at risk of not meeting its original trajectory.
15. Detail of the outpatient activity undertaken can be seen in the tables below. While the outpatient activity undertaken met the requirements of the sprint, the numbers of clock stops achieved were off set by the numbers of patients on the waiting lists that 'tipped over' to 18 weeks waiting. For example, 79 patients of the ophthalmology waiting list were seen and treated (or had their clock stopped as a result of their appointment) through this activity, however this was offset by 336 patients 'tipping over' to waiting 18 weeks or above.
16. The Trust did not deliver the levels of day case activity expected through the sprint due to several factors. The expected capacity that was to be provided through Mount Stuart did not materialise. Also negotiations with the independent sector were unable to progress due tariff requests which made this option financially unviable. Some other internal options were not able to progress due to annual leave and competing demands for clinical teams. Details of the day case activity can be seen below.

Day cases – delivery vs plan

Month	Planned	Delivered	Variance
February	63	19	-44
March	63	14	-49

14. The Trust continues to experience 65-week breaches despite ongoing improvement against this metric. The February position improved from January. The main contributor to this issue remains long waiters in orthopaedics, although issues have arisen in ophthalmology due to short notice absence. The Trust continues to work through improvement plans including the sourcing of mutual aid from another Trust in the region. The outputs of these actions have the potential to reduce the 65ww position to ~40 patients at the end of March 26.
15. The Trust will see PTL growth at EPIC Go Live due to reduced activity. We have based our planning on maintaining 75% of our outpatient activity for the first 6 weeks post Go Live, although some specialities have needed to reduce to 50% for a short period and some specialities are not reducing activity at all. The Go live plans will continue to prioritise cancer and clinically urgent activity over this period. We have taken learning from the Go Live processes at both North Devon District Hospital and more recent go lives at ESNFT which our operational teams have attended and experienced, and we have built this into our planning.
16. The Trust activity stabilisation process are now fully embedded with a twice weekly in depth review of activity versus plan and any system issues that could impact on waiting list management and performance. Early reviews have shown the Trust is managing the basic processes such as 'outcoming' appointments and recording RTT status well. Next month report will include a break down of activity undertaken versus the scheduled reductions for go live.
17. As part of planning for 26/27, a clear understanding of the activity required to meet performance has been undertaken and plans are underway to ensure this activity is being undertaken in the most cost effective way possible. To support the committee understanding of the specialities with most challenge, the below charts outline the current waiting list size by speciality. Further detail on plans and progress will be shared with committee.

Total Waiting List by Specialty: Torbay and South Devon NHS Foundation Trust



18. Activity to the end of March 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 5.2% for UEC and 4.1% for non-elective admissions.
- Elective outpatient 1st activity is 0.3% behind last year and 4.5% below plan although there has been an increase in outpatient attendances with procedure recorded.
- Elective inpatients are below planned levels of activity. Under delivery in Orthopaedic elective activity being the main area of variance. For day cases, activity is above both plan and last year.

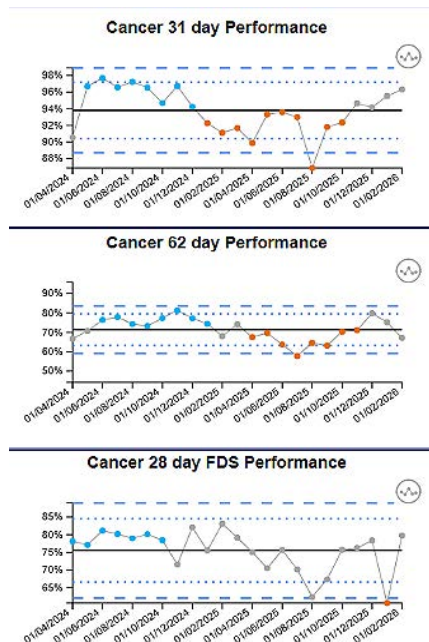
Activity to the end of March and variance to plan and previous year:

Setting	Attendance Type	24/25	25/26 Plan	25/26	variance against Plan	variance to last year 24/25
Day Case	Spell	40,234	41,038	41,157	0.3%	2.3%
Elective	Spell	3,455	3,982	3,329	-16.4%	-3.6%
Non-Elective	Spell	39,678	40,869	41,290	1.0%	4.1%
		83,367	85,889	85,776	-0.1%	2.9%
First	Attendance	90,930	94,869	90,621	-4.5%	-0.3%
	Procedure	27,255	26,062	27,383	5.1%	0.5%
Follow-up	Attendance	243,446	256,013	241,655	-5.6%	-0.7%
	Procedure	86,720	73,593	87,960	19.5%	1.4%
		448,351	450,537	447,619	-0.6%	-0.2%
A&E Dept Type 1	Attendance	79,466	85,955	84,432	-1.8%	6.2%
A&E Dept Type 3	Attendance	41,494	41,998	42,901	2.2%	3.4%
		120,960	127,953	127,333	-0.5%	5.3%

17. 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 114.2%. This has been supported through improvements in counting and coding, particularly in day case activity and outpatients' activity with a procedure.
18. The committee 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, particularly the expected activity reductions for EPIC go live.

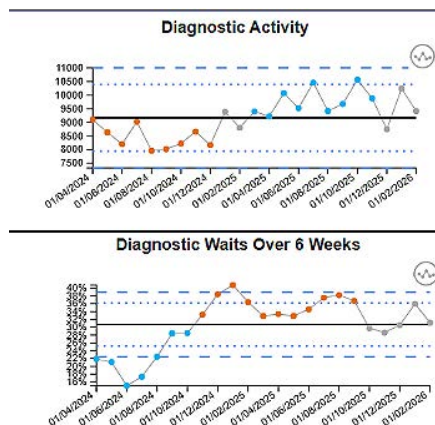
6. Cancer and Diagnostics

19. As per the previous report forecast the core 28-day faster diagnosis was met in February with performance at 79.7% against the national target of 75. 62-day cancer performance worsened to 67.1% for the same period.



20. A risk has been identified to cancer 28-day faster diagnosis standard performance due to the activity reductions required in dermatology and the contribution of dermatology to the overall Trust cancer position. Robust scrutiny is being given to ensure all available capacity is being prioritised to cancer and clinically urgent patients to limit any potential impacts. Further mitigations are currently being mobilised for dermatology, including mutual aid, insourcing and additional sessions. A robust review will be undertaken two weeks post go live with an aim to increase activity back to 100% ahead of schedule.
21. Based on current activity reductions planned in Dermatology and the requirement to maintain capacity for clinically prioritised patients on follow up pathways, The Trust 28-day performance is forecasted to reduce to 56% in April and 48% in May. The reason that the position will worsen in May is that the time to FDS in Dermatology will increase to ~50 days at the end of April. The Trust has sourced an additional 550 diagnostic and treatment appointments in May which will reduce the time to FDS to 32 days at the end of May. The additional appointments in May and the contribution of Dermatology to the overall Trust cancer position will therefore worsen performance. The worsening in May and the reduction of the time to FDS will enable the Trust to recover to national standard in June, based on the current scheduled activity for June and the further reduction of Dermatology FDS time to 24 days. The Trust has modelled the potential impacts on 62-day and based on current conversion rates and treatment at point of FDS rates, there is no significant impact foreseen on this standard. All of the above modelling is based on expected USC referral rates being at 175 per week, to Easter, and 200 post Easter. If referrals received is significantly different to this, then the modelling will be inaccurate.

22. Diagnostic performance (DM01) has remained a challenge throughout FY25/26 with a worsening of performance in February (37%) 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 cystoscopy. Latest forecast for March is showing an improvement to 31% including across the most challenged areas.



23. A recovery plan is now in place for cystoscopy, non-obstetric ultrasound and DEXA which will be enacted from April and this is detailed below.

Cystoscopy

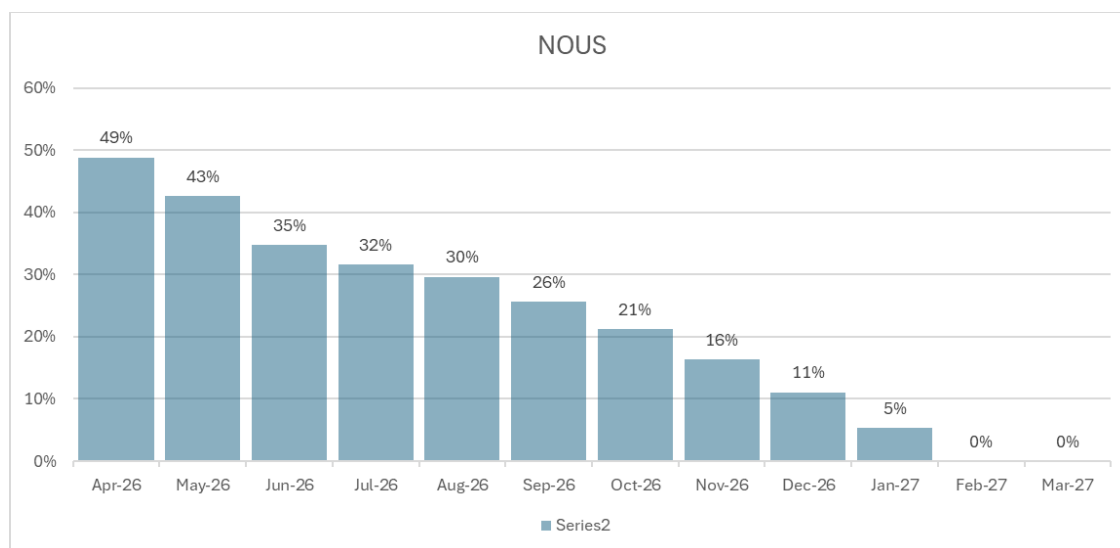
DM01 Performance 35%	
Action Plan	Progress
Capacity and Demand work completed 45 slots per week required to maintain demand - An additional 15 slots per week to address backlog	Locum and Substantive recruitment has been completed and aim to deliver 60 slots per week by 1 st June, anticipated to achieve under 5% by August 2026

Dexa

DM01 Performance 70%	
Action Plan	Progress
Further outsourcing to YMS to commence on 5th May 2026 giving 72 additional slots per week for 10 weeks	- Current waiting list is 561, an additional circa 120 DRSS referrals have been identified and vetting and uploading to CRIS is in progress - Routine capacity is currently at 36 per week with an additional 72 per week via YMS will give 1080 slots. With current demand, it is anticipated that Dexa will recover to under 5% by September 2026
Plan to move Dexa into Radiology in process – routine capacity of 100 scans per week compared to 36 in Rheumatology	- CRIS integration in progress - Space for Dexa identified within Radiology footprint - Recruitment to 2 x B5 Radiographers and 1 x B7 Reporting Radiographer to be agreed once budgets confirmed for 26/27 – awaiting confirmation of whether additional posts can be funded or additional ask. Training and development funds confirmed from HEE.

NOUS

DM01 Performance 50%	
Action Plan	Progress
Outsourcing of backlog (1000), however, this has continued to grow	- Due to commence 5th May 2026 – 1000 scans to be cleared over 9 weeks (circa 30-32%) - Once this has commenced, further ERF provisionally reserved for additional capacity if decision is made to bring recovery forward
Recruit to vacancies	1 x trained and competent and undertaking additional lists 1 x start date in July, with anticipated competency completed by September 2026 - Recruited to Superintendent role



24. The Committee is asked to take **satisfactory** assurance against delivery of the 62-day and 28-day cancer performance targets, noting the risks identified due to EPIC go live. **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 Committee AGREE the overarching assurance ratings to those matters reviewed.

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

Cancer Performance	Limited	Satisfactory
Diagnostic Performance	Limited	No Change

Finance & Operations Committee

Month 12 Finance Report

Date of meeting	Date report produced
29 th April 2026	20th April 2026

Author(s)		Report approved by	
Name and title:	Nichola Rees Finance Partner	Name and title:	James Corrigan/Andrea Wright Chief Finance Officer Director of Operational Finance

Date: 20th April 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 Finance and Performance Committee on the financial position 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 5).

The Trust is reporting a year end position of **£22.4m** deficit against a planned deficit of **£8.0m**. The **£14.4m** adverse variance relates to DSF withheld for Q3 and Q4 of **£15.4m**, offset with **£1.0m** favourable variance due to additional dental income variance to plan.

The Trust delivered £41.6m CIP, against a plan of £41.5m (slide 5), albeit with lower recurrent delivery than planned: recurrent £20.9m (vs £32.8m plan) and non-recurrent £20.6m (vs £8.7m plan).

The planned exit underlying deficit position for 25/26 (before national/system support) has deteriorated from £81.8m planned recurrent deficit to £99.5m forecast recurrent underlying deficit, mainly due to the under delivery of recurrent CIP. Additional analysis of latest run rates and worked WTEs have provided assurance that this position remains materially correct, taking a balanced view of risk and probability.

The Trust is reporting a cash balance of £35.5m as at 31st March 2026, £32.8m higher than planned. The higher than planned cash balance is mainly due to higher than planned capital creditor balances relating to late issues of additional capital funding, and will unwind in 2026/27 as the capital creditors pay through. The 2026/27 finance plan includes £10.2m revenue PDC deficit cash support drawn in Q1-2 and repaid in Q4, however the Trust will aim to manage liquidity without drawing on this support, minimising PDC dividend expense (slide 13).

As at month 11 the Devon ICS reported a year to date £71.2m deficit, £65.4m higher than plan, £22.4m is related to withheld deficit support funding (DSF). The forecast for the year end is £64.4m higher than plan at system level; £26.9m of this is due to withheld deficit support funding (slide 15). Month 12 ICS reporting is not yet available although all system partners have informally reported that forecast has been achieved.

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.

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

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Financial Performance	Satisfactory	No change
CIP	Limited	No change
Financial Risks	Limited	No change
Workforce	Limited	No change

Appendices

Appendix 1 – Finance Report

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

Executive Committee - Review

Key recommendations and actions requested

The Finance & Performance Committee is requested to AGREE the overall assurance level relating to the financial position of TSDFT as SATISFACTORY assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce.

The Board is also asked to NOTE the following:

- The Trust financial performance is off plan by £14.4m at the year end , reflecting withholding of Q3 and Q4 deficit support funding £15.4m, partially

offset with £1.0m of additional dental income. The Trust has received PDC Revenue Support to mitigate the cash impact of the loss of DSF.

How does this report further our Trust Strategy?

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

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

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

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



Monthly Financial Performance Report

Month 12

Executive Summary

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the financial year end position for the year ending 31st March 2026.

The deficit target for 25/26 is **£8.0m**, including **£30.8m** of Deficit Support Funding (DSF) and **£18.9m** of regional support. This is after a CIP target of **£41.5m** (slide 5). As at month 12 the Trust is reporting a year end position of **£22.4m** deficit against a planned deficit of **£8.0m**. The **£14.4m** adverse variance relates to DSF withheld for Q3 and Q4 of **£15.4m**, offset with **£1.0m** favourable variance due to additional dental income variance to plan.

At the year end the Trust delivered £41.6m CIP, against a plan of £41.5m (slide 5), albeit with lower recurrent delivery than planned: recurrent £20.9m (vs £32.8m plan) and non-recurrent £20.6m (vs £8.7m plan).

The planned exit underlying deficit position for 25/26 (before national/system support) has deteriorated from £81.8m planned recurrent deficit to £99.5m forecast recurrent underlying deficit, mainly due to the under delivery of recurrent CIP. Additional analysis of latest run rates and worked WTEs have provided assurance that this position remains materially correct, taking a balanced view of risk and probability.

The Trust is reporting a cash balance of **£35.5m** as at 31st March 2026, **£32.8m** higher than planned, mainly due to higher than planned capital creditor balances. The 2026/27 finance plan includes **£10.2m** revenue PDC deficit cash support drawn in Q1-2 and repaid in Q4, however the Trust will aim to manage liquidity without drawing on this support, minimising PDC dividend expense (slide 13).

As at month 11 the Devon ICS reported a year to date £71.2m deficit, £65.4m higher than plan, £22.4m 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 15). Month 12 ICS reporting is not yet available although all system partners have informally reported that forecast has been achieved

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 12

	M12				Financial Year			
	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
Operating Income	81.3	60.0	101.4	41.4	728.8	718.6	769.2	50.5
Operating Expenditure - Pay	(53.8)	(30.5)	(59.1)	(28.6)	(389.0)	(375.6)	(411.4)	(35.8)
Operating Expenditure Non-Pay and Financing Costs	(34.8)	(31.2)	(43.0)	(11.8)	(373.4)	(381.9)	(395.6)	(13.8)
Surplus / (Deficit) excluding DSF	(7.4)	(1.7)	(0.7)	1.0	(33.5)	(38.8)	(37.9)	1.0
Deficit Support Funding (DSF)	0.0	2.6	0.0	(2.6)	0.0	30.8	15.4	(15.4)
Surplus / (Deficit) including DSF	(7.4)	0.9	(0.7)	(1.6)	(33.5)	(8.0)	(22.4)	(14.4)

The Trust's financial position at the end of March shows a year end position of **£22.4m** deficit against a planned deficit of **£8.0m**. The **£14.4m** variance relates to Q3 and Q4 deficit support funding of **£15.4m** not received offset with a **£1.0m** additional allocation of dental income. The position excluding DSF is **£37.9m** deficit at the year end.

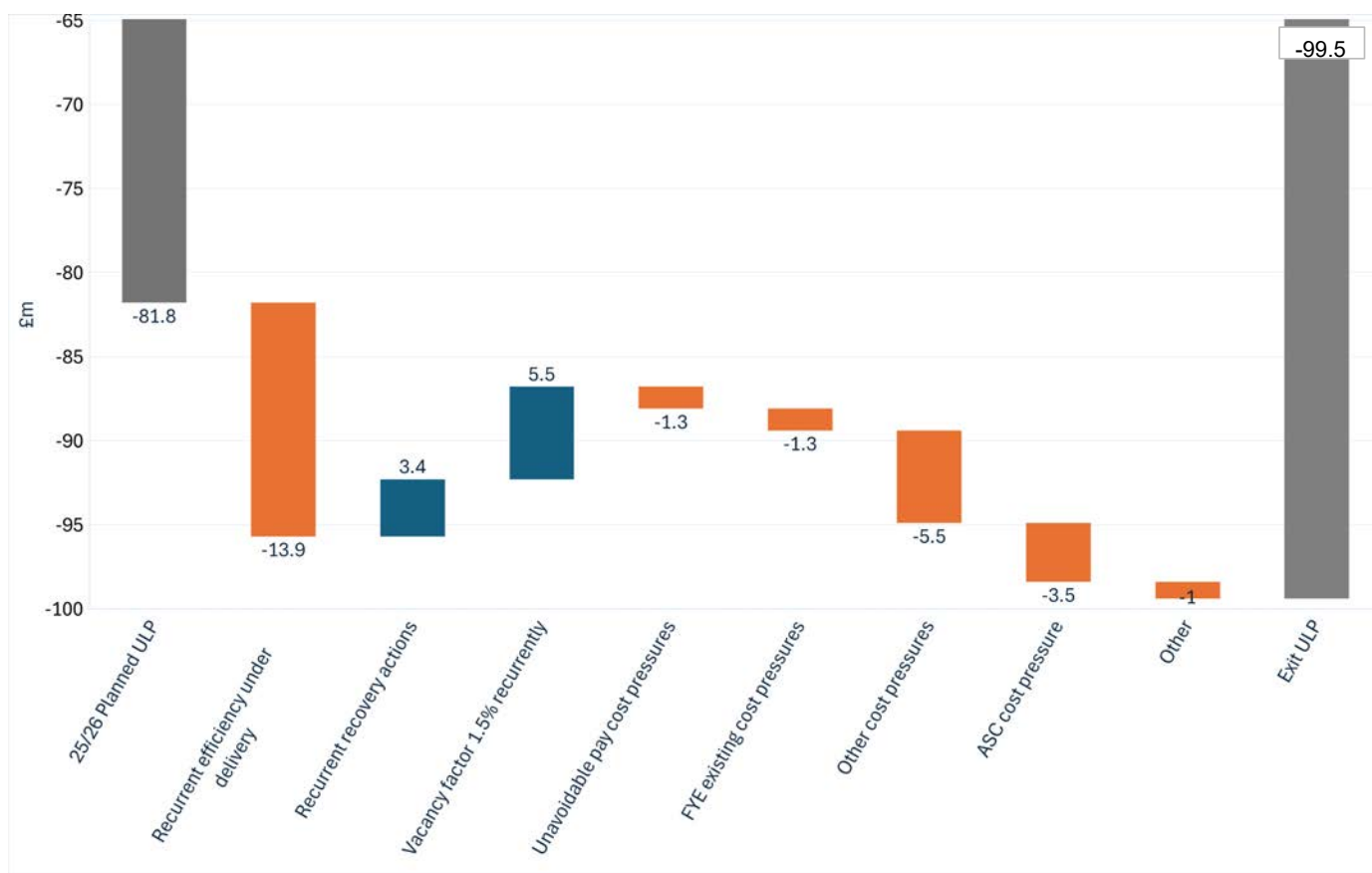
At year end Operating Income excluding DSF is **£50.5m** favourable to plan (favourable variances include - £23.6m additional pension contribution central funding, Pass Through Drugs & Devices £3.8m, Council grant income £0.7m, £5m Winter Surge Funding, £5m System Development Funding, £1m Strategic Support, other income incl. R&D & Education £10.4m, CIP delivery of £1m). Pay costs **£35.8m** adverse to plan mainly **£23.6m** pension costs (offset with income), **£12.2m** medical staffing pressures, and year end provisions. Non pay costs **£13.8m** adverse to plan (slide 10). DSF is **£15.4m** adverse to plan where M7-12 funding is being withheld.

The Committee can take **satisfactory assurance** that the plan for the year 2025-26 date has delivered.

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



Torbay and South Devon
NHS Foundation Trust



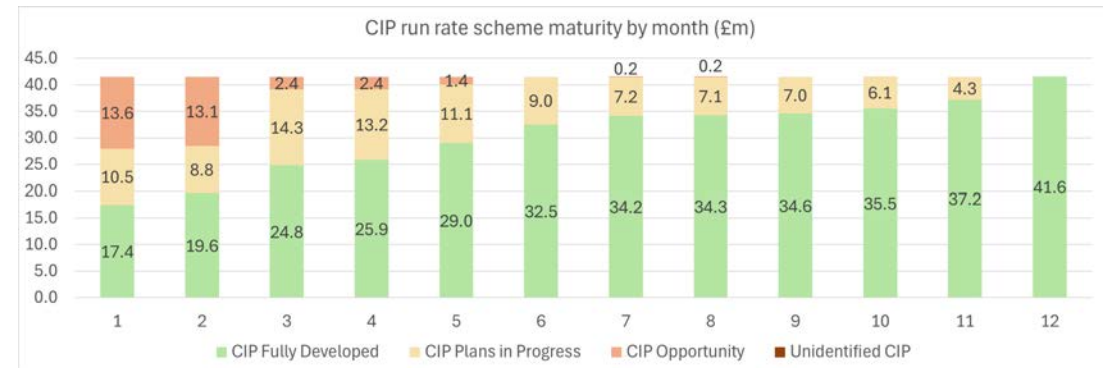
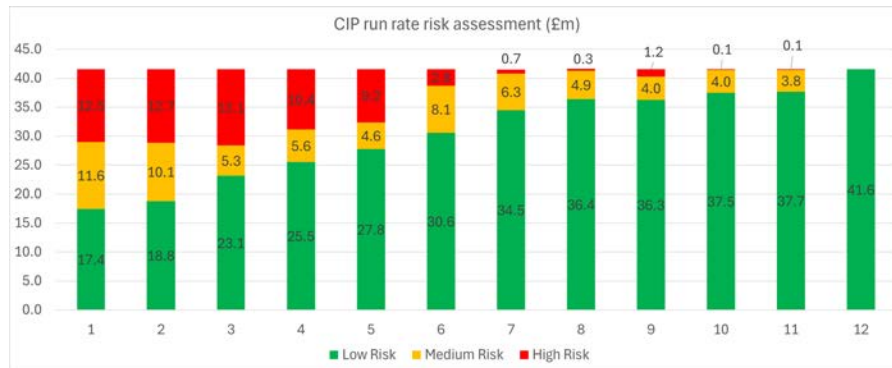
	£'m
25/26 Planned ULP	-81.8
Recurrent efficiency under delivery	-13.9
Recurrent recovery actions	3.4
Vacancy factor 1.5% recurrently	5.5
Unavoidable pay cost pressures	-1.3
FYE existing cost pressures	-1.3
Other cost pressures	-5.5
ASC cost pressure	-3.5
Other	-1
Exit ULP	-99.5

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

Efficiencies/CIP – maturity & risk

	Financial Year		
	Plan CIP delivery £m	Actual CIP Delivery £m	Var +/- £m
Recurrent efficiencies	32.8	20.9	(11.9)
Non-recurrent efficiencies	8.7	20.6	11.9
Total	41.5	41.6	0.0
Recurrent %	79%	50%	
Non-recurrent %	21%	50%	



At the year end The Trust is reporting £41.6m of CIP achievement, marginally ahead £41.5m plan. The recurring figure is £20.9m (£11.9m less than plan) and non-recurring £20.6m (£11.9m ahead of plan).

There is **limited assurance** around delivering the full efficiency requirement due to lower than planned levels of recurrent delivery.

Efficiencies/CIP - by Care Group

Total CIP Delivery Care Group	Delivered Full Year		
	Plan £m	Delivery £m	Var +/-
Families & Communities	6.4	6.9	0.5
Medicine and Urgent Care	4.6	5.0	0.4
Planned Care and Surgery	8.4	9.0	0.6
Shared Corporate Services	13.0	11.2	(1.8)
Children and Family Health Devon	0.7	1.1	0.4
Adult Social Care – Torbay	8.4	8.4	(0.0)
Total	41.5	41.6	0.0
Total Recurrent CIP Delivery Care Group	Delivered Full Year		
	Recurrent Plan £m	Recurrent Delivery £m	Var +/-
Families & Communities	3.8	4.9	1.1
Medicine and Urgent Care	4.0	2.2	(1.8)
Planned Care and Surgery	5.6	3.5	(2.1)
Shared Corporate Services	11.3	2.2	(9.1)
Children and Family Health Devon	0.1	0.0	(0.1)
Adult Social Care – Torbay	8.1	8.1	(0.0)
Total	32.8	20.9	(11.9)
Recurrent as a % of Total	79%	50%	

At the year end the Trust delivered CIP of £41.6m although with a lower than planned level of recurrent efficiency. The reduction in forecast delivery on recurrent workforce savings has been made with other non-recurrent transactions.

Care Group Summary

Care Groups	M12				Financial Year			
	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
Children and Family Health Devon (CFHD)	0.1	(0.0)	(0.1)	(0.1)	1.9	0.0	1.1	1.0
Families & Communities	(10.9)	(13.4)	(13.9)	(0.5)	(127.2)	(140.5)	(140.3)	0.2
Medicine and Urgent Care	(7.8)	(7.8)	(7.7)	0.1	(93.2)	(95.3)	(95.5)	(0.2)
Planned Care and Surgery	(13.2)	(13.0)	(13.4)	(0.4)	(153.5)	(158.7)	(159.2)	(0.5)
Corporate	(4.5)	(3.8)	(4.1)	(0.3)	(50.1)	(51.8)	(51.0)	0.9
Workplace (Estates)	(2.3)	(2.5)	(2.6)	(0.1)	(30.8)	(30.9)	(31.0)	(0.1)
Reserves & Other Income (Inc Fin Costs)	39.7	48.4	48.6	0.3	513.6	566.0	553.0	(13.0)
Adult Social Care – Torbay	(8.6)	(6.9)	(7.5)	(0.6)	(94.3)	(96.7)	(99.5)	(2.8)
Surplus / (Deficit) Total	(7.4)	0.9	(0.7)	(1.6)	(33.5)	(8.0)	(22.4)	(14.4)

CFHD: Full year outturn £1.0m favourable to plan due to continued vacancies and non pay underspends across all service areas.

Families and Communities: Full year outturn £0.2m is favourable to plan. This is driven by over delivery of CIP, partially offset by growth pressures.

Adult Social Care (Torbay): Full year outturn (£2.8m) is adverse to plan. The outturn position is principally driven by growth in client numbers across Dom care (£1.1m) Residential Long Stay (£0.4m) and increases in package of care costs driven by complexity in Supported Living establishments (£1.3m).

Medicine & Urgent Care: Full year outturn (£0.2m) adverse variance due to ED Medical staffing (£0.4m), Cardiology consumables (£0.4m) and escalation capacity (£0.6m) partially offset with underspends within wards £0.8m and over delivery of CIP £0.4m.

Planned Care: Full year outturn £0.5m adverse variance due to overspends on consumables £1.2m, medical pay £1.2m, other elective recovery activity costs £0.4m and CDC contract funding shortfall £0.3m. These adverse variances were partially matched by additional income generation (£1.2m) and release of deferred income (£1.4m).

Workplace: The full year outturn is an adverse variance of (£0.1m). This is mainly due to an adverse variance (£0.7m) arising from the under-delivery of the facilities catering and car parking CIP. This position is partially mitigated by favourable variances of £0.4m from estates vacancies and utilities underspends, together with £0.2m from reduced facilities costs.

Corporate: The full year outturn is £0.9m favourable to plan, which reflects £1.6m arising from vacancy underspends and over-achieved income, together with a £0.6m favourable R&D surplus. These have been partially offset by cost pressures totalling £0.9m across insurance, procurement transformation, people digital and operational support, and a further £0.4m adverse variance due to CIP under-delivery

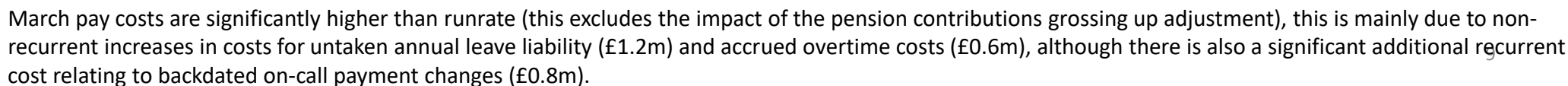
Reserves & Other Income (inc Finance costs) : Full year outturn £13.0m adverse mainly due to DSF not received for Q3-4 £15.4m offset with £1m additional dental funding and underspends on financing costs (£1.2m favourable). Additional pay and income of £23m has been recognised to gross up for central pension contributions, this is neutral to plan.

Workforce

	Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Class	Plan £m	Actual £m	Var +/- £m	Full Year Plan £m	Forecast £m	Var +/- £m	WTE Plan	WTE Worked	Var +/-
Non-executive directors	(0.2)	(0.2)	0.0	(0.2)	(0.2)	0.0	6.60	5.42	1.18
Pay - substantive	(349.2)	(385.0)	(35.8)	(349.2)	(385.0)	(35.8)	6,033	6,296	(263)
Pay - bank	(19.3)	(20.2)	(0.9)	(19.3)	(20.2)	(0.9)	308	333	(25)
Pay - agency	(7.1)	(6.2)	0.9	(7.1)	(6.2)	0.9	63	75	(12)
Grand Total	(375.8)	(411.5)	(35.8)	(375.8)	(411.5)	(35.8)	6,411	6,710	(299)

- At the year end there are 299 wte higher than plan, largely due to undelivered CIP reflecting an expectation of reducing 230 WTE in the CIP programme from month 7. There are additional efficiencies that have been delivered above plan in other areas of non pay and income as part of the revised recovery to ensure the CIP plan fully delivered in year.
- The year end financial position £35.8m higher than plan for overall pay costs, materially due to £23.0m central pension costs (offset with income), with substantive posts higher than plan due to shortfalls in the recurrent pay efficiency programme, medical staffing pressures, industrial action, and year end provisions.

Torbay and South Devon



Non-Pay Summary

	M12				Financial Year			
	PY 24/25	CY 25/26			PY 24/25	CY 25/26		
Description	Actual £m	Plan £m	Actual £m	Var +/- £m	Actual £m	Plan £m	Actual £m	Var +/- £m
CNST	(0.7)	(0.8)	(0.8)	0.0	(9.1)	(9.9)	(9.7)	0.2
Drugs costs	(4.0)	(3.9)	(4.5)	(0.6)	(50.0)	(48.0)	(52.3)	(4.3)
Non-executive directors	(0.0)	(0.0)	(0.0)	0.0	(0.2)	(0.2)	(0.2)	0.0
Other non-pay operating costs	(7.1)	(5.2)	(10.9)	(5.7)	(65.1)	(67.6)	(69.5)	(2.0)
Procurement	(13.3)	(11.2)	(15.3)	(4.1)	(132.8)	(134.7)	(139.9)	(5.1)
Purchase of social care	(9.7)	(9.4)	(10.5)	(1.1)	(110.6)	(113.4)	(116.6)	(3.1)
Financing Costs	0.0	(0.7)	(1.0)	(0.3)	(5.6)	(8.0)	(7.5)	0.5
Operating Expenditure Non-Pay and Financing Costs	(34.8)	(31.2)	(43.0)	(11.8)	(373.4)	(381.9)	(395.6)	(13.8)

Non-pay YTD **£13.8m** adverse to plan:

- Pass through drug costs **£2.9m** adverse (offset with income), other drugs **£1.4m** adverse (rheumatology, general surgery, outpatients)
- Procurement and Other Non-Pay Operating costs **£7.1m** adverse to plan comprising of:
 - Corporate **£4.1m** adverse mainly under delivery of CIP **£1.7m**, other non pay **£2.4m** (insurance, procurement transformation, people digital and NHP)
 - EPR increased costs **£1.4m**, pass through devices **£0.7m** (both offset with income), year end provisions **£2.5m**, care groups other non pay **£0.5m**, workplace estates **£0.5m**.
 - Planned care favourable due to over delivery of CIP **£1.7m** (offset under delivery income) and other non pay **£0.3m**. CFHD **£0.6m** favourable
- Purchase of social care **£3.1m** adverse to plan due to growth in client numbers and complexity **£3.7m** adverse, offset by an accrual benefit **£0.6m** favourable
- Finance costs favourable **£0.5m**, CNST **£0.2m** favourable

ERF Income Position against 19/20 Baseline

Care Group	M12 Income 19/20 £m	M12 Income 25/26 £m	M12 Income Variance £m	M12 Income Variance %
Planned Care and Surgery	56.8	60.5	3.7	107%
Medicine and Urgent Care	11.0	15.8	4.8	143%
Families and Communities	6.5	8.6	2.1	132%
Grand Total	74.3	84.9	10.5	114%

- The table shows the M12 position against the 24/25 version of the 19/20 ERF baseline adjusted for number of working days and the 25/26 tariff uplift.
- The Trust is recurrently funded to deliver 110% of 19/20 baseline elective activity. In order to meet the national requirement of 5% improvement in RTT performance, the Trust had to deliver 114% for which it received £2.8m in variable funding. The Trust has achieved this with a year end variance of 114%, improvements in outpatient procedure coding making a significant contribution to this position.

Productivity Metrics (national data) – M9 25/26 vs M9 24/25

M9	M9 2526 vs M9 2425
Inflation adj. expenditure growth	1.2%
Cost weighted activity growth	4.0%
Implied productivity growth	2.7%

- 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 9, implied productivity is improved from same period in 24/25 by 2.7%
- 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 continues to show improvement from last year but further opportunity to return to pre-covid levels of productivity. Reasonableness of this opportunity to be tested. Work to understand this in more detail and to analyse at specialty level is underway along with collaboration and learning with colleagues at NHSE region and Trusts across the region. A new productivity analyser tool is being implemented to support better understanding.

A productivity workstream is now getting underway as part of the refresh of the Trusts Improvement plan (Our Plan for Better Care). This is increasing focus on productivity and improve governance arrangements. Productivity work is being linked to SLR, Clinical Service Reviews and other transformation and CIP work. It will address cross cutting themes such as theatre utilisation and outpatient efficiency.

SLR deep dive meetings are taking place with key specialties to understand opportunity and develop improvement actions.

Cash Position – Month 12

	Plan £m	Actual £m	Variance £m
Opening cash balance	£3.3	£26.7	£23.4
Operating surplus/(deficit) - excluding finance costs	-£1.0	-£15.3	-£14.3
Capital Non-Cash movements (depr&amort)	£23.6	£23.9	£0.3
Working Capital Movement	£15.8	-£10.8	-£26.7
Net cash generated from / (used in) operations	£41.7	£24.5	-£17.3
Net Capital Expenditure (Purchase/Disposals)	-£54.5	-£58.7	-£4.1
Interest Received	£1.1	£1.7	£0.6
Net cash generated from/(used in) investing activities	-£53.5	-£57.0	-£3.5
PDC paid/received	£23.9	£76.4	£52.6
Loans paid/received	-£2.0	-£2.0	-£0.0
Capital on finance leases and PFI	-£5.1	-£4.3	£0.8
Interest element on loans, finance lease and PFI	-£2.5	-£2.2	£0.3
Net cash generated from/(used in) financing activities	£14.3	£68.0	£53.7
Closing cash balance	£2.6	£35.5	£32.8

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(15.3)
Finance income	1.8
Finance expense	(3.1)
PDC dividend expense	(6.1)
Other gains/(losses) including disposal of assets	(0.1)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(22.9)
Capital donations/grants/peppercorn lease I&E impact	0.4
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.1
TOTAL Provider Surplus/(Deficit) - System performance measure	(22.4)

The closing cash balance for M12 is £32.8m 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 **£17.3m** below plan, mainly due to £15.4m withheld Q3-4 DSF with the remaining difference primarily related to the timing of creditor payments.
- Investing activities show a **£3.5m** variance, reflecting capital purchases above plan associated with additional PDC funding.
- Financing activities show **£53.7m** primarily due to higher than planned capital PDC drawn to date, together with an additional £15.4m of revenue PDC drawn to mitigate the loss of DSF.

Cash Risk: The Trust has no immediate cash risks, liquidity will require close monitoring through 2026-27 as capital creditor balances unwind.

Cashflow Forecast – Month 12

	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Start Date 01.04.2026	£m	£m	£m	£m	£m	£m
Cash Balance B/F	46.0	30.6	25.4	12.9	13.0	12.6
Total Receipts	57.1	69.2	60.6	64.9	61.1	60.6
Total Payments	(72.5)	(74.5)	(73.0)	(64.8)	(61.4)	(65.4)
Net Movement	(15.4)	(5.3)	(12.5)	0.1	(0.4)	(4.7)
Cash Balance C/F	30.6	25.4	12.9	13.0	12.6	7.9

The Month 12 cashflow forecast has been prepared based on the following basis:

- The forecast for M01 - M06 2026/27 is based on the most recent 2026/27 plan with a break-even position, however this could be subject to change as there is potential for a further iteration of the plan.
- The 2026-27 finance plan includes £10.2m of PDC revenue Support drawn down in Q1-2 and repaid in Q4 (to match the profile of the planned revenue deficit). This forecast excludes the drawdown of Revenue PDC Cash Support, reflecting the Trust objective to manage without drawing additional cash support to minimise associated PDC Dividend charges.
- The capital outflows and associated funding sources are as per the M12 2025-26 capital plan and the 2026-27 Trust financial plan.
- This forecast assumes 100% of CIP is achieved.

Balance Sheet – Month 12

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	299.2	319.4	20.3
Other Non-Current Assets (Receivables)	4.0	4.2	0.1
Cash & Cash Equivalents	2.6	35.5	32.8
Working Capital (excl cash)	(21.6)	(59.2)	(37.6)
Non-Current Liabilities (Loans/Leases/Other)	(52.1)	(52.5)	(0.4)
Total Assets Employed (Assets + Liabilities)	232.2	247.4	15.2
Public Dividend Capital	309.7	359.5	49.9
Revaluation	61.0	59.4	(1.6)
Surplus / (Deficit) Sub Total	(8.9)	(22.9)	(14.0)
I&E reserves	(129.6)	(148.7)	(19.1)
Reserves Total	232.2	247.4	15.2

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(15.3)
Finance income	1.8
Finance expense	(3.1)
PDC dividend expense	(6.1)
Other gains/(losses) including disposal of assets	(0.1)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(22.9)
Capital donations/grants/peppercorn lease I&E impact	0.4
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.1
TOTAL Provider Surplus/(Deficit) - System performance measure	(22.4)

- Fixed Assets are higher than plan **£20.3m** reflecting additional capital funding received. There were also some movements in the opening balances in relation to impairments and revaluations at the time of the planning process.
- Cash is **£32.8m** higher than plan, explained in detail in cashflow report.
- Working capital (excl cash) variance of **£37.6m**, mainly related to higher than planned capital creditor balances.
- Revaluation reserve movement £1.6m mainly relates to the transfer of the cumulative revaluation surplus following the disposal of Dartmouth Hospital (£1.34m).
- PDC capital drawdown to the end of M12 is **£57.8m**, £34.5m above the plan reflecting additional capital schemes approved. PDC revenue drawdown is **£23.4m**, £15.4m above plan, to mitigate the loss of DSF.
- Capital expenditure was delivered in line with plan, including donated and PFI, **£76.9m**.

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

As at month 11 the Devon ICS reported a year to date £71.2m deficit, £65.4m higher than plan, £22.4m 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.

Outturn financial performance for the System is not yet available, but informally all system partners are reporting achievement of the forecast outturn position.

Description	Month 11			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	6.7	6.7	(0.0)	0.0	(0.0)	8.0	8.0	(0.0)	0.0	(0.0)
Devon Partnership NHS Trust	(0.0)	0.9	0.9	0.0	0.9	0.0	2.7	2.7	0.0	2.7
Royal Devon University NHS FT	(0.7)	(41.2)	(40.5)	0.0	(40.5)	0.0	(44.0)	(44.0)	0.0	(44.0)
Torbay and South Devon NHS FT	(10.7)	(21.0)	(10.3)	12.9	2.6	(8.0)	(22.4)	(14.5)	15.4	1.0
University Hospitals Plymouth NHS FT	(1.0)	(16.6)	(15.5)	9.6	(6.0)	0.0	(8.6)	(8.6)	11.5	2.9
Total	(5.8)	(71.2)	(65.4)	22.4	(43.0)	0.0	(64.4)	(64.4)	26.9	(37.5)

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 11 is as follows:

Section	ICS Assurance	Trend from previous month	ICB Assurance	Trend from previous month
Overall assurance	Not assured	No change	Satisfactory	No change
Financial performance to plan	No assurance	No change	Satisfactory assurance	No change
Financial performance to revised target outturn	Satisfactory assurance	No change	N/A	N/A
Workforce	No assurance	No change	N/A	N/A
Savings and efficiencies	No assurance	No change	Satisfactory assurance	No change

Devon Financial Escalation Framework – TSDFT Assessment

Dimension	Measure	RAG thresholds	Month	Month	Month
			10	11	12
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	-1.60%	-1.80%	-1.80%
	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	0.00%	0.00%	0.10%
	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	-1.90%	-1.90%	-1.80%
	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	0.10%	0.10%	0.10%
	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	-2.30%	-2.30%	-2.30%
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	0%	0%	0%
	Percentage efficiency delivery against plan year to date	Red rating where less than 95% Green rating where plan value achieved or exceeded	92%	92%	100%
	Percentage forecast recurrent efficiency delivery against plan	Red rating where less than 95% Green rating where plan value achieved or exceeded	65%	65%	64%
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 Red rating where YTD expenditure is less than 70% of forecast straight-line profile	46%	58%	100%
	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	81%	96%	104%
	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%

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 12 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 to plan at M12
- The forecast achievement of recurrent savings at 50% of plan.

Capital plan

- Funding approval status of schemes is at 100% with funding approval with significant (49%) increase to the forecast value of the programme.
- Capital expenditure profile YTD is at 100% of plan, with 47% spent in the final month.

Finance & Operations Committee

Electronic Patient Record (EPR) Progress Report

Date of meeting	Date report produced
29 th April 2026	17 th April 2026

Author(s)		Report approved by	
Name and title:	Kevin Pirie EPR Operational Director	Name and title:	Adel Jones - SRO
		Date:	17th April 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 describes the implementation of the Epic EPR at Torbay and South Devon in the period between the end of March and 17th April.

Progress of the electronic patient record (EPR) implementation:

Following the successful FLD 4.5 review the Trust engaged with NHSE Region on a detailed assessment of our preparedness and management of operational, performance and clinical safety issues ahead of sign off by Sir Jim Mackey. The key lines of enquiry that were addressed were:

- Data Migration and Reporting
- Data Quality Challenges
- Go Live Elective Activity and Performance
 - Pre-Go Live Preparation
 - 6 Week Elective Activity Plan
 - Monitoring Restoration
 - Dashboards
 - Mitigating Impacts

Formal approval to proceed to go-live was received on 31st March 2026. Please see Appendix 1 – *Sir Jim Mackey comms*

Headlines from the first 2 weeks of Epic Go-live:

- The Trust completed core programmatic data migration activity and PAS migration over the weekend of 28th / 29th of March. This included the successful migration of outpatient and day case appointments, referrals, waiting lists and future orders (231,222 records migrated with 0 recorded errors)
- At approximately 12am on 3rd April, final cutover of remaining systems commenced. A number of legacy systems remained available to staff to enable continued documentation (e.g. SystmOne maternity, Symphony ED and ICCA critical care). The integration team successfully completed remaining go-live dependent integrations between midnight and 2:00am, enabling the Trust to go live as planned at 2:00am on the 3 April across all clinical areas.
- Staff have performed well against key clinical safety metrics, including timely medication administration, laboratory specimen collection, vital signs documentation, barcode medication administration (BCMA) compliance, and VTE assessment completion. All of these indicators are trending positively as staff become more familiar with Epic workflows.
- As at 10th April 2026 approximately 1,200 Super User shifts have been provided across hospital and community sites. The programme has used dedicated Teams channels to coordinate support between super user teams which has worked well. These channels are also monitored by change and analyst teams and additional support has been directed to support areas / staff where required.
- There have been no serious issues (Priority 1) logged since go-live. Typically, we would expect to see a small number in early days post go-live. The Trust has logged fewer helpdesk calls than is typically seen during an Epic go-live. There are two key factors: we are adopting an existing live system and significant effort was put into addressing risk areas ahead of go-live. This has enabled teams to resolve a larger % of issues more quickly, reducing the impact for our staff. Additionally, strong super users support at the elbow has resulted in a number of issues addressed in real time which reduces the number of tickets logged.
- The reception from staff across Torbay and South Devon has been very positive. From day one, clinical teams reported that the transition felt smoother than anticipated, with several comparing it favourably to previous system implementations. Staff consistently praised the calm, supportive presence of super users and floor walkers, and as the week progressed managers reported visible growth in confidence, with staff who had completed a couple of shifts already stepping up to support their peers.

A full description of the key Go-Live events including our “*Snagging List*” is provided in Appendix 2 -*One Devon EPR Programme TSD First Week*

Our Go Live Activity Stabilisation Executive Summary is provided in Appendix 3

Benefits Realisation

Alongside the successful Epic go-live earlier this month, progress with benefits realisation has continued. Benefits register profiles for all transactional benefits have been translated into approved POD's and EQIA resulting in approximately £800k of transactional benefits having an identified route to cash. Focus will now turn to transformational benefits – During the last couple of months Care Group involvement has been limited due to the huge operational pressures during our preparation for Go-live. Now that we start to head towards Epic stabilisation, realisation plans can again move forward. The Benefits Analyst within the EPR programme will support the PMO to develop POD's for remaining cash releasing and non-cash releasing benefits. The EPR and PMO teams will then meet with benefit owners to ensure delivery plans remain current post go live and any additional benefits not yet documented are captured. This process will be aligned to other interdependencies in Outpatient Transformation and Admin Review plans.

Key Decisions –

- The final Go-No Go decision was taken by Adel Jones on Friday 3rd April at 1:45am

Key Program risks –

The approach to risks associated with Epic has been reviewed by the Trusts external risk expert and recommendations made to the Epic and Risk team. These recommendations are attached as Appendix 5 – *Review and Rationalisation of Epic risks*

Assurance Ratings

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. Sir Jim Mackey Go-Live Comms
 2. One Devon EPR Programme TSD First Week
 3. Go Live Activity Stabilisation Executive Summary
 4. Review and Rationalisation of Epic risks
- Included in the Finance and Operations Committee Items for 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	
Computer infrastructure risks - Datacentres	2830, on Datix, no escalation 2831, on Datix, no escalation
Failure to meet cybersecurity and information governance standards	2838, on Datix, no escalation
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.



Quality People Committee

Perinatal Quality and Safety – Executive Summary report

Date of meeting	Date report produced
24 th March 2026	13 th March 2026

Author(s)		Report approved by	
Name and title:	Joanna Bassett - Director of Midwifery	Name and title:	Nicola McMinn CNO

Date: 18th March 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 Committee 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 committee on critical elements of the maternity safety agenda by. • Outlining the Trust position on perinatal mortality and morbidity • Reporting progress and compliance with priority areas of focus. • Provide system level assurance on maternity quality and safety. 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
2.1 Alert- Perinatal mortality	Limited	Some improvement due to reduced rate perinatal mortality in February
2.2 Alert- Impact of Epic rollout on training compliance	Satisfactory	Mitigation planned and in place to address shortfall
2.3 Alert- Neonatal care outside of commissioned pathways	Limited	Ongoing thematic review in place – will need to await learning from this.
3.0 Assure	Satisfactory	Mitigations and oversight in place
4.0 Advise	Satisfactory	Progress evident in improvement work that is being monitored via MatNeolST
5.1 Celebrating success. Maternity Incentive Scheme (MIS)	Significant Satisfactory	Improvement from last year when Trust non-compliant with MIS Progress being made with psychological support and leadership capacity

Appendices

Appendix 1. Perinatal Governance & Safety Report (1st November 2025 – 31 December 2025).

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

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

Key recommendations and actions requested

The committee 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 committee is also asked to:

- Confirm the assurance rating
- Note the overall progress in maternity safety, quality, and culture.
- Note the continued oversight of the service by NHSE via the MatNeo Improvement Support team which is being supported at executive level by the monthly progress meetings.
- Note the thematic review that is being conducted into preterm births that occur outside the commissioned service for a level 1 special care baby unit
- Continue to Support the ongoing culture and wellbeing initiatives
- Note the training compliance risk that is being influenced by Epic training requirements.

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

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

Perinatal Quality and Safety Report – Executive Summary.

1.0 Introduction and background

The purpose of the report is to provide the Committee 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 Perinatal mortality and morbidity

In January 2026 we recorded a further neonatal death which is the fourth death since May 2025 as well as a stillbirth at 28 weeks gestation. A baby also required therapeutic cooling in a tertiary unit following care at home with two independent /private midwives. The reviews for these cases are following national frameworks with professional regulatory oversight where indicated.

2.2 Impact of Epic rollout on training compliance

The training data for February has seen a small deviation in compliance rates which is anticipated to worsen due to the requirement for all staff to complete Epic training during February and March. This risk has been added to the risk register with additional sessions and prioritisation for continuing of some training as mitigating factors to ensure safety.

2.3 Neonatal care outside of commissioned pathways

Four babies were born between 28–32 weeks at Torbay due to inability to transfer in utero; one neonatal death occurred. This incident is being reviewed as a PSII by the central patient safety team. The other incidents are being reviewed as PSR's completed by perinatal team. Exceptions are reviewed and reported on monthly to provide rationale, with oversight of the SW Neonatal network. The maternity governance team are currently undertaking a thematic review to look for any common themes within these and all cases of neonatal care outside of agreed pathways in the past 12 months.

3.0 Assure

3.1 Reduction of perinatal mortality

No perinatal deaths occurred in February which may indicate stabilisation. There is also evidence of improving escalation processes and emergency responses in clinical situations.

3.2 Training compliance

Although most of the mandatory training has been temporarily paused due to EPR training requirement, compliance remains high in most areas.

There is a lower compliance for Safeguarding children level 3. This is due to almost half of the Resident Drs being non-compliant on joining the Trust in October 2025. The safeguarding midwife provides educational opportunities whilst awaiting the formal training to be completed. A decision has been made to ensure all Drs have either attended or are booked to attend Safeguarding training before agreeing to aspirational study leave.

4.0 Advise

4.1 Neonatal workforce stabilisation.

The plan to address the Qualified in Specialty Neonatal Nurse (QIS) ration continues with some marginal improvement. A new neonatal medical workforce plan is being drafted to capture the new British Association of Perinatal Medicine (BAPM) recommendations

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. An independent review of the Birthrate+ methodology confirms that the Birthrate Plus workforce planning approach remains robust and fit for purpose, while recommending enhancements to better reflect contemporary practice. The review highlights rising administrative and non-clinical workload, increasing intrapartum complexity, and growing antenatal activity as key pressures that need fuller recognition in workforce modelling.

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. Two monthly progress meetings have been held with evidence of milestone progress being made.

5.0 Celebrating Success

5.1 Maternity Incentive Scheme

Year 7 concluded on 3rd March 2026. Following board overview a declaration of full compliance for all ten safety actions was submitted. A perinatal compliance lead is now in post to support the assurance and oversight required for perinatal services and they will continue to work with the team to enable ongoing compliance.

5.2 Culture and leadership.

Progress has been made in the effectiveness of the perinatal leadership team. The QUAD leadership team continue to support psychological safety workstreams and clearer escalation behaviours. The clinical psychology team have begun to support the team. The feedback from the listening events is being formulated into themes to be actioned and feedback to all staff.

6.0 Assurance recommendations and summary

The committee 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 committee is also asked to:

- Confirm the assurance rating
- Note the overall progress in maternity safety, quality, and culture.
- Note the continued oversight of the service by NHSE via the MatNeo Improvement Support team which is being supported at executive level by the monthly progress meetings.
- Note the thematic review that is being conducted into preterm births that occur outside the commissioned service for a level 1 special care baby unit
- Continue to Support the ongoing culture and wellbeing initiatives
- Note the training compliance risk that is being influenced by Epic training requirements

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
2.1 Alert- Perinatal mortality	Limited	Some improvement due to reduced rate perinatal mortality in February
2.2 Alert- Impact of Epic rollout on training compliance	Satisfactory	Mitigation planned and in place to address shortfall
2.3 Alert- Neonatal care outside of commissioned pathways	Limited	Ongoing thematic review in place – will need to await learning from this.
3.0 Assure	Satisfactory	Mitigations and oversight in place
4.0 Advise	Satisfactory	Progress evident in improvement work that is being monitored via MatNeolST
5.1 Celebrating success. Maternity Incentive Scheme (MIS)	Significant Satisfactory	Improvement from last year when Trust non-compliant with MIS Progress being made with psychological support and leadership capacity

Quality and People Committee

Title: Maternity & Neonatal staffing Report (1 July 2025 – 31 December 2025)

Date of meeting	Date report produced
24 th March 2026	4 March 2026

Author(s)		Report approved by	
Name and title:	Deputy Director of Midwifery & Gynaecology – Maria Mortimore Inpatient and Community Matron – Mair Davies	Name and title:	Director of Midwifery & Gynaecology – Joanna Bassett Nicola McMinn - CNO

Date: 24th March 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 is a summary of the measures that are in place to ensure that there are optimum levels of midwifery, obstetric and neonatal staffing within the maternity and neonatal service. This includes midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, and red flag incidents. Also included are details of specialist roles, fill rates, escalation processes and recruitment,

It reflects NICE guidance around safe staffing levels as well as Ockenden recommendations. This is monitored by the Maternity Governance and Service Group.

The purpose of the report is to provide an update to the Quality People Committee and provide assurance around systems and processes to ensure continuous monitoring and oversight around safer staffing levels as per NICE guidance, NG4 (2015).

The guidance recommends that the maternity establishment is reviewed at Board level at least every 6 months. The Quality People Committee should note the following key issues:

- The birth to midwife ratio falls well within the national recommendation of 1:28
- Good position in relation to % of women receiving one-to-one care in labour.
- The Obstetrics & Gynaecology medical workforce continues to experience capacity issues, although this is an improving picture following support being provided by the Trust.
- The significant fall in the vacancy rate for registered midwifery staff.
- The continued challenges in relation to QIS nurses in SCBU and the ongoing action plan to address these.

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

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
O&G medical workforce capacity	Satisfactory	Some positive change but continuing oversight and planning still required.
Challenges in relation to QIS (Qualified in Speciality) nurses within SCBU	Satisfactory	Some improvement

Appendices

N/A

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 Operations Group.

Key recommendations and actions requested

The Quality Assurance Committee is asked to:

- Note the mitigations taken within the maternity service to ensure safety and quality.
- Note the ongoing service requirements of the Obstetrics and Gynaecology team.
- Note the rise in sickness rates within maternity staff and the mitigations taken to address this.
- Note the significant fall in vacancy rate for midwifery staff within this reporting period
- Note the ongoing action plan to address the challenges in relation to QIS nurses in SCBU.
- Note that workforce recommendations form part of the recommendations of the Maternity and Neonatal Improvement Support report (MatNeolST – formerly MSSP).

How does this report further our Trust strategy?

This report describes how staffing and acuity levels are managed within the maternity and neonatal service to ensure that care is provided that is both safe and of a high quality for the pregnant population and their families in Torbay and South Devon. It also describes the mechanisms that are in place that monitor these levels and actions taken to ensure these are maintained.

How does the report support the Triple Aim

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

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	
People	
Strategy and Transformation	

Risk
Lack of consultant obstetrician and gynaecology staffing Risk score = 12 Action taken: 2 Recruited in early 2025. Advert out for 2 new consultants: one replacement, one new post. Once appointed risk can be closed. 3478
Risks lodged on Datix:
N/A
External Standards affected by this report and associated risks
NHS England licence and regulations National policy, guidance

1.0 Introduction

This report covers the period from 1 July 2025 to 31 December 2025 and details compliance with the standards set out in national and regulatory frameworks (as set out below).

2.0 Context and Standards

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

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

‘Growing, retaining and supporting our workforce.’

The Clinical Negligence Scheme for Trusts (CNST) maternity incentive, Year 7, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

- a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.
- b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
- c) The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
- d) All women in active labour receive one-to-one midwifery care.
- e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period.

3.0 Midwifery Staffing Establishment

3.1 Birthrate Plus®

Considering the Ockenden Review (Dec 2020), Trusts are required to articulate how they are meeting the minimum maternity staffing requirements as set out by the most recent Birthrate Plus ® report. Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity

units since 1988, with periodic revisions as national maternity policies and guidance are published.

A BR+ establishment review was completed at TSDFT in September 2025 and the final report received in October 2025. A variance of **-3.81wte** within the registered midwifery workforce was identified. 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 uplift identified is required to support these complexities with additional specialist midwifery roles. This uplift has been included as part of Business Planning plan for 26/27. 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. The report has also been presented to the Executive Committee for their consideration.

3.2 Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the John MacPherson midwifery and support staff within maternity for this reporting period:

Month	Day Registered %	Night Registered %	Day Unregistered %	Night Unregistered %
July 2025	86.1	95.4	87	83.6
August 2025	83.7	91.9	87.3	92.8
September 2025	76.3	85.9	92.2	96.7
October 2025	64.4	76.6	89.4	95.1
November 2025	67.9	74.8	91.9	75.5
December 2025	66.9	91.8	93.6	90.3

Fill rates alternate for several reasons, these include gaps caused by sickness absence, ongoing vacancies or staff who are working in a supernumerary capacity. The benefit of having an integrated model of midwifery care in place means the service can mitigate less than 100% fill rates by redeployment of staff across the flexible midwifery service. Integrated midwives can cover community work, intrapartum care as well as inpatient antenatal and postnatal care.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Temporary staffing solutions – bank staff or staff working additional hours.
- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.

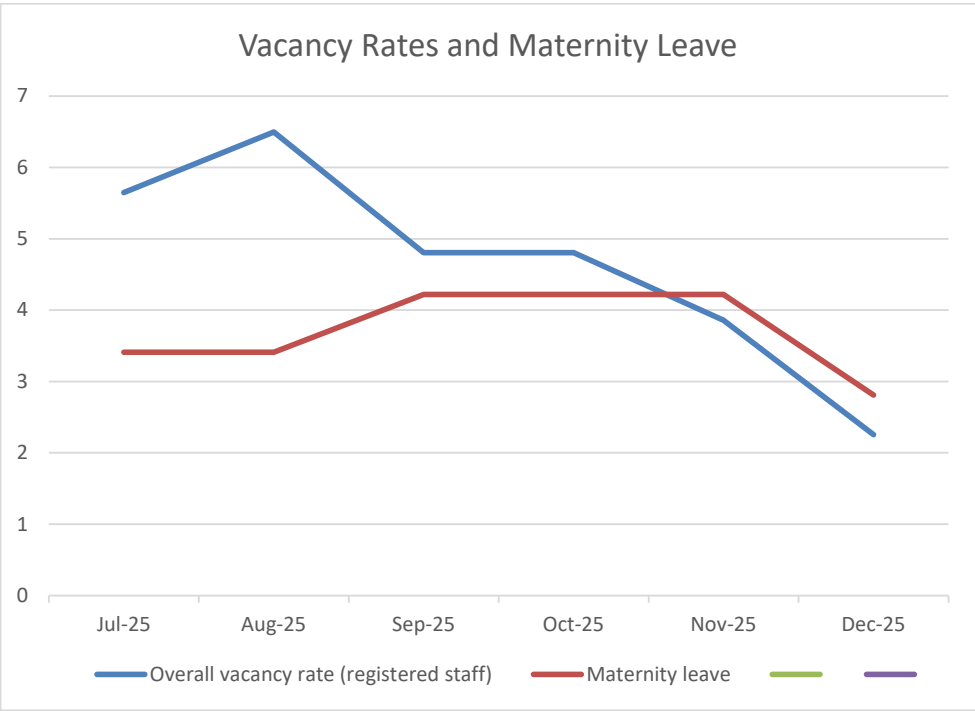
- Request additional support from the maternity matrons/managers.

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

3.3 Monthly Establishment Review

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

3.3 Recruitment
Chart 1: Vacancy Rates and Maternity Leave



During this 6-month reporting period there has been a further significant fall in the monthly vacancy rate from 5.647wte in July to 2.255wte in December 2025 (Chart 1). This demonstrates an overall fall in vacancy rate for the whole year of 7.845wte, from 10.1wte January 2025 to 2.255wte in December 2025.

The maternity service has transferred existing Band 6 establishment to increase the establishment of Band 5 preceptee midwife posts from 5.4wte to 6.4wte for a 12-month period. These are 12-month fixed term posts which support in growing the future workforce and readying newly qualified midwives for band 6 midwifery positions. The preceptee midwives are provided with support from the Education Midwives and receive additional support through inclusion in the Trust-wide preceptee programme. This temporary transfer in establishment was made to provide support with a regional shortage in available preceptee posts across the South West.

There is a very low rate of attrition in the maternity workforce at TSDFT, and active succession planning is in place, all the preceptee midwives who completed their preceptorship year in September 2025 were successful in applying for substantive band 6 midwifery posts within the Trust at the completion of their programme.

3.4 Retention

Retention work within the Maternity Service is now being led by the Senior Leadership Team, with support from the Professional Midwifery Advocates (PMAs) and the Strategic People Partner. This followed the Retention Lead Midwife stepping down from her role in August 2025.

Culture and Leadership is the theme of one of the five workstreams that are part of the Maternity and Neonatal Improvement Support programme (MatNeolST) with NHS England. Current priorities within the workstream are:

- Provision of psychological support sessions commencing in March 2026
- Psychological safety work
- Formulation of a roles and responsibilities document
- Individual staff listening events held and feedback will be disseminated

There has also been a focus within the service on providing progression opportunities. These have included:

- 6-month secondment opportunity into a Clinical Effectiveness Midwife post.
- Progression of the Labour Ward Coordinator competency framework and the opportunities for Band 6 midwives to complete these and develop skills required to apply for a Labour Ward Coordinator post.
- Opportunity for a 0.5wte Ward Manager post in early 2026.

Whilst the Professional Midwifery Advocates (PMAs) continue to provide support with staff wellbeing there is currently no Lead Midwife for the PMAs. This role is now being scoped and a job description being written, this will then follow the appropriate job matching and recruitment process at the beginning of next year. The role will be funded by the re-allocation of some of the external funding that was previously used for the Retention Midwife role.

3.5 Specialist Midwives

The Birth Rate Plus report from October 2025 recommended that 14.39wte of the total establishment are not included in the clinical numbers, this includes management positions and specialist midwives. For this reporting period there were 10.2wte specialist and management midwives in post for TSDFT, leaving a deficit of -4.19wte according to the BirthRate Plus recommendations. This gap has been acknowledged within the diagnostic element of the Maternity Neonatal Improvement Support programme and will form part of the recommendations to be considered in the ongoing improvement plan for perinatal services. Plans are already in place to appoint to some of the roles via existing establishment – the Lead Professional Midwifery Advocate role and a Fetal Monitoring Lead Midwife role.

3.6 Birth to Midwife Ratio (Table 2)

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

The current national recommendation is a ratio of 1:28 midwives. Between July 2025 – December 2025 there was an average birth rate per month of 148 births. This is a slight increase from the previous reporting period of 143 births per month. This has resulted in a Midwife to Birth ratio as displayed in Table 1. The birth to midwife ratio falls within the national recommendation.

The complexity and acuity of women, both medically and socially, continues to increase. This is evidenced by the increased rates of medical interventions, such as induction of labour and caesarean section, and a subsequent rise in the length of stay for women, in addition to increasing safeguarding requirements and support for vulnerable women and families.

Discussions continue regionally regarding the value of birth to midwife ratio, as the use of acuity tools to monitor optimum staffing levels are deemed to be more reliable and useful. TSDFT maternity services currently utilise the Birthrate Plus (BR+) acuity tool on Labour Ward and use the antenatal and postnatal BR+ acuity tool on John Macpherson Ward, to provide a more accurate reflection of the acuity within the service.

Table 2: Midwife to Birth ratio (exc. DOM, Deputy DOM, Matrons and Specialist roles)

Time period	Midwife: Birth Ratio
Jul 25	1:17
Aug 25	1:16
Sep 25	1:19
Oct 25	1:17
Nov 25	1:17
Dec 25	1:18

3.4.2 Nationally Mandated Workforce Models across Maternity Pathway

TSDFT continues to provide a fully integrated maternity service. Compliance with Midwifery Continuity of Carer (MCoC) is recorded monthly, but there are currently no national trajectories for this.

The establishment within most of the community midwifery teams has increased over the reporting period and most teams are close to being fully established, which further supports the Continuity of Carer aims.

We are now part of Maternity and Neonatal Improvement Support Programme (MatNeolST) through NHS England, as are all the Maternity Services within Devon. The diagnostic report that has been published includes findings and recommendations around the requirements for the perinatal workforce and work is underway to progress these.

4.0 Women receiving one-to-one care in labour

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

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

Time period	%
Jul 25	100%
Aug 25	100%
Sep 25	100%
Oct 25	100%
Nov 25	98.6%
Dec 25	100%

The maternity service works extremely hard to ensure this standard is met and in the six-month reporting period this remained at 100% other than one month where this was achieved 98.6% of the time, this is a very rare exception.

5.0 Obstetric, Neonatal Medical & Neonatal Nursing Workforce

5.1 Obstetric workforce:

There has been a slightly improving picture regarding the capacity of the obstetric workforce during this reporting period. A required uplift was noted as part of the November 2023 CQC maternity inspection and the requirement to ensure sufficient medical staffing is a CQC ‘Must Do’ action. A full-service review around capacity and workforce within the speciality was concluded in October 2023, resulting in a recommendation for an uplift of 4.0wte consultants, a business case was written, and the Trust Executive approved an uplift of 2.0wte. These posts have now been recruited to; one consultant started in February 2025 and the other in March 2025. Further approval has been received to recruit to an additional 1.0wte equivalent consultant post (in addition to a 1.0wte replacement post) and it is planned that these posts will be advertised early in 2026. Ongoing workforce requirements remain in remuneration and

protected time to complete obstetric leadership roles. This will be included in business planning for 26/27 as well as through a perinatal workforce strategy.

5.2 Neonatal medical workforce:

The neonatal medical workforce does meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing. Examples of rotas have been provided which confirm this and will be used as part of the evidence that will be submitted for CNST.

5.3 Neonatal nursing workforce:

There are defined service specifications for neonatal nursing requirements as outlined by the British Association of Perinatal Medicine (BAPM) and NHSE Service Specification for Neonatal Critical Care (2024). Without a Qualified in Speciality (QIS) nurse on shift, the neonatal unit would have to declare a temporary inability to accept babies, and maternity services would not be able to provide facilities for women in labour/birth activity during that period. Women in labour or those who may labour would need to be diverted to an alternative unit. The Maternity Services Escalation policy is in place and describes the necessary actions that would be taken in this instance. During this reporting period, there have not been any instances where the unit has not been able to accept internal admissions due to staffing constraints.

Quarterly neonatal network workforce returns continue to be completed and submitted to the network for review and form part of a network response to NHSE regarding regional workforce and establishment. Once Q4 return has been submitted, further analysis can be undertaken to look at activity and acuity against the existing workforce establishment.

5.3.1 Workforce analysis:

Although there have continued to be challenges within this reporting period regarding the continued vulnerability in ensuring optimum staffing levels. There has been an improvement in the neonatal nursing workforce trajectory as detailed in 5.4.2; to note there has been some successful recruitment of band 5 nurses which is providing a pipeline of candidates to complete QIS training. Whilst there is an established regional educational pathway to support this training, the timeline for completion and consolidation is around two to two and a half years meaning there will still be some workforce resilience challenges in the short term. The contributory factors to the workforce gaps are a combination of retirement, long-term sickness, maternity leave, vacancies and short notice absence.

Currently the workforce structure is under review, recognising the limited workforce planning that had historically been in place, to ensure it meets the needs of the service now and in the future. A case for change, outlining rationale: the increasing acuity and complexity that the service experiences and the need for resilience and responsiveness with a proposal to address this, has been drafted. This has been reviewed with the Care Group Senior Leadership team and agreement given to progress.

The issues highlighted in relation to the neonatal workforce are also reflective of the challenges being experienced both at regional network and national level.

5.3.2 Neonatal Nursing Action Plan:

- The action plan will be presented to the Trust Board as part of the Maternity Incentive Scheme (CNST) requirements and shared with the ODN and ICB.
- This action plan will be monitored through the monthly SCBU Quality & Safety meeting, and progress will be reported through paediatric governance for oversight.

Neonatal Workforce Action Plan						
Date	Action	Owner	Target	Status	Update inc date	Update inc date
01/11/2025	Review of existing establishment structure to ensure it meets service needs now and for the future.	ADNPP/Matron/Unit Manager	01/07/2026	In progress	1: Case for change consultation paper written with approval from Care Group. 2: Engagement with Strategic People Partner to support process 3: Formulation of Band 3 Neonatal HCSW Job description in progress. (05/03/26)	
20/12/2025	Recruitment - Seek support from attraction and recruitment team to bolster current strategy	Matron/Unit Manager	30/04/2026	In progress	1: Reviewing unit structure and recruitment team roles to discuss options 2: Adverts updated to reflect the unit culture and be more enticing 3: Explored options and costings for advert in RCNi for QIS 4: Commenced to University programme leads to encourage soon to qualify nurses to apply for B5 vacancy (05/03/26)	
31/12/2025	Approval for time limited incentive payment for substantive staff covering additional duties to provide short term resilience for safe staffing numbers	ADNPP/Matron	30/01/2026	Completed	1: Paper outlining challenges and costings prepared and shared with Chief Nurse 2: Approval from CNO and Finance until 31/03/26 (05/03/2026)	
01/03/2026	QIS pipeline - ongoing development of Neonatal Nurses	Matron/Unit Manager	Ongoing	In progress	1: 2x Band 5 progressing with training on 25/26 QIS training cohort - due to complete summer 2026 2: Further 2x Band 5 to be supported to attend 26/27 cohort 3: Recent recruitment of Band 5 - expectation to commence following completion of NFP.	
01/03/2026	Ongoing Mitigation for short notice absence/vacancy/ long term sicknesses ensure unit is operational	Matron/Unit Manager	Ongoing	In progress	1: Use of QIS bank staff on NHSP 2: Practice Educator is currently in the clinical numbers 3: ENWP and Unit Manager cover on ad hoc basis (05/03/26)	
05/03/2026	Leadership development of team to support career development, retention and succession planning	Matron/Unit Manager	31/12/2026	Not started	Link to MNWP Culture & Leadership workshop action	
				Not started		
				Not started		
				Not started		

5.4 Anaesthetic Workforce:

Safety action 4 of the maternity incentive scheme states that evidence must be provided which demonstrates that a duty anaesthetist is immediately available 24 hours a day for the obstetric unit and should always have clear lines of communication to the supervising anaesthetic consultant. If the duty anaesthetist has other responsibilities, then they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

The following demonstrates compliance with this standard by month.

	July 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25
% compliance	100%	100%	100%	100%	100%	100%

6.0 Maternity Red flags

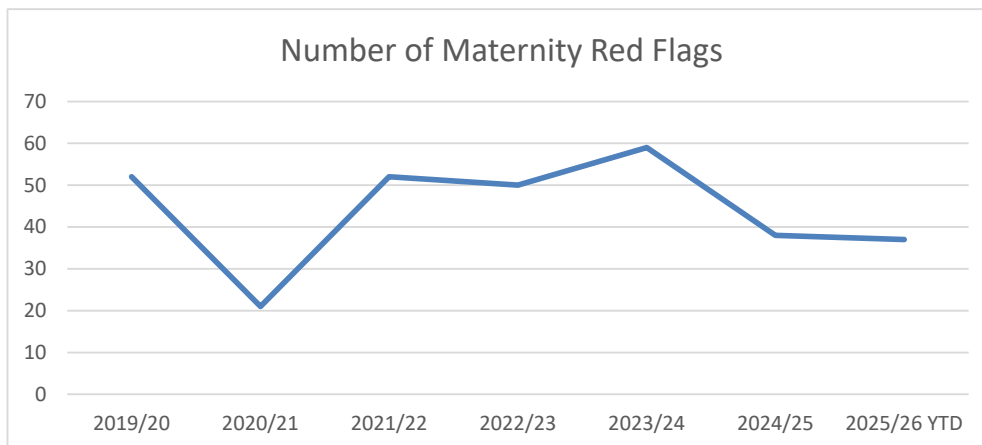
NICE guidance identifies several events that can be viewed as red flags. These indicate that there may not be enough midwives available to meet the acuity demand. 9 red flag events were identified by NICE, whilst locally we have added a further flag (denoted with an *):

Red flag events and actions taken in response to these are captured using the Birthrate Plus ® Acuity Tool. The midwifery red flags for the reporting period are detailed in Table 3 below

Table 3

Red flag	Description	Incidence						Tot
		Jul	Aug	Sept	Oct	Nov	Dec	
RF1	Delayed or cancelled time critical activity	0	0	0	1	0	1	2
RF2	Missed or delayed care	1	0	0	0	3	1	5
RF3	Missed medication	0	0	0	0	0	0	0
RF4	Delay in providing pain relief	0	0	0	0	0	0	0
RF5	Delay between presentation and assessment	0	0	0	0	2	0	2
RF6	Full clinical examination not carried out when presentation in labour	0	0	0	0	0	0	0
RF7	Delay of ≥2 hours between admission for induction of labour and beginning of process	2	0	4	3	2	4	15
RF8	Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0
RF9	1:2:1 care in labour	0	0	0	0	2	0	2
RF10*	Unable to facilitate out of hospital birth	0	3	1	1	1	2	8
RF11	Coordinator unable to maintain supernumerary status- providing 1:1 care in Labour	0	1	2	0	2	0	5
RF12	Coordinator unable to maintain supernumerary status - Not providing 1:1 care	1	3	2	2	4	1	13
	Totals	4	7	9	7	16	9	

Maternity Red Flags	Number
2019/20	52
2020/21	21
2021/22	52
2022/23	50
2023/24	59
2024/25	38
2025/26 YTD	37



From our analysis of the system, red flags continue to occur predominantly during periods of high acuity. Each red flag event is reviewed by the Maternity Matron and, where appropriate, discussed with the Labour Ward Coordinator using the same governance process applied to supernumerary status. This ensures that any deviation from expected care standards is scrutinised and addressed in real time.

All red flag instances within this reporting period were triggered intentionally as part of a proactive safety strategy. This approach reflects a conscious decision to prioritise safety across the maternity service, even when operational pressures are high.

Persistent Pressure on Induction of Labour (RF7)

- RF7 accounts for 15 incidents, making it the single largest **contributor** to red flags.
- These delays typically reflect:
 - Insufficient midwifery staffing to commence induction promptly.
 - High acuity on the labour ward diverting staff away from planned care.

Increasing Difficulty Maintaining Supernumerary Coordinator Status (RF11 & RF12)

- Combined, RF11 and RF12 contribute 18 incidents.
 - RF11 (Coordinator providing 1:1 care): 5
 - RF12 (Coordinator not providing 1:1 care): 13
- This is a significant safety signal:
 - Coordinators are pulled into direct care.
 - Loss of oversight increases risk of delayed escalation, reduced situational awareness, and compromised flow.

Much work has been undertaken to improve the resilience of this team with more planned. Challenges in maternity with short term acuity raises out of hours are difficult to negotiate with a smaller workforce and without an on-call system of staffing escalation.

Rising Incidents in November

- November shows the highest monthly total (16).
- Drivers:
 - Increased acuity and activity.
 - Sickness absence.

Out-of-Hospital Birth Capacity (RF10)

- 8 incidents where the service was unable to facilitate out-of-hospital birth.
- This reflects:
 - Acute staffing shortages preventing safe deployment of integrated midwives away from Labour Ward.
 - Impact on service user choice and experience.
- Repeated inability to offer this pathway may affect public confidence and requires strategic workforce planning.

Missed or Delayed Care (RF2)

- 5 incidents recorded.
- While not the highest category, this is a core safety concern and often correlates with competing clinical priorities.

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

There is a national safety recommendation that all Labour Wards have a supernumerary Labour Ward Coordinator (LWC) on duty 24 hours a day. This specialist role ensures that a clinical expert is available to oversee safety within the department, provide support, advice, and clinical interventions as needed.

Our maternity staffing and escalation framework sets out that the LWC must remain in a supernumerary role. All instances where the LWC has not been working in a supernumerary capacity are recorded via the Birthrate Plus® acuity tool.

The ongoing ambition remains to achieve 100% supernumerary status for Labour Ward Co-ordinators. Table 3 (above) demonstrates our compliance with this ambition for the period July to December 2025.

From March 2023, an additional red flag was introduced (RF12) to monitor compliance with supernumerary status when the Co-ordinator is caring for women who do not require constant observation (e.g., when relieving for breaks). This should not occur on a regular or recurrent basis. During the current six-month reporting period, 13 instances of this red flag were recorded. While this is higher than the previous period, it remains within expected parameters given the size and complexity of the service. The increase reflects temporary pressures in staffing from short term increases in acuity. The unpredictability of workload in an acute maternity setting means complete elimination of these occurrences is unlikely.

Additionally, **RF11 – Coordinator unable to maintain supernumerary status while providing 1:1 care** was triggered five times during this period. This reflects rare but necessary decisions made during high acuity to ensure safe care delivery.

The service continues to operate a robust escalation plan with clearly defined actions for the LWC to take during periods of high acuity or unexpected staff absence. The LWC providing direct care on Labour Ward remains one of the final steps in this escalation process, due to the safety-critical nature of maintaining a helicopter view of the maternity service. The LWC will return to supernumerary status at the earliest opportunity. During times of increased demand, specialist midwives and midwifery managers will work clinically to support the service and uphold safety standards.

The service has progressed the development competency framework for aspiring labour ward coordinators which enables experienced and competent band 6 midwives to take charge if required in the unexpected absence of the LWC.

7.0 Acuity Data

Acuity of the patients on Labour Ward is captured via acuity monitoring, available from the Birthrate Plus ® Acuity Tool. The acuity tool has now been introduced on John MacPherson, the mixed ante and post-natal ward, this is utilised to assist in the safe allocation of staff across the maternity service.

Chart 2: Staffing v Workload Example

The chart below indicates the number of occasions in this reporting period where staffing met the acuity level, this is indicated in green. Red and amber indicate that staffing levels were not met.

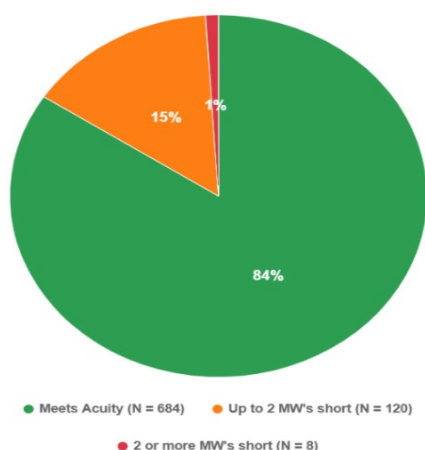
The data for this period indicates that on labour ward staffing levels were classified as red <1% of the time during the reporting period (a red classification indicates that staffing was more than 2 midwives short) and that 11% of the time staffing levels were up to 2 midwives short (Amber). Therefore, staffing levels met the acuity levels 88% of the time.

On John Macpherson Ward staffing levels were red 18% of the time and staffing levels met the acuity levels 82% of the time.

Staffing levels met acuity (Chart 2)

Labour Ward July – December 2025

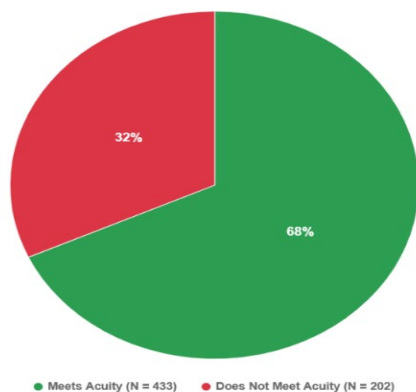
Acuity Summary
01/07/2025 to 31/12/2025



*The % is rounded to nearest whole number

John MacPherson, July – December 2025

Acuity Summary
01/07/2025 to 31/12/2025



*The % is rounded to nearest whole number

Staffing levels across the service met with acuity levels on most occasions (over 80% on Labour Ward and 60% on John MacPherson). On John MacPherson the majority of occasions where acuity exceeds staffing are due to staffing levels being one staff member short. The data and staffing pattern has been analysed and shows that most pressure occurs out of hours when staffing reduces whereas 'in hours' staffing often exceeds acuity. Maternity managers and ward managers are trialling the redeployment of existing staff members from a day shift to a night, it is anticipated that this will approve the staffing vs acuity data on John MacPherson.

When staffing falls short of acuity the service considers operational safety and deploys available staff to the most appropriate location to maintain safety. Almost all staff are multi-skilled and able to work across locations in maternity.

Whilst labour ward acuity data reflects short, high-intensity intrapartum care episodes, mixed antenatal/postnatal ward data captures a broader spectrum of care needs over longer stays. Acuity on these wards is driven by the combined dependency of mother and baby, antenatal monitoring requirements, and postnatal recovery — often with overlapping needs. This results in different patterns of workload, skill mix requirements, and bed utilisation, meaning direct comparison with labour ward data is not appropriate without adjustment for case mix and care model : -

1. **Acuity scores are not directly comparable**

A “high acuity” shift on a mixed ward may reflect sustained moderate needs across many patients rather than a small number of intense intrapartum cases.

2. **Staffing ratios differ**

Labour ward ratios are based on one-to-one care in labour; mixed ward ratios must account for aggregate care hours across AN and PN categories, plus neonatal needs.

3. **Bed occupancy and turnover patterns**

Mixed wards may appear “less acute” in headline scores but can be operationally busier due to constant admissions/discharges, multiple care pathways, and dual mother–baby dependency.

4. **Skill mix planning**

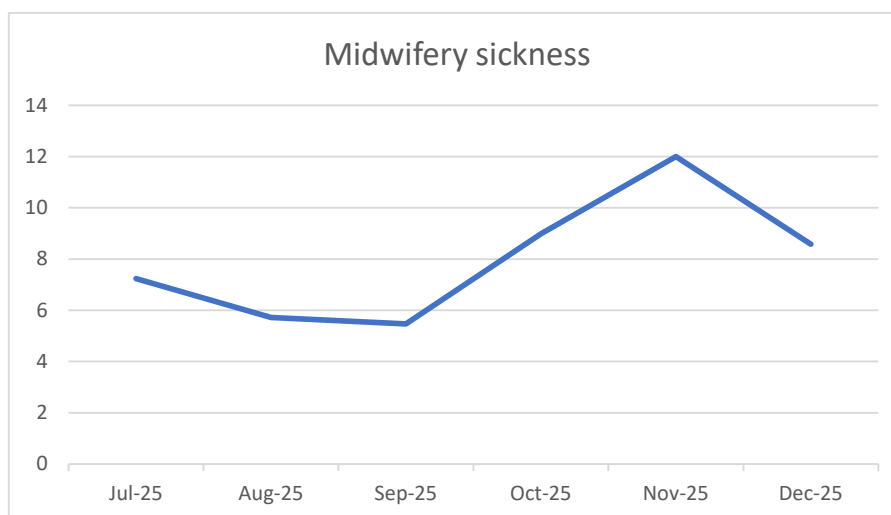
Data should inform not just numbers of staff but the type — e.g. postnatal breastfeeding support, antenatal monitoring expertise, neonatal care skills

Within the reporting period staffing met acuity levels most of the time. Regularly (monthly) there are short periods where staffing cannot meet the acuity needs.

8.0 Sickness

There has been an increase in sickness rates within maternity in this reporting period. This is the first increase in the last 4 reporting periods. This rise was first evident in October 2025 and peaked in November 2025 further investigation has shown that there were a significant number of staff on long term sickness during this period that was not linked to work related issues.

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

Chart 4: Midwifery Sickness Percentage

9.0 Escalation and Interventions to Assure Safety

There are ongoing challenges in relation to determining an appropriate model for midwifery escalation. This is a common issue in maternity services across the country, and, at present, there is no clear resolution that can be found for this issue. There are plans to review the escalation rota after consultation with the other maternity services within the ICS and region. In the interim, the senior leadership team continue to provide mitigation and support in times of high acuity to ensure there remains safe cover and proportionate work life balance for our teams.

10.0 Conclusion

There is an improving picture in terms of the Consultant workforce in Obstetrics & Gynaecology, following support from the Board to recruit to additional and replacement posts.

There is also a significant fall in the vacancy rate for registered maternity staff within this reporting period, leaving a vacancy rate of just 2.25wte in December 2025. This evidences the positive feedback that the maternity service has received, via NHS England, from the midwifery students working within the service who have demonstrated a strong desire to secure a post within TSDFT's Maternity Services. The falling vacancy rate also demonstrates the service's attraction to external candidates.

The senior professional leadership team will continue to work with workforce and the finance team to ensure we strengthen, and triangulate service-held maternity establishment data to ensure accuracy of funded establishment.

The finalised workplace establishment review report has been received with a recommendation for an uplift in registered maternity staff of 3.81wte, this currently remains with the Board for their consideration.

Workforce recommendations form part of the MSSP diagnostics report that was published in early 2025. These recommendations have been shared as part of a full

overview report of the diagnostic process and form part of the exit criteria needed to be achieved to exit the support programme.

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

11.0 Assurance and Recommendations

Overall, there is a satisfactory level of assurance around the maternity and neonatal workforce metrics. This assurance level relates to the improvement within the Obstetric and Gynaecology Consultant workforce and the falling vacancy rate within the Midwifery staffing levels. There is also satisfactory assurance in relation to the reduced ratio of QIS (Qualified in Speciality) nurses within SCBU due to the impact such ratios can have on the ability to staff the unit at optimal levels as well as impacting on the maternity service.

The Committee is requested to:

- Note the mitigations taken within the maternity service to ensure safety and quality.
- Note the ongoing service requirements of the Obstetrics and Gynaecology team.
- Note the rise in sickness rates within maternity staff and the mitigations taken to address this.
- Note the significant fall in vacancy rate for midwifery staff within this reporting period
- Note the ongoing action plan to address the challenges in relation to QIS nurses in SCBU.
- Note that workforce recommendations form part of the recommendations of the MSSP report.

The committee is asked to receive and note this paper.

The Committee are asked to agree the recommended assurance rating and take **SATISFACTORY** assurance for point 5.1 and 5.3.



Quality and People Committee

Health inequalities report

Date of meeting	Date report produced
28 April 2026	21 April 2026

Author(s)		Report approved by	
Name and title:	Helen Davies-Cox, Head of Personalised Care	Name and title:	Nicola McMinn, Chief Nurse
	Andy Simpson, Public Health and Personalised Care Manager		

Date: 21 April 2026

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

Executive summary
Reducing health inequalities is a key priority for the NHS and a statutory responsibility for NHS Foundation Trusts under the Health and Care Act 2022. NHS England has also introduced new expectations through the Statement on Information on Health Inequalities (November 2025), which requires NHS organisations to demonstrate how they identify, monitor and address inequalities in access, experience and outcomes. This report provides an update on the Trust’s progress in establishing a framework to support the identification and monitoring of health inequalities across its services. During the past year the Trust has begun to develop the governance structures and analytical framework required to support this work, including the establishment of the Health Equity Enabling Group and the development of an initial set of Key Lines of Enquiry (KLOEs) to guide organisational oversight. The Trust has also begun developing an inequalities reporting framework which will enable the routine monitoring of inequalities across key service areas including elective care, outpatient services, non-elective admissions and cancer pathways. This work is intended to ensure that the Trust is able to meet NHS England reporting requirements while also strengthening the organisation’s ability to identify areas where inequalities in access or outcomes may exist.

While good progress has been made in establishing the organisational framework for this work, the programme remains at an early stage of maturity. Further development is required to strengthen the availability of inequalities intelligence, improve the completeness of demographic data, and embed inequalities analysis within routine operational and clinical governance processes.

Evidence shows that people living in the most deprived communities experience poorer health outcomes and face greater barriers to accessing healthcare. Strengthening the Trust's understanding of these inequalities will support the organisation to design services that are more equitable and responsive to the needs of all communities.

While governance arrangements and an initial reporting framework have now been established, the Trust's health inequalities programme remains at an early stage of maturity. Further work is required to strengthen demographic data quality, analytical capability and routine inequalities reporting. For this reason it is proposed that the Committee take LIMITED assurance at this stage, with the expectation that assurance will strengthen as the framework becomes embedded during 2026/27.

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
NHS England mandated reporting	Limited	N/A
Key Lines of Enquiry	Limited	N/A
Suggested reporting	Limited	N/A

Appendices

Appendix 1. Health Inequalities Key Lines of Enquiry (KLOEs)
 Appendix 2. Proposed Inequalities Reporting Indicators
 Appendix 3. Data Quality Position
 Appendix 4 – Governance Structure
 Appendix 5 – NHS England Requirements Mapping
Included in the Quality and People Committee Items for Information pack

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

This report has been presented to the Health Equity Enabling Group and SQAG

Key recommendations and actions requested

The Committee are asked to AGREE the overarching assurance rating and take LIMITED assurance as to those matters reviewed.

How does this report further our Trust strategy?

Supporting health inequalities aligns closely with Trust strategy, recognising the widening health gaps faced by the most deprived communities. This report shows commitment to reducing inequity through personalised, preventative and integrated care.

NHS England has an expectation that providers use high-quality, disaggregated data to understand population needs, tackle unwarranted variation and target interventions toward Core20PLUS5 groups. By embedding health inequalities insight into planning, governance and service redesign, we can ensure that our focus is on prevention, early intervention and community wellbeing, and that this is underpinned by evidence; enabling us to improve access, outcomes and experiences for those who need it most.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Improves outcomes for marginalised and vulnerable individuals.
Quality of services provided	Improves the experience of care
Sustainable and efficient use of resources	

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Reducing recognised health inequalities, improving access, experience and outcomes for patients and service users.
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	Use high-quality, disaggregated data to understand population needs, tackle unwarranted variation and target interventions toward targeted populations.
Finance	

Risk

Primary Risks

- Failure to meet statutory inequalities reporting requirements due to limited data availability and infrastructure.
- Inability to provide complete and reliable analysis due to demographic data quality issues.

- Delayed operational change because health inequalities intelligence is not systematically used in pathway redesign.

Mitigations

- Establishment of the Health Equity Enabling Group with defined objectives
- Development of draft KLOEs and reporting metrics
- Engagement with BI to improve data quality and analytics
- Alignment with EPR programme to ensure capture of required demographic fields
- Strengthened governance routes for strategic and operational oversight

Residual Risk

Residual risk is still moderate until EPR implementation is complete, data quality improves, and reporting becomes routine.

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risks

NHSE statement on information on health inequalities
The Health and Care Act 2022
Equality Act 2010
National policy, guidance DAPB4019: Reasonable Adjustment Digital Flag

Health inequalities report

1. Introduction and background.

Health inequalities refer to the unfair and avoidable differences in health outcomes and access to healthcare experienced by different groups within the population. These differences are often associated with factors such as socioeconomic deprivation, ethnicity, disability, geography and other characteristics that influence an individual's ability to access healthcare services and achieve optimal health outcomes.



Addressing health inequalities is a key strategic priority for the NHS and is reflected within the NHS Long Term Plan, the Core20PLUS5 framework and the Health and Care Act 2022. The Act places duties on NHS organisations to consider the impact of their decisions on health inequalities and to take appropriate steps to reduce them.

In November 2025 NHS England published its Statement on Information on Health Inequalities. This sets out expectations for NHS organisations to develop robust arrangements for identifying, analysing and reporting health inequalities across their services. These arrangements should ensure that organisations are able to understand where inequalities exist and take appropriate action to address them.

The Trust's approach is aligned with the NHS England Core20PLUS5 framework, ensuring that the organisation focuses on reducing inequalities affecting the most deprived communities and other locally identified vulnerable population groups.

Within this context the Trust has begun to develop its organisational approach to health inequalities, with the aim of strengthening the use of population intelligence and ensuring that equity considerations are embedded within service delivery, improvement activity and strategic decision-making

2. Purpose of report

The purpose of this report is to provide assurance to the Quality and People Committee regarding the Trust's progress in establishing the governance arrangements, analytical capability and reporting framework required to meet NHS England's expectations in relation to health inequalities.

The report outlines the structures that have been established to oversee the Trust's health inequalities work, the development of Key Lines of Enquiry to guide organisational oversight, and the emerging reporting framework that will support the monitoring of inequalities across key services.

It also describes the next phase of work required to strengthen inequalities intelligence and embed this work more fully within operational and clinical governance processes.

3. Governance and Oversight Arrangements

To support this work the Trust has established the Health Equity Enabling Group, which provides strategic oversight and coordination of the Trust's health inequalities programme, which provides organisational leadership and coordination for the health inequalities programme. The group brings together colleagues from clinical services, quality improvement, information and equality and diversity functions in order to develop a coordinated approach to this agenda.

The Health Equity Enabling Group is responsible for overseeing the development of the Trust's health inequalities framework, including the establishment of reporting arrangements, the identification of priority areas for improvement and the development of the organisation's analytical capability in relation to inequalities.

Oversight of this work is provided through the Trust's existing governance structures. The Health Equity Enabling Group reports through the Safety and Quality Assurance Group, with escalation to the Quality and People Committee where appropriate. This ensures that health inequalities remain visible within the Trust's broader quality governance arrangements and that progress is subject to appropriate scrutiny.

Executive sponsorship for this programme is provided by the Chief Nurse, reflecting the importance of this work to the Trust's commitment to equitable and high-quality care.

4. Progress to Date

Since establishing the Trust's health inequalities programme, several foundational elements have been developed to support organisational oversight and reporting.

Key progress to date includes the establishment of the Health Equity Enabling Group, providing a dedicated forum for the coordination of the Trust's health inequalities work. Initial Key Lines of Enquiry (KLOEs) have also been developed to

support systematic oversight of inequalities across leadership, intelligence, access and outcomes.

Work has also begun to design a Trust-wide inequalities reporting framework, which will enable key services to analyse activity, access and outcomes across different population groups. Initial priority areas for reporting have been identified, including elective pathways, outpatient services, non-elective admissions and cancer services.

These developments represent an important first step in strengthening the Trust's ability to identify and monitor inequalities across its services.

5. Development of the Health Inequalities Framework

As part of the Trust's work to strengthen oversight of health inequalities, an initial set of organisational Key Lines of Enquiry has been developed. These KLOEs are designed to support systematic consideration of how the Trust identifies, monitors and responds to inequalities in access, experience and outcomes.

The KLOEs focus on several key areas including leadership and governance, the use of population intelligence, equitable access to services and the monitoring of patient experience and clinical outcomes across different population groups. Together these domains provide a framework through which the organisation can assess whether inequalities are being appropriately identified and addressed within clinical services.

Further work is underway to embed these KLOEs within existing governance processes and to ensure that they inform both operational performance discussions and quality improvement activity across the Trust.

6. Emerging Inequalities Reporting Framework

Alongside the development of the governance framework, the Trust has begun to develop an inequalities reporting framework that will allow key service areas to be monitored through an inequalities lens.

The intention is that this framework will enable the Trust to analyse activity, access and outcomes across different population groups using indicators such as deprivation, ethnicity and other relevant demographic characteristics.

Initial areas identified for analysis include elective waiting lists, outpatient activity, non-elective admissions and cancer pathways. These areas have been selected because of their scale, their relevance to national priorities and the potential for inequalities to arise in access or outcomes.

The development of this reporting framework will allow the Trust to strengthen its understanding of potential inequalities within these pathways and support more targeted improvement work where differences in access or outcomes are identified.

7. Current Challenges and Risks

While progress has been made in establishing the foundations for this work, several challenges remain. These primarily relate to the completeness of demographic data, the analytical capacity required to support inequalities reporting and the need to embed inequalities analysis within routine service governance.

The quality and completeness of demographic information within clinical systems remains variable, which limits the ability to undertake detailed analysis across all population groups. Work is therefore underway to improve data capture as part of the Trust's wider digital and information programmes, including the implementation of the new Electronic Patient Record.

In addition, the development of inequalities reporting requires dedicated analytical support from business intelligence teams. As the framework develops, the prioritisation of inequalities reporting within the BI work programme will be important to ensure that the necessary intelligence can be produced on a sustainable basis.

Finally, it will be important to ensure that inequalities insights are translated into practical service improvement activity. Continued engagement with clinical and operational teams will therefore be required to ensure that inequalities intelligence informs pathway redesign and quality improvement initiatives.

8. Next Steps

Over the coming year the Trust will continue to develop its health inequalities programme, with a particular focus on strengthening the availability and use of inequalities intelligence.

Priority areas of work will include improving the completeness of demographic data, developing a routine inequalities dashboard for organisational oversight, and supporting clinical services to use inequalities insights to inform quality improvement activity and pathway redesign.

Health inequalities improvement priorities 2026-27:

- Analyse waiting times and outcomes by deprivation, ethnicity, sex, and age.
- Target underserved communities: prioritise deprived, rural, and coastal areas to develop Neighbourhood Health Services: work with ICS partners to embed multidisciplinary teams in local hubs.
- Strengthen prevention: expand programmes tackling smoking, obesity, alcohol, in high-prevalence groups.
- Embed equity in planning: co-design pathways with disadvantaged communities.
- Align with ICS priorities: function as a key partner in system initiatives such as the South Local Care Partnership Strategy and Torbay's *Turning the Tide on Poverty*.

This work will enable the Trust to move beyond establishing governance structures and begin to demonstrate how inequalities analysis informs service development and operational decision-making.

9. Assurance, Recommendations and Summary

The Trust has made progress in establishing the foundations required to support the identification and monitoring of health inequalities. Governance arrangements have been established, an initial framework for oversight has been developed and work is underway to create a reporting structure that will allow inequalities to be monitored across key service areas.

However, this work remains at an early stage of development and further work is required to strengthen the availability of inequalities intelligence and embed this work within operational governance and service improvement processes.

It is recommended that, noting the information contained within this report and recognising that the Trust's health inequalities framework is at an early stage of development, the Committee agree the proposed overarching assurance rating and take LIMITED assurance in relation to the matters reviewed.

The Committee is asked to:

1. NOTE the update on progress against NHS England's Statement on Information on Health Inequalities.
2. ENDORSE the proposed Health Inequalities reporting framework and associated Key Lines of Enquiry (KLOEs).
3. AGREE the overarching assurance rating of LIMITED assurance for inclusion within the Trust's governance framework and Annual Report.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
NHS England mandated reporting	Limited	N/A
Key Lines of Enquiry	Limited	N/A
Suggested reporting	Limited	N/A



Quality and People Committee

WRES, WDES, Equality Objectives and Action Plans

Date of meeting	Date report produced
28 April 2026	22 April 2026

Author(s)		Report approved by	
Name and title:	Sharifa Milford Al Hashemy, Joint Head of Inclusion, Diversity and Equity	Name and title:	Jess Piper Chief People Officer

Date: 23 April 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 presents the 2026 Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Equality Objectives and Action Plans for Torbay and South Devon NHS Foundation Trust (TSDFT). The report draws on data from the period 1 April 2025 to 31 March 2026, including ESR workforce data snapshots and the 2025 NHS Staff Survey. The WRES findings indicate that whilst there have been some modest improvements, significant disparities persist for Global Majority staff. White candidates remain 2.77 times more likely to be appointed from shortlisting than Global Majority candidates. Global Majority staff continue to report higher levels of discrimination, harassment and abuse, and are considerably less likely to believe the organisation provides equal opportunities for career progression. Board-level representation of Global Majority staff (6.67%) remains well below the workforce proportion (12.8%). The WDES findings show persistent inequalities for Disabled staff. Disabled staff are nearly three times more likely to enter the formal capability process. They consistently report higher rates of bullying, harassment and abuse from managers, colleagues and patients/public, are significantly less likely to believe the organisation provides equal opportunities for career progression, and report lower levels of feeling valued. No Disabled individuals are represented at executive board level.

The Equality Objectives and actions plans correspond to the organisational data and aligns to national frameworks such as the High Impact Action Plan and Equality Delivery System. It was agreed in previous committees that a single action plan is proposed which aligns to equality reporting (pay gap reporting, WRES and WDES) alongside organisational cultural priorities (Culture Plan) and national frameworks (HIA) is proposed. The proposed Equality objectives and 12-month priorities have been designed to respond to these.

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
WRES	Limited	↓ Improving marginally
WDES	Limited	→ Stable with persistent disparities
Equality Objectives and Action Plans	Satisfactory	↑ Progressing

Appendices

Appendix 1: WRES Report 2026 | Appendix 2: WDES Report 2026 | Appendix 3: High Impact Action Plan and Equality Objectives (TSDFT Diversity & Inclusion Framework, April 2026)

Included in the Quality and People Committee Items for Information Pack

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

This report has not been considered by other committees prior to this meeting. The WRES and WDES reports are submitted annually to NHS England and are presented directly to the Quality and People Committee followed by Board. The papers will be shared with the Inclusion Steering Committee.

Key recommendations and actions requested

The Quality and People Committee is asked to: (1) Note the findings of the 2026 WRES and WDES reports and the persistent disparities identified for Global Majority and Disabled staff. (2) Approve the Equality Objectives and action plan priorities for 2026/27 as set out in the TSDFT Diversity & Inclusion Framework. (3) Support the recommended focus areas for 2026/27 including: development of staff networks, embedding of the Restorative Just and Learning Culture approach, equitable senior/executive recruitment processes, and talent development opportunities for underrepresented groups. (4) Note that WRES and WDES submissions will be submitted to NHS England by the required deadline.

How does this report further our Trust strategy?

This report directly supports the Trust's People and Culture strategic priority and the commitment to being an inclusive employer. The WRES, WDES and Equality Objectives are aligned to the TSDFT Diversity & Inclusion Framework and its four

priorities: creating a culture that fosters belonging, building a diverse leadership team, accelerating progression of underrepresented talent, and reducing health inequalities for local communities. The equality objectives also connect to the national High Impact Action Plan and Equality Delivery System (EDS).

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Reducing health inequalities for patients and local communities is one of the four inclusion equality objectives. Addressing discrimination and inequity experienced by staff from underrepresented groups supports a healthier, more engaged workforce.
Quality of services provided	A diverse and inclusive workforce improves decision-making and care quality. Addressing staff experience of discrimination and bullying supports psychological safety and reduces errors.
Sustainable and efficient use of resources	Improving staff retention and reducing turnover among Global Majority and Disabled staff through equitable recruitment, progression and experience supports a sustainable workforce and reduces the cost of recruitment and sickness absence.

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Staff experience directly impacts on quality of care and patient safety. Inclusive workplaces support staff wellbeing and reduce errors. Reducing health inequalities for patients is an explicit equality objective.
Leadership and Governance	Low Global Majority and Disabled representation at Board and senior levels impacts governance effectiveness and decision-making. Equitable leadership pipelines are a priority objective.
Performance	WRES and WDES are mandated NHS England performance metrics. Progress against indicators is tracked nationally and informs regulatory assessments.
People and Culture	High direct impact. WRES, WDES and equality objectives are central to the Trust's People and Culture strategy, including staff

	experience, belonging, progression and inclusion priorities.
Strategy and Business Intelligence	Equality reporting data and workforce demographics inform the Trust's strategic planning, talent pipeline decisions and organisation-wide improvement programmes.
Finance	Indirect impact. Improved staff retention and reduced turnover among underrepresented groups has positive financial implications for the Trust.

Risk

Failure to address persistent disparities in the experience of Global Majority and Disabled staff carries reputational, regulatory and workforce risk. Non-compliance with WRES and WDES reporting requirements would represent a breach of NHS England mandated standards. The data indicates continued risk to staff experience, retention and wellbeing, particularly for those from underrepresented groups.

Risks lodged on Datix:

No specific Datix risks currently lodged in relation to WRES/WDES. The action plans arising from these reports will be monitored through the Inclusion Steering Group reported to the Quality and People Committee.

External Standards affected by this report and associated risks

NHS England WRES and WDES mandatory reporting requirements. Equality Act 2010 (Public Sector Equality Duty). NHS People Plan 2020/21. NHS Equality Delivery System (EDS). National High Impact Action Plan for workforce race and disability equality. Failure to submit annual WRES and WDES returns to NHS England would constitute non-compliance with mandated reporting obligations.

WRES, WDES, Equality Objectives and Action Plans

1. Introduction and background

This report presents the annual returns for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for Torbay and South Devon NHS Foundation Trust (TSDFT), alongside the Trust's Equality Objectives and Action Plans for 2026/27. The WRES was first mandated in 2016 and the WDES in 2017. Both require NHS trusts to compile and submit standard national reports demonstrating findings and progress against indicators relating to the representation and experience of Global Majority and Disabled staff respectively. The data period for both submissions is 1 April 2025 to 31 March 2026, with workforce data taken as a snapshot from ESR on 31 March 2026. Staff survey data is drawn from the 2025 NHS Staff Survey. Bank staff are not included in either submission. As of 31 March 2026, the total Trust workforce stood at 7,390 staff, of whom 946 (12.8%) were

recorded as being from a Global Majority background and 546 (7.4%) were recorded as having a disability.

2. Purpose of report

This report is provided to the Quality and People Committee to enable the Committee to fulfil its oversight responsibilities in relation to workforce equality. The report provides: (1) an analysis of WRES and WDES data for the period 2025/26, including trends over three years; (2) identification of key issues and areas requiring action; and (3) the Trust's Equality Objectives and action planning priorities for 2026/27 as set out in the TSDFT Diversity & Inclusion Framework. The Committee is asked to receive assurance that the Trust has completed its mandatory reporting obligations and to approve the proposed equality objectives and action plan priorities for the year ahead.

3. Workforce Race Equality Standard (WRES) 2026

The WRES requires NHS trusts to report annually against nine indicators covering workforce representation, recruitment, disciplinary processes, training access, staff experience and Board composition. The key findings for 2025/26 are summarised below.

4. WRES Key Findings 2025/26

As of 31 March 2026, Global Majority staff represent 12.8% of the total workforce (946 of 7,390), an increase from 11.26% in the previous year. Global Majority staff are underrepresented in senior non-clinical roles, with 0% representation at Bands 8c to VSM. In Medical and Dental grades, Global Majority representation is highest among trainees (36.1%) but falls sharply at consultant level (17.1%). White candidates are 2.77 times more likely to be appointed from shortlisting than Global Majority candidates, a persistent and concerning disparity. The relative likelihood of Global Majority staff entering formal disciplinary processes is lower than for White staff (0.56), though small numbers require cautious interpretation. Global Majority staff are slightly more likely than White staff to access non-mandatory training and CPD (97.15% vs 90.37%). Staff survey data shows improvements in some indicators: the gap in harassment from patients narrowed significantly by 2025, driven by a sharper decrease for Global Majority staff (29.1% in 2023 to 22.2% in 2025). However, Global Majority staff continue to report higher rates of discrimination from colleagues (15.7% vs 7.4% for White staff) and remain significantly less likely to believe the organisation provides equal opportunities for career progression (47.6% vs 53.0%). Board-level Global Majority representation at 6.67% remains well below the workforce proportion of 12.8%.

5. Workforce Disability Equality Standard (WDES) 2026

As of 31 March 2026, 546 staff (7.4% of the workforce) are recorded as having a disability on ESR, an increase from 6.39% the previous year. Disabled representation is broadly consistent across non-clinical and clinical band clusters, but falls notably at Medical and Dental grades (2.1% total). The likelihood of appointment from shortlisting is effectively equal between Disabled and non-Disabled candidates (14.76% vs 14.79%), a positive finding. However, Disabled staff

are nearly three times more likely to enter the formal capability process than non-Disabled staff (0.37% vs 0.12%), a significant disparity requiring attention. Staff survey data reveals persistent and in some areas widening inequalities. Disabled staff report higher rates of harassment and bullying from patients (27.9% vs 19.2%), managers (16.3% vs 8.2%) and colleagues (22.9% vs 15.4%). Disabled staff are less likely to believe the organisation provides equal career opportunities (45.3% vs 54.9%), feel more pressured to work when unwell (25.1% vs 17.4%), and are less satisfied that their work is valued (32.6% vs 43.6%). Reasonable adjustment implementation is positive at 76.3%, though there may be inconsistency. Engagement scores show a small but stable gap between Disabled (6.31) and non-Disabled (6.83) staff. At executive board level, no Disabled individuals are represented.

6. Assurance recommendations and summary

This report also presents the Trust's Equality Objectives and Action Plans for 2026/27, as set out in the TSDFT Diversity & Inclusion Framework. The four equality priorities are: (1) Create a culture that fosters belonging; (2) Build a diverse leadership team; (3) Accelerate progression of underrepresented talent; and (4) Reduce health inequalities for local communities. These objectives are directly informed by WRES and WDES findings and align to the national High Impact Action Plan and Equality Delivery System. For 2026/27 the Trust will focus on: continuing to develop staff networks as safe spaces for staff voice; embedding the Restorative Just and Learning Culture approach; ensuring equitable senior and executive recruitment processes; and creating talent development opportunities for underrepresented groups. The equality objectives will be shared across RDUH and TSDFT to maximise alignment and impact from shared resources.

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
WRES	Limited	↓ Improving marginally
WDES	Limited	→ Stable with persistent disparities
Equality Objectives and Action Plans	Satisfactory	↑ Progressing

The Committee is asked to note the assurance ratings above and to approve the action plan priorities for 2026/27. Progress against WRES and WDES indicators will be reported to the Quality and People Committee on an annual basis.

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

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

Board of Directors

Directors' Register of Interests

Date of meeting	Date report produced
7 th May 2026	28 th April 2026

Author(s)		Report approved by	
Name and title:	Sarah Fox Corporate Governance Manager	Name and title:	Cath Parnell Chief of Staff
		Date:	30/04/2026

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 this report is to provide assurance that the Fit and Proper Person Regulation (FPPR) is being applied correctly in respect of the Trust's director appointments. As part of this process Board Directors are asked to review and confirm any Interests they hold and that are contained on the Register of Directors' Interests. This process has been completed and a register attached which details those interests. 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

Register of Directors' Interests

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

Audit and Risk 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.

How does this report further our Strategy

It is important that the suitability and probity attached to director's appointments is reviewed on a regular basis to ensure the Trust's directors continue to adhere to the fit and proper persons regulations and there are no conflicts attached to their decision-making.

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	

REGISTER OF BOARD OF DIRECTORS' INTERESTS AS AT 21 APRIL 2026

This register lists the declared interests of the Chairman, Non-Executive, Executive and Associate Directors of Torbay and South Devon NHS Foundation Trust that are relevant and material to the Foundation Trust.

Name	Position	Directorship, including non-executive directorship held in private companies or PLCs (with the exception of those of dormant companies)	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely, or possibly seeking, to do business with the NHS	A position of authority in a charity or voluntary body in the field of health and social care	Any connection with a voluntary or other body contracting for NHS services	Any other matter which may result in a conflict of interest
NON-EXECUTIVE DIRECTORS							
Christopher Balch	Chair	-	-	-	Board Member LiveWest Housing Association	-	Trustee/Vice-chair, SW Lakes Trust Emeritus Professor of Planning, University of Plymouth Member Royal Town Planning Institute
Martin Beaman	Non-Executive Director	-	-	-	-	-	-
Liz Edwards-Smith	Non-Executive Director	Director, Evalesco Consulting Director, Plymouth Citizen's Advice Bureaux	-	-	-	-	Trustee, Citizen's Advice Plymouth
Ashish Ghadiali	Non-Executive Director	Director, Radical Ecology CIC Director Peregrine Pictures Ltd Director, Newlyn Art Gallery Ltd	-	-	-	-	Chair, Newlyn Art Gallery Climate Task Force Member, Devon County Council Chair, Steering Committee, Early Career Researchers

							in Cultural and Heritage Institutions Arts and Humanities Research Council Co-opted member, Exeter and North Devon Colleges Group
Mark Greaves	Non-Executive Director	NED Chair, Delt Shared Services Chair PFK (UKI) Ltd Delt Trading Ltd	-	-	-	Spouse is non-medical partner, Rame Group (GP practice) Spouse is Director, Kernow Health East Ltd	Governor and Chair of Finance and Estates Committee, Arts University Plymouth SDH Developments
Paul Richards	Non-Executive Director and Senior Independent Director	Director, Becky Falls Ancient Woodland Park Limited	-	-	-	Crown Representative for Cabinet Office	-
Chris Saxby	Non-Executive Director		-	-	-	-	Governor and Vice-Chair, and Chair of Audit and Risk Committee, City College Plymouth
Robert Williams	Non-Executive Director	-	-	-	Trustee, Devon Community Foundation	-	-
EXECUTIVE AND ASSOCIATE DIRECTORS							
Joe Teape	Chief Executive	-	-	-	-	-	Director, TSD Subsidiary
James Corrigan	Chief Finance Officer	-	-	-	-	-	Director, TSD Subsidiary
Adel Jones	Chief Operating Officer	-	-	-	-	-	-
Kate Lissett	Chief Medical Officer	-	-	-	-	-	Director, SDH Developments Ltd
Emily Long	Director of Corporate Governance & Trust Secretary	-	-	-	-	-	-
Nicola McMinn	Chief Nurse	-	-	-	-	-	-
Jess Piper	Chief People Officer	-	-	-	-	-	

Simon Tapley	Chief Strategy and Planning Officer	-	-	-	-	-	-

Workplan - Public Board of Directors 2026/27

	May	July	September	November	January	March
Preliminary matters						
	Apologies for Absence Quoracy and Declarations Minutes of the last meeting Chair's Welcome Chief Executive's Briefing BAF	Apologies for Absence Quoracy and Declarations Minutes of the last meeting Chair's Welcome Chief Executive's Briefing BAF	Apologies for Absence Quoracy and Declarations Minutes of the last meeting Chair's Welcome Chief Executive's Briefing BAF (full DRR)	Apologies for Absence Quoracy and Declarations Minutes of the last meeting Chair's Welcome Chief Executive's Briefing BAF	Apologies for Absence Quoracy and Declarations Minutes of the last meeting Chair's Welcome Chief Executive's Briefing BAF	Apologies for Absence Quoracy and Declarations Minutes of the last meeting Chair's Welcome Chief Executive's Briefing BAF (full DRR)
For Approval						
	Risk Management Strategy/Policy					Review of Board Workplan
For Review						
	Patient Story Our Plan for Better Care Strategy Operational Plan	Patient Story Our Plan for Better Care Workforce Plan	Patient Story Our Plan for Better Care	Patient Story Our Plan for Better Care	Patient Story Our Plan for Better Care	Patient Story Our Plan for Better Care
Reports from Board Sub Committees, Charity and Subsidiaries						
Audit						
Charity				Charity Committee Annual Report/video		
Finance and Performance	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status
Quality and People	Perinatal Quality and Safety Report Maternity Staff Bi-Annual Report WRES/WDES Health Inequalities	Perinatal Quality and Safety Report Mortality Scorecard Patient Safety/Learning from Deaths	Perinatal Quality and Safety Report Mortality Scorecard Patient Safety/Learning from Deaths Safer Staffing Infection Prevention and Control Annual Report	Perinatal Quality and Safety Report Maternity Staffing Bi-Annual Report Children Safeguarding Annual Report Adult Safeguarding Annual Report Patient Experience Annual Report	Perinatal Quality and Safety Report Mortality Scorecard Patient Safety/Learning from Deaths	Perinatal Quality and Safety Report Mortality Scorecard Patient Safety/Learning from Deaths Safer Staffing CNST
Consent Items						
	Review of Directors' Interests					
Closing Matters						
	AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting
Future Items						
Items for Information	IPQR Working Lives of Resident Doctors Cultural Insights Report Annual Staff Survey Freedom to Speak Up Guardian Bi-Annual Report 7 Hour Standards and 7 Day Working Report	IPQR CQC Registration Clinical Audit Annual Report Medicines Management Annual Report Cultural Insights Report End of Life Annual Report Talent Management	IPQR Working Lives of Resident Doctors NMC Fitness to Practice Cultural Insights Report	IPQR Working Lives of Resident Doctors 7 Hour Standards and 7 Day Working Report Cultural Insights Report Freedom to Speak Up Bi-Annual Report	IPQR Research and Development Annual Report Patient Safety Incidents Annual Report CQC National Inpatient Survey Cultural Insights Report	IPQR Working Lives of Residents Doctors CQC Maternity Patient Survey Cultural Insights Report Pay Gap



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors - Items for Information

Date: Thursday 7 May 2026

Time: 12.30 pm - 2.30 pm

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

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Working with you, for you

TSDFT Public Board of Directors - Information Pack

Board Room, Hengrave House



07/05/2026 12:30 - 14:30

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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 (item 2.6)
- Risk Management Framework appendices (3.1)
- Planning 2026.27 appendices (3.2)
- Our Strategy Appendix (item 3.3)
- Our Plan for Better Care Report Appendix (item 3.4)
- Perinatal Quality and Safety Report Appendix (item 4.3.1)

Finance and Operations Committee

- Electronic Patient Record Progress Report (item 4.2.3)
- Integrated Performance and Quality Report (item 4.2.1)

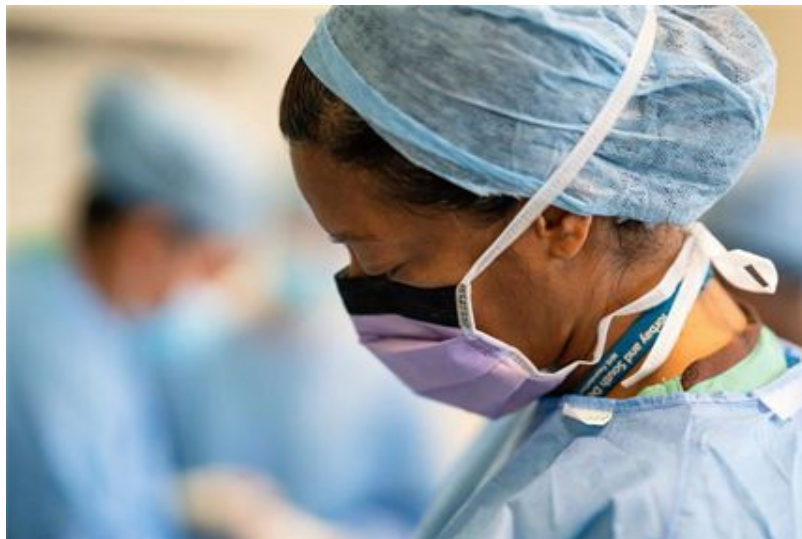
Quality and People Committee

- 72 Hour Standards and 7 Day Working Report
- Cultural Insights Review Group Update
- Freedom to Speak Up Bi-Annual Report
- National Staff Survey
- Working Lives of Resident Doctors



BOARD ASSURANCE FRAMEWORK

2026/27



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 (April 2026)		Previous assessment: Satisfactory (March 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, with the 10% reduction target only partially achieved at this stage.		
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	• EPIC and DCIQ are now in place; however, their full potential to support real-time risk identification, triangulation and escalation is not yet consistently realised across all areas • Variation remains in data quality, coding and utilisation of system functionality, limiting the ability to generate a single, integrated view of patient safety risk • Action: complete review of care group and corporate risk alignment and refresh BAF narrative and controls
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
1. Safety Huddles 2. Clinical leadership and Matron Audits 3. Education, training and competency assessments in falls, pressure ulcer prevention and medication safety 4. Incident reporting	1. Patient Safety and Quality teams monitoring incident trends and learning from review and leading QI programmes 2. Divisional and Corporate Governance structure (SQAG/QAC/Risk Group) 3. Mortality review group: structured learning and escalation of themes 4. Nursing and Medical leadership oversight through quality dashboard/IPR 5. IPQR review (EOG/ExCo) 6. Care Group risk review meetings linked to corporate risk oversight. 7. Triangulated quality and safety review across incidents, mortality, complaints and external scrutiny themes.	1. Internal/external audit review 2. External regulatory assessment (CQC, NHSE, peer reviews) 3. Benchmarking against national data (Model Hospital) 4. Board level scrutiny via QAC, ARC and Board meetings

SUPPORTING OBJECTIVE: Restore and sustain delivery of key operational performance standards through improved patient flow, real-time risk escalation, and full implementation of clinical harm stratification for long waits. While the October 2025 target was not fully achieved, the introduction of Epic Systems and Datix Cloud IQ provides enhanced capability for real-time oversight, triangulation and scrutiny of harm risks, supporting improved identification, escalation and mitigation of delays in care.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality and People Committee
Current assessment: Satisfactory (April 2026)		Previous assessment: Satisfactory (March 2026)
Overarching comment & rationale for assessment: The organisation continues to work towards restoring and sustaining operational performance standards through strengthened patient flow processes, real-time risk escalation, and implementation of clinical harm stratification for long waits. While improvements have been made in the identification and prioritisation of patients at risk of harm, the October 2025 target was not fully achieved, reflecting ongoing capacity pressures and variability across divisions. The introduction of Epic Systems and Datix Cloud IQ is enhancing the organisation's ability to provide real-time oversight, improve triangulation of risk, and strengthen scrutiny of harm associated with delayed care; however, this capability is not yet consistently embedded across all areas. Continued focus on cross-care group coordination, consistent application of escalation thresholds, and strengthened use of data to inform decision-making is required to improve assurance of timely access and reduce harm associated with delays in 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 triangulation between long-wait harm, flow pressures, staffing and care group risks. - Inconsistent articulation of when operational pressure should escalate as a strategic quality risk. - Data timeliness does not yet provide full real-time assurance on harm from delayed care.
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Frontline operational teams managing patient flow to meet performance standards - Clinical teams implementing harm stratification for long waiting patients and escalating risks - Local ward leadership monitoring performance and addressing bottlenecks - Daily ward huddles and twice daily board rounds	- Safety and Flow meetings 3 times a day - Risk escalation committees ensuring long wait patients with potential harm are prioritised - Regular reporting to ExCo - CMO and CNO leadership	- Internal audit reviewing operational processes - CQC/NHS assess access standards and safety of long waits - Independent harm reviews associated with delayed care - Benchmarking against national standards for waiting times and elective and urgent care - Board level scrutiny via Audit committee and QAC

SUPPORTING OBJECTIVE: By December 2025, deliver targeted prevention and early intervention programmes achieving a 10% improvement in access to screening, health promotion, or support for long-term conditions.		
Executive lead: Chief Nursing Officer		Board oversight Committee: Quality and People Committee
Current assessment: Limited (April 2026)		Previous assessment: Limited (March 2026)
Overarching comment & rationale for assessment: Targeted prevention and early intervention programmes continue to support access to screening, health promotion and long-term condition management, with some evidence of improved uptake in specific areas. However, the December 2025 target of a 10% improvement has not been fully achieved, with ongoing variation across communities and capacity constraints limiting consistent delivery and impact. There remains limited assurance on the extent to which these programmes are reducing inequalities or delivering sustained improvement in outcomes. Work is underway to strengthen oversight, improve data quality and consistency, and better align programme delivery with population health need, including enhanced triangulation of		

uptake, outcomes and community-level risk. Continued focus on targeted outreach, partnership working and robust monitoring is required to improve access and demonstrate measurable impact.		
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:
- Frontline public health and community teams delivering screening, health promotion, and early intervention services. - Local leadership monitoring programme uptake and outreach activities. - Patient engagement, education, and proactive risk identification in primary and community care.	- Population Health / Public Health teams providing oversight, reporting, and quality assurance. - Regional leadership reviewing programme performance and equitable access. - Executive oversight via quality and performance dashboards	- Internal Audit of prevention and early intervention programme delivery and effectiveness. - External review from regulators or national bodies assessing public health programme outcomes. - Benchmarking against national screening and long-term condition management standards. - 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 (April 2026)	Previous assessment: Limited (March 2026)
Overarching comment & rationale for assessment: Real-time patient feedback mechanisms are established across most service areas, with routine collection and reporting of Friends and Family Test (FFT) and local experience measures. However, the December 2025 target of 100% implementation and consistent use has not been fully achieved. Variation remains in the reliability of data collection, the quality and timeliness of action planning for low-scoring services, and the extent to which feedback is translated into measurable improvement. Assurance is further limited by inconsistent triangulation between patient experience data, complaints, incidents and wider care group risk intelligence. Work is underway to strengthen oversight, improve consistency of implementation, and enhance the visibility and impact of “you said, we did” actions. Continued focus on embedding feedback into governance processes and ensuring clear escalation of concerns is required to demonstrate sustained improvement in patient experience.	
Risk to delivery:	
Aggravating 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%. • Data triangulation with complaints, compliments, and incidents not fully embedded. • Limited external benchmarking of patient experience performance. • Weak triangulation between FFT, complaints, PALS, incidents and service risk registers. • Limited evidence that low patient experience scores consistently drive risk escalation or improvement plans. • Action: refresh patient experience escalation framework and reporting.
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 (April 2026)

Previous assessment: Satisfactory (March 2026)

Overarching comment & rationale for assessment: The organisation has maintained overall compliance with core patient safety and quality standards at or above the 95% threshold while delivering within the agreed financial position. Ongoing operational pressures, workforce constraints and increasing demand continue to present risks to sustainability; however, monthly performance monitoring, targeted improvement actions and Board oversight provide reasonable assurance. During this period, further work has been undertaken to strengthen the integration of quality, safety and financial performance with care group and corporate risk reporting, improving alignment between local risks, the Corporate Risk Register and the BAF. This is enhancing the organisation's ability to identify and escalate cross-cutting risks and supports a more anticipatory approach to risk management. Continued focus is required to ensure consistent triangulation of data, timely escalation and sustained delivery of standards across all service areas.

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. • Current controls do not consistently demonstrate how financial, workforce and quality pressures interact at care group level. • Strategic controls and assurance mechanisms need clearer linkage to underlying operational risk themes
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. • Quality Governance Committees and Finance & Performance Committee providing oversight.	• Internal Audit reviewing compliance with safety, quality, and financial standards. • External regulators (CQC, NHS England/Improvement) assessing performance and compliance. • Benchmarking against peer organisations for quality and financial performance. • Board-level scrutiny through Audit Committee and quarterly reporting.

SUPPORTING OBJECTIVE: By March 2026, deliver a trust-wide IPC improvement programme that embeds evidence-based practices in 100% of clinical areas, achieves ≥95% compliance in monthly IPC audits, provides targeted training to 100% of frontline staff, and ensures all identified infection risks are escalated and acted upon within 24 hours, with monthly assurance reports to the Board through the IPQR.

Executive lead: Chief Nursing Officer

Board oversight Committee: Quality and People Committee

Current assessment: Limited (April 2026)

Previous assessment: Limited (March 2026)

Overarching comment & rationale for assessment: The trust-wide IPC improvement programme has strengthened the embedding of evidence-based practices, with high levels of audit compliance and delivery of targeted frontline staff training across most clinical areas. However, the March 2026 objective has not been fully achieved, with ongoing variability in compliance and consistency of practice across some services, particularly in the context of operational pressures and workforce challenges. While escalation processes and monthly reporting through the IPQR are established, assurance remains limited in relation to the sustainability of improvements and the consistent triangulation of audit findings, incidents, outbreaks and wider care group risk intelligence. Work is underway to strengthen alignment between IPC risks, care group oversight and the Corporate Risk Register to

ensure timely escalation and a more proactive approach to risk management. Continued focus is required on embedding consistent practice, improving data quality and ensuring that identified risks are reliably escalated and acted upon within required timeframes.		
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 (April 2026)		Previous assessment: Satisfactory (March 2026)
Overarching comment & rationale for assessment: Assurance in relation to maternity safety has reduced this month and remains limited. While elements of personalised care, safety compliance and patient experience show areas of progress, the March 2026 objectives have not been fully achieved, and there is insufficient assurance that improvements are consistently embedded or sustainable across the service. Ongoing workforce pressures, clinical acuity and the complexity of the current service model continue to present risk, with variability in the consistent delivery of personalised care plans, timely escalation and the reliability of safety processes. Work is being strengthened through the Perinatal Improvement Board and wider care group and corporate risk alignment to improve oversight, triangulation of harm, compliance and experience data, and to ensure that risks are clearly articulated and escalated. However, further work is required to demonstrate sustained reduction in avoidable harm, consistent compliance with regulatory standards and improved experience for women and birthing people.		
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 Action: continue executive-led review of maternity risks through Perinatal Improvement Board and refresh strategic controls/assurance
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Maternity clinical teams delivering personalised care plans and adhering to safety protocols. - Ward/department managers monitoring daily compliance and initiating improvement actions.	- Maternity Governance Group and Safety Champions monitoring compliance, harm events, and experience metrics. - Care Group leadership reviewing performance dashboards and overseeing corrective actions.	- Internal Audit reviewing maternity compliance, harm reduction initiatives, and patient experience processes. - External regulatory review (CQC, NHS England) assessing safety, compliance, and patient experience.

Tab 2.1 Board Assurance Framework (item 2.6)

• Staff completing mandatory training and participating in continuous professional development. • Staff intelligence including trainee feedback	• Executive oversight through Quality & Safety Committee and Board reporting. • Perinatal Improvement Board chaired by CNO	• 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 (April 2026)	Previous assessment: Limited (March 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: Satisfactory (April 2026)	Previous assessment: Limited (March 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.	Executive Development days – Team development using established and recognised	Recruitment to substantive COO underway.

- CPO/CFO roles now substantively appointed and in post. - COO resigned in March 2026 with agreed last date of 4th May. Interim arrangements in place and recruitment process underway - Tension between organisational focus and system priorities including Devon ICB and wider system financial pressures - RSP resource and support has been withdrawn as Trust is no longer part of the Recovery Support Programme. - Potential for organisational changes / changes to group model	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 annual achievement reviews and initiation of 360 reviews for the Executive team - Interim COO arrangements agreed. National recruitment process underway- interview date planned for 1st May 2026.	Executive portfolio review and consultation underway and due for completion in Mid-April 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:
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 (April 2026)		Previous assessment: Limited (March 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:	
- Significant and competing priorities for delivery could delay the improvement workstream. - It is recognised additional resource will be required to drive improvements in risk management across the organisation including review of all risks and refreshing risk training for the wider organisation. This has been actioned with interim resource starting work week commencing 15 September 2025.		- Regular reporting to Board and Audit Committee, liaising with HOIA and RSP colleagues to ensure all stakeholders are sighted. - A Governance Delivery Group has been convened with key stakeholders from the governance team and wider personnel to progress the workstream deliverables and improve oversight of governance delivery and improvement moving forward. - The deep dives on risk and NED perceptions of risk are laying the groundwork for revised governance infrastructure	
		Gaps in control & associated actions: - 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. - A review and refresh of governance below Board and Sub Committees is underway (Tier 2, 3 and 4) - Work is underway to further refine the BAF and ORM to strengthen alignment with the Trusts strategic objectives and strategic risks.	

	(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 undertaken in October 2025. Further assessment planned May 2026	- 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 (April 2026)		Previous assessment: Limited (March 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 prioritised 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 refinement. Presented to QPC

	People Committee and Trust Board. April update - We have started the review of the Trust Policies to align with our Just and Learn plan and approach.	with continued monitoring of actions and trends via PEGG, and QPC - April update - Engagement framework to be designed to ensure feedback, learning and improvement from the staff network groups are fed into the cultural insights group and culture plan. - April update - ER dashboard and reporting to CPO now in place – next step is to include in monthly EOG reporting. - April update - Restorative Just and Learn proposal has been developed and has been presented to the QPC with actions to include policy change being implemented by ER and overseen by CIRG and with update to be presented to QPC May - April update – have received the NSS and NETs results and are undertaking an analysis of the themes to ensure this is fed into the CIRG reporting and action planning.
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 (April 2026)	Previous assessment: Limited (March 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, RTT long waiters, Diagnostics		
Risk to delivery:		
Aggravating factors: • Demand growth in excess of expected levels. This has been experienced in UEC and also cancer. • Reliance on insourcing/outsourcing to deliver elective activity, due to not delivering levels of productivity required • 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	Mitigating factors: • Action – Work with partners, e.g. ICB and SWAST on demand management plans. This will roll into system-wide work in 2026/27 • Action – Q4 UEC sprint in place • Action – Delivery of UEC improvement plan milestones, escalated focus on ward improvement programme and inter-professional standards for Q4. • Action – Delivery of elective care improvement plan milestones including recruitment to anaesthetics and orthopaedics posts • Re-work of the CDC contract – October 25 has been completed and agreed. This is being enacted in Q4.	Gaps in control & associated actions: • Demand management plans are not clearly defined, despite ongoing work, there is limited assurance that sufficient demand management will be in place for 2026/27 • UEC improvement plan refocused to deliver intended benefits Complete interventions designed and overseen by UEC group • Elective Care Improvement Group and performance processes strengthened, led by DCOO. • Workforce v demand reviews to be undertaken in ED and medical wards and presented to executives – recruitment ongoing • Operational Planning to account for required increases in activity and productivity – Q4
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 - Elective Delivery Plan and Meeting	- 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

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 (April 2026)		Previous assessment: Limited (March 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 place 16th/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 (April 2026)		Previous assessment: Limited (March 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).	• Director of Capital Developments oversight of capital programme, supported by Capital Investment Delivery Group. • Director of Estates and Facilities oversight of reactive and proactive estate operations and technical compliance to maintain existing assets. • Building a Brighter Future Committee oversight of capital programme delivery and	• Internal Audit reviews of capital governance, procurement, and risk management. • External Audit assurance on capital accounting and asset management. • NHSE scrutiny and approval of major capital schemes and business cases. • Health & Safety Executive, CQC, and Fire Authority inspections.

• Risk registers maintained at project, programme, and corporate levels. • Routine monitoring of backlog maintenance profile and capital scheme progress. • Monthly finance and performance reporting on capital delivery. • Clinical and operational engagement to ensure continuity of services during works. • EFM Compliance and Performance Group manage oversight of maintenance schedules.	• operational estates and facilities management. • Audit & Risk Committee scrutiny of estate risk management and capital governance. • Finance Committee review of business cases, capital allocation, and affordability. • Board-level oversight of estate strategy, capital pipeline, and risk profile. • System-level assurance via ICB capital planning processes. • Independent compliance audits (fire safety, HTM, HBN, statutory requirements). • Use of external cost advisors and design assurance panels for key schemes.	• PLACE assessments and national ERIC and PAM data benchmarking. • External specialist reports (e.g., sustainability, structural surveys, engineering audits). • Gateway Reviews and independent project assurance for large capital projects.

SUPPORTING OBJECTIVE: Develop a full understanding of the current contract and cost of delivery of adult social care; including health, to ensure the services can be provided within the funding received. When this understanding is obtained, identify core demand and capacity available to reach trajectories for TSD against the nationally recognised KPIs.

Executive lead: Chief Strategy and Planning Officer

Board oversight Committee: Finance and Operations Committee

Current assessment: Limited (April 2026)

Previous assessment: Limited (March 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.

Full paper produced for public board in march. Decision taken to give notice on s75. 12 month transition process commenced, regular board updates will 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	- ICB review of financial position - Work with NHSE RSP Team

- Board		
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 (April 2026)		Previous assessment: Satisfactory (March 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. - CFHD transferred to DPT from 1st April 2026. Minor issues highlighted that are being dealt with.		
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 (April 2026)		Previous assessment: Limited (March 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	- 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	- 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

assets are environmentally inefficient. • Inadequate technology to monitor and manage the environmental performance of the estate.	performance, waste management optimisation and control of volatile gases. • Green plan has been refreshed by the Board in September 2025.	Workstreams. (Date subject to appointment of sustainability lead)
Three lines of defence:		
First Line of Defence - Operational and Management Controls	Second Line of Defence - Oversight Functions and Internal Assurance	Third Line of Defence - External Assurance:
- Sustainability Group - Workplace Performance & Compliance Group - Healthcare Technical Memorandums - Workplace SLT	- Executive Committee - Our Plan for better care - BBF Committee - Board	- ICB Sustainability Group - Property Assurance Model - National ERIC Return - External Audits

PEOPLE AND CULTURE		
OVERARCHING CORPORATE OBJECTIVE: To develop a people strategy aligned to the Trust's long-term vision, priorities and values, which delivers a workforce plan that ensures the right workforce is in place and that fosters a positive, inclusive culture with high levels of staff engagement to support improved patient outcomes.		
SUPPORTING OBJECTIVE: Develop and deliver a sustainable, workforce strategy and plan that delivers an efficient, agile, skilled and high performing workforce aligned to system and organisational priorities.		
Executive lead: Chief People Officer	Board oversight Committee: Quality and People Committee	
Current assessment: Limited (April 2026)	Previous assessment: Satisfactory (March 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.	• April update – People Strategy completed and new people services model approved by Exec Co and is now in the process of implementation aligned to the future of people service transformation programme. • April update – OPFBC people programmes have been reviewed and reset and proposed programmes are being agreed at the Oversight Group via the CPO in April. • April update – WTE reduction target of 311 includes a 90 stretch target. Finance currently rebasing budgets and distribution of the revised targets across care groups. Month by month tracking and monitoring to be overseen by the new workforce programme group – first meeting in April – this group will report up through the Finance Delivery Group and OPFBC. Care groups will monitor and review through EOG. Workforce plan presented to Board for review in April and requires further improvements and targets to be added for appraisal and sickness. • April update – medical e-rostering implementation from May.
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. - Weekly meetings between finance, PMO and Workforce to review the CIP schemes ensuring all aligned to WTE and the overall workforce plan.	- 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 - New workforce programme group	- 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: Satisfactory (April 2026)

Previous assessment: Limited (March 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.	- April update – Culture plan in place and being monitored by PEGG and QPC. - April update - Revised OPFBC culture transformation programme awaiting approval in April. - April update - Wellbeing business case approved in principle, but funding not identified to support so further work required with the Finance team. Wellbeing stakeholder group to be reconvened and a plan for a wellbeing summit and launch of the revised offer is planned for May. The Board have undertaken the Cares Well workshop/engagement with the programme – ongoing commitment, actions and next steps to be overseen by CPO. - April update - FTSU service being reviewed to ensure the

		Trust is compliant and that the service is strengthened to meet the national FTSU requirements. options appraisal was reviewed by Exec Co in March and is due back for a decision in April. • April update – culture plan underway and overseen by PEGG and QPC as per above objective. • April update – OPFBC 5.3 programme complete for 2025/26 with satisfactory 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:
• 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 (April 2026)		Previous assessment: Limited (March 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,	• April update – new people services model aligned to the national future of people services transformation programme has been approved by Exec Co and

	skills, systems, and leadership to enable the organisation to deliver its strategic people priorities, meet regulatory expectations, and drive long-term workforce sustainability.	the Organisational change and formal consultation process is now underway for implementation of phase 1 in May. • April update - People and Education Governance Group (PEGG) strengthened as part of the governance review. • April update - 5.2 OPFBC programme completed and removed from OPFBC people programmes as organisational change and the future if people services transformation programme is now underway. • April update - EDI CQC action is now embedded into the Culture Plan action plan and monitored by CIRG and QPC. • April update – People metrics dashboard in place and now being presented and reported through EOG and QPC – further improvements required to include specific targets, ER metrics and month by month tracking. New dashboard to be set up to support monitoring of the workforce plan. • April update - New workforce programme group set up to oversee delivery of the workforce plan. First meeting in April.
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 and QPC. • New workforce programme group to be established	• 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 (April 2026)		Previous assessment: Satisfactory (March 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 (April 2026)		Previous assessment: Satisfactory (March 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 - Closedown report for 25/26 and proposed 26/27 plan discussed at a board development session and formal paper to be presented at May Board		
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 (April 2026)		Previous assessment: Satisfactory (March 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. • Strategy signed off by Board of Directors in March. Stakeholder engagement plan will then be activated in advance of Public Board in May. • Launch of engagement formally 14th April by CEO and CSPO		
Risk to delivery:		
Aggravating factors:	Mitigating factors:	Gaps in control & associated actions:
• Complexity of the partnership landscape	• Strong emphasis of process on engagement and listening	• Challenges

Challenging financial/performance position and competing pressures for staff and leaders	Support of communications team	
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 (April 2026)		Previous assessment: Satisfactory (March 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 (April 2026)		Previous assessment: Satisfactory (March 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 from across our services, primary care, local authority, mental health and VCSE community support. A key enabler will be the development of a framework for		

sharing ownership for health and care services with our local community which will describe the roles and relationships of different partners as well as facilitating improved engagement, involvement and collaborative decision-making.

Early implementation of our strategy is expected to involve:

- Exploring options that are likely to be easier to implement quickly – for instance where GP services are already located adjacent to our community facilities (e.g. Ashburton or Dawlish).
- Targeting opportunities where we have identified potential benefits with primary care partners, such as putting in place “interface services” like phlebotomy, assessment and triage.
- Working with primary care, VCSE, mental health and Council partners to consider co-location of other complementary services within a framework that we can evaluate and adjust or build on accordingly.

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

Formal programme board is now set up with plans on a page.

Intention to have a full session at a future Board Development session

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 (April 2026)	Previous assessment: Limited (March 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. CMO/CNO working with colleagues across Devon on a new clinical strategy for Devon, this will be checked for alignment with the Trust strategy.		
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 (April 2026) **Previous assessment:** Limited (March 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)	- 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	- 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.

decisions, with many schemes including the Torbay Hospital scheme deferred by a decade. - External approval processes (NHSE, DHSC, Treasury) are lengthy and subject to political priorities. - Dependence on wider system prioritisation may dilute Trust-specific bids.	invitation to submit a further in year bid. New six facet survey has been commissioned and will be completed before the end of the year.	
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 (April 2026)		Previous assessment: Limited (March 2026)
Overarching comment & rationale for assessment: Epic has successfully gone live and is bedding in as expected, with initial issues under review and resolution. Several follow-up activities are progressing, including archiving data from systems that have now been replaced (anticipated to take over a year) and finalising the business-as-usual (BAU) operating model. While these actions are underway, ongoing attention is required to ensure legacy systems are fully retired and that the digital infrastructure continues to meet business requirements. The EPR Programme, in collaboration with EPRR teams, continues to evaluate datacentre cyber-attack risks and maintain robust safeguards to support rapid recovery. In parallel, teams are coordinating business continuity arrangements to address any potential disruption to critical services during the post go-live stabilisation period and as legacy systems are decommissioned.		
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.	• 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.	• Risk remains of sophisticated cyber-attacks despite existing security measures. ◦ Cyber Security Manager conducts best practice reviews, self-assessed and reported to the Audit & Risk Committee. • Ongoing capital and revenue investment needed to maintain and improve digital infrastructure.

- Delays in datacentre and infrastructure upgrades and patching. - Limitations to ASC (Adult Social Care), and Health services due to aging PARIS platform.	- 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. - 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.	- IM&T and CIDG operate a rolling 5-year capital investment plan for key infrastructure upgrades. This remains at risk due to budget restrictions. - Datacentre relocation is delayed due to Openreach circuit installation issues. - The move will remain uncertain until Openreach confirms installation dates. - Surveys are done and wayleave documents submitted. - Current datacentre infrastructure risks persist.
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 (April 2026)

Previous assessment: Satisfactory (March 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 still in discussion of becoming an XR testbed for the Health Innovation Networks, strengthening our regional and national innovation capabilities position.

Our University of Exeter ADHD AI partnership continues to progress well with a peer reviewed paper being published in JMIR and testing in play, alongside two further funding applications now submitted and awaiting outcomes with ESA and UKRI. Our horizon scanning function and innovation communications plan are now drafted.

Our funded Digital Skills bootcamp is well underway, running weekly with ASC staff to build a community network of digital innovation champions. The Multiverse Data and AI Academy is in week 12 with 20 apprentices studying across levels 3 to 6. We continue building our broader talent pipeline through apprenticeships (South Devon College) and postgraduate research partnerships (Falmouth University), though financial pressures have capped some opportunities; external sponsorship conversations are underway. We are also transitioning to the OneDevon LMS, bringing consistency across Devon organisations and a £30k per year cost saving to our organisation, though this involves significant work for our LMS team and some difficult decisions around previous partner access through our HIVE LMS.

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. A number of innovations are now at a stage requiring regulatory support to progress; we are in active discussion with the NHS England regional team regarding funding to support this, including for the eye-tracking MND wheelchair and the CareLink remote monitoring system.

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 (April 2026)		Previous assessment: Satisfactory (March 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. The Trust has recently submitted a balanced financial plan for 2026/27 following receipt of £57.8m of non-recurrent deficit support funding and is required to deliver a £54.4m cost improvement programme. A final submission is expected at the end of April 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	- 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 April. - Board decision taken in March 2026 to serve notice on the S75 agreement with Torbay Council. - 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 April - 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 April - Work ongoing to reduce the risk of non-delivery of the CIP target
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: Green (April 2026)		Previous assessment: Limited (March 2026)
Overarching comment & rationale for assessment: As at 31 March 2026, the Trust delivered its forecast outturn deficit of £22.4m against a planned deficit of £8m. Excluding deficit support funding loss in the second half of the year (quarters 3 and 4) the Trust has delivered an outturn £1m better than initial plan (subject to audit).		
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 - 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 (April 2026)

Previous assessment: Limited (March 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, CMOs) 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.

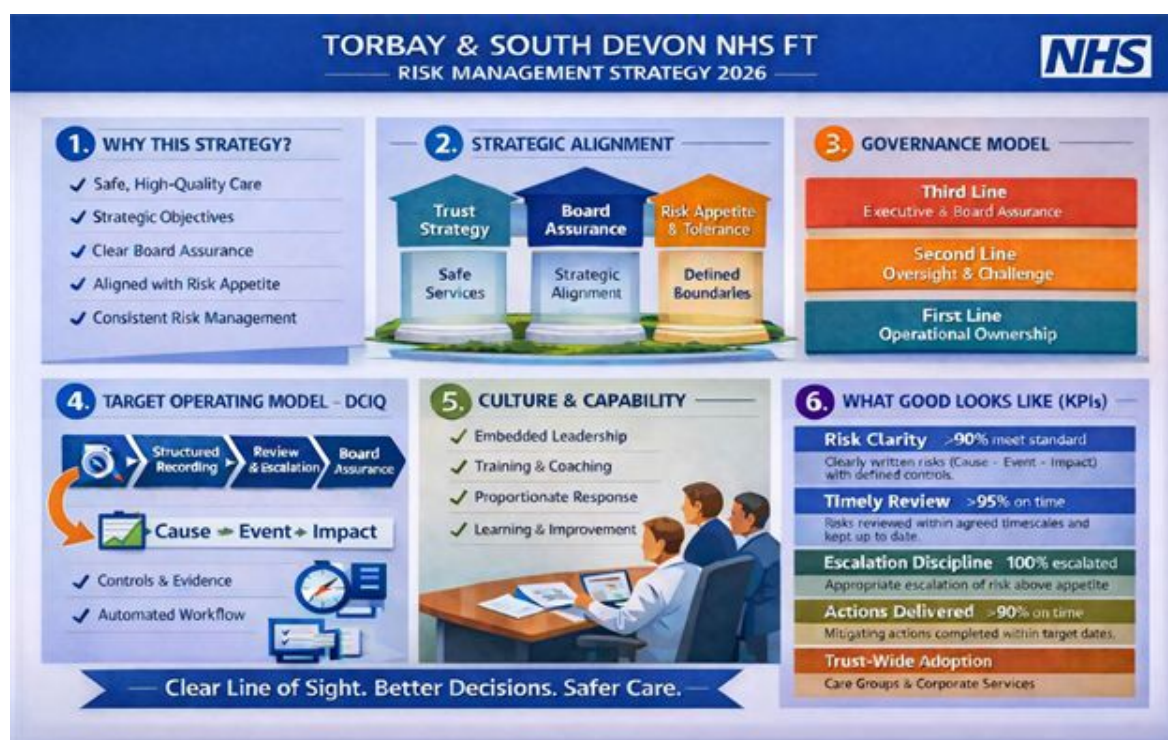
Torbay and South Devon NHS Foundation Trust

Risk Management Strategy

Part A - Risk Management Strategy

Version 1.0 | April 2026

Document Control	
Document Title	Risk Management Strategy
Part	Part A – Risk Management Manual
Version	1.0 (Draft for approval)
Status	Draft – pending Board Approval
Author	Corporate Governance Team
Owner	Chief Executive Officer
Approved by	Board of Directors
Approval date	May 2026
Review date	May 2027 (or earlier if required)
Replaces	Previous Risk Management Strategy



1. Introduction and Organisational Context

Torbay and South Devon NHS Foundation Trust (TSDFT) is a unique integrated health and care organisation, bringing together acute hospital services, community health services, and – currently – adult social care, delivered in partnership with Torbay Council. The Trust faces significant operational, financial and regulatory challenges, and this Strategy is designed to strengthen the Trust's approach to risk management in the context of those challenges and the strategic response to them. The Trust's purpose is to support the people of Torbay and South Devon to live well, through high-quality, safe and sustainable services.

TSDFT operates within the NHS Devon Integrated Care System (ICS), under the strategic oversight of NHS Devon Integrated Care Board (ICB). The Trust is a key system partner and its approach to risk management must reflect not only its own governance requirements but also its responsibilities within the wider Devon health and care system. This includes alignment with ICB system-level risk management expectations, reporting frameworks and the Joint Forward Plan.

Where appropriate, alignment has been created in terms of risk management systems and processes with other organisations in the wider system, such as Royal Devon University Healthcare NHS Foundation Trust (RDUH), supporting coherent system-level governance consistency across Devon's acute and integrated care providers.

Effective identification, assessment and management of risk is essential to the delivery of safe, high-quality care, the achievement of the Trust's strategic objectives, and the maintenance of regulatory and system assurance. This Risk Management Strategy sets out how TSDFT will manage risk in a consistent, proportionate and transparent way, aligned to its overarching strategy, governance framework and risk appetite.

The Strategy describes the Trust's intended target state for risk management, including the transition to Datix DCIQ as the Trust's primary risk management system, and the arrangements required to support improved risk quality, oversight and assurance.

2. Purpose of the Strategy

This Strategy provides the framework within which the Trust's Risk Management Policy (Part B), Operating Manual (Part C) and supporting guidance will operate. It is intended to support consistent application across all services - acute, community, mental health, and social care - while remaining proportionate and practical for frontline teams.

The purpose of this Strategy is to:

- Set out a clear, shared and system-aware approach to risk management across the Trust
- Support the delivery of the Trust's strategic objectives and Board Assurance Framework
- Ensure alignment with the Trust's Risk Appetite Statement and agreed tolerance boundaries
- Describe the Trust's target operating model for risk management, including the use of Datix DCIQ
- Align risk management practice with the expectations of NHS Devon ICB and system partners
- Improve the quality, consistency and usefulness of risk information for Care Groups, executives and the Board
- Support compliance with external requirements including the CQC Well-Led framework, NHS England provider oversight, and the Trust's Foundation Trust licence

The Trust's target state is a risk management framework that:

- Produces clear, high-quality risk records using the Cause–Event–Impact structure
- Provides meaningful visibility of risk from frontline services to Board
- Supports proactive decision-making and timely escalation
- Clearly identifies where controls are effective and where gaps exist

- Is fully embedded within DCIQ as the single source of truth
- This represents a shift from risk management as a reporting process to a core management tool for improving quality, safety and performance.

3. System and Regulatory Alignment

3.1 NHS Devon Integrated Care Board

TSDFT operates as a provider within the NHS Devon ICS. The ICB holds system-wide risk oversight responsibilities, and the Trust's risk management arrangements are designed to be compatible with ICB reporting expectations and system-level risk frameworks. Where risks have potential system-wide impact - including those relating to urgent and emergency care, elective recovery, population health and workforce - the Trust's escalation processes reflect the need for timely ICB visibility.

The Trust's Risk Management Strategy and Board Assurance Framework (BAF) are reviewed for alignment with ICB system risk reporting requirements. The Trust participates in Devon system governance forums and ensures that principal risks with system implications are visible to appropriate ICB oversight bodies.

3.2 Royal Devon University Healthcare NHS FT

TSDFT and RDUH are Devon's two major NHS Foundation Trusts. Both organisations share patient pathways, workforce, digital infrastructure, and system governance obligations. In developing this Strategy, the Trust has reviewed RDUH's risk management framework and approach to ensure consistency where it supports system coherence.

Areas of specific alignment include the Datix DCIQ platform (both Trusts use the same system, supporting consistent risk data architecture), the Yellowfin reporting and dashboard environment (jointly configured), and the consequence and likelihood matrices (aligned to NPSA standards across both organisations). This alignment reduces friction for staff working across both organisations and supports meaningful system-level risk comparison.

3.3 University Hospitals Plymouth NHS Trust

University Hospitals Plymouth NHS Trust (UHP) is the tertiary centre for Devon and Cornwall and shares clinical pathways with TSDFT across a range of specialties, including oncology, complex surgery, neurology and vascular services. As a key system partner, UHP's risk management arrangements are relevant to the Trust where shared pathways, patient transfers and system-level delivery create interdependencies that may give rise to shared or escalating risks.

Where risks arise from or are materially affected by shared UHP pathways, the Trust's escalation processes ensure timely visibility to appropriate governance forums and, where required, to NHS Devon ICB. The Trust will engage with UHP through system governance arrangements to ensure that pathway-level risks are appropriately identified, owned and managed across organisational boundaries.

3.4 Future System Alignment

As the Trust develops its neighbourhood model and the Devon ICS matures, future iterations of this Strategy will consider alignment with Cornwall Partnership NHS Foundation Trust and Devon Partnership NHS Foundation Trust, where shared pathways, workforce or governance arrangements create relevant interdependencies. The Trust will also engage with other system partners through the South West Peninsula Board governance arrangements.

3.5 Regulatory Framework

This Strategy is designed to support TSDFT's compliance with:

- CQC Well-Led framework, specifically the requirements relating to governance, risk management, and Board assurance
- NHS England Provider Oversight Framework, including Trust oversight ratings and regulatory submissions
- NHS Foundation Trust licence conditions
- NHS England Risk Management Standards
- NHS Constitution obligations to patients, staff and the public
- Care Quality Commission (CQC) registration requirements across all regulated activities

4. Alignment with Trust Strategy and Board Assurance Framework

4.1 Alignment with the Trust Strategy

The Trust's overarching strategy sets out its purpose to support the people of Torbay and South Devon to live well, through high-quality, safe and sustainable services delivered in partnership. Effective risk management is a key enabler of this strategy.

By ensuring that risks to quality, safety, performance, workforce, finance and sustainability are identified early and managed appropriately, the Trust strengthens its ability to deliver its strategic priorities and respond to emerging challenges. This Strategy aligns risk management activity explicitly to the Trust's strategic objectives, ensuring that risks are understood and escalated in the context of their potential impact on delivery.

4.2 Board Assurance Framework

The Board Assurance Framework (BAF) is the primary mechanism through which the Board gains assurance on the achievement of the Trust's strategic objectives. Risks managed under this Strategy are aligned to the BAF objectives, providing a clear line of sight between operational risk management and Board-level assurance.

The Trust maintains a Corporate Risk Register to provide Executive and Board oversight of its most significant operational risks. Further detail is set out in the Risk Management Policy and Operating Manual.

The Trust's Corporate Risk Register (CRR) and BAF principal risks provide the structure through which significant risks are monitored, challenged and assured. This Strategy reinforces the role of the BAF and CRR as the cornerstone of Board assurance, supported by consistent risk identification, scoring, escalation and reporting across the Trust.

The BAF maps directly to TSDFT's corporate objectives. The following principal risk domains are reflected in the BAF:

BAF Objective Domain	Scope
Quality, Safety, Clinical Outcomes and Patient Experience	Risks to the delivery of safe, high-quality care and positive patient experience
Leadership and Governance	Risks to governance effectiveness, regulatory compliance and leadership capacity
Performance	Risks to delivery of constitutional and contractual performance standards, and estates
People and Culture	Risks to workforce capacity, capability, culture and staff wellbeing
Strategy and Business	Risks to the delivery of strategic objectives and organisational transformation
Finance	Risks to financial sustainability, efficiency and resource stewardship

BAF Objective Domain	Scope
Partnership and System	Risks arising from or affecting system-level delivery, ICB relationships and partnerships
Organisational Transition	Risks associated with material changes to the Trust's operating model, including service redesign, strategic review, and the transition arising from the Board's decision in March 2026 to serve notice on the Section 75 partnership agreement with Torbay Council. This includes risks to service continuity, contractual and financial sustainability, workforce, and the co-design of a revised service model with Torbay Council and Devon ICB for implementation from April 2027.
Health Inequalities and Population Health	Risks relating to the Trust's contribution to reducing health inequalities and improving population health outcomes, aligned to the NHS Devon ICS system BAF for 2026/27
Digital and Data (system-aligned)	Risks relating to digital maturity, data infrastructure, analytics capability, cyber security and information governance compliance, aligned to the NHS Devon ICS system BAF for 2026/27

The BAF domains for Health Inequalities and Population Health, and Digital and Data (system-aligned) have been added to align with the NHS Devon ICS system Board Assurance Framework for 2026/27, as proposed by the South West Peninsula Board (March 2026). NHS provider Boards have been asked to receive and endorse the system BAF risk themes and appetite levels. The Trust's BAF domains will be reviewed annually to ensure continued alignment with the system BAF and any changes to NHS Devon ICB strategic objectives.

5. Risk Appetite and Tolerance

The Trust's approach to risk is underpinned by a clear and Board-approved Risk Appetite Statement, which defines the level of risk the Trust is willing to accept in pursuit of its strategic objectives.

The Risk Appetite Statement recognises that the delivery of integrated health and care services is inherently complex and carries unavoidable risk, which must be actively identified, understood and managed rather than avoided. Risk appetite is defined by risk category, with agreed tolerance boundaries set by the Board and reviewed annually.

These thresholds are applied consistently across the Trust's risk registers and Board Assurance Framework, enabling clear escalation, oversight and decision-making. Where risks exceed the Trust's defined tolerance threshold, they are escalated to the next management tier in accordance with the Risk Management Policy. This may mean escalation from service to divisional level, from division to Care Group, or from Care Group to Corporate and Executive oversight, depending on the score and nature of the risk. Separately, where Risk Group and the Executive Committee judge that a risk threatens delivery of a strategic objective, it may be recommended for inclusion on the Board Assurance Framework. Escalation does not remove accountability from the originating Risk Owner but ensures appropriate visibility, challenge and support.

Risk Appetite Principles

The Trust has a low tolerance for risks to patient safety, clinical quality and regulatory compliance.

Risk appetite is reviewed annually by the Board and is reflected in the BAF, risk register scoring thresholds, and escalation protocols.

Risk appetite is applied consistently across all risk categories using the Trust's approved consequence and likelihood matrices.

The Trust's risk appetite is aligned to the system-level risk appetite framework proposed for 2026/27 by the South West Peninsula Board (NHS Devon and NHS Cornwall and Isles of Scilly ICB Cluster). The system framework uses five appetite levels - Very Low, Low, Moderate, High and Very High - with associated tolerance score bands. As an NHS provider within the NHS Devon ICS, the Trust has aligned its appetite levels with this framework at the qualitative level.

The full Risk Appetite Statement, including category-level appetite positions and their alignment to the system BAF, is set out in the supporting Risk Appetite Statement document.

6. Risk Governance and Accountability

Effective risk management within the Trust relies on clear accountability, robust governance and strong clinical and managerial ownership. The Trust operates a three-lines-of-defence model:

Line	Role and Accountability
First Line	Care Groups, services and teams identify, own and manage risks as part of day-to-day delivery. Risk Owners are accountable for maintaining accurate, current risk records and ensuring appropriate controls and actions are in place.
Second Line	The Patient Safety and Corporate Governance functions provide oversight, challenge, quality assurance and support. The Risk Group, chaired by the Chief Nursing Officer, provides organisational oversight of the risk management framework and alignment of operational risks with the BAF.
Third Line	Executive and Board oversight provides independent assurance through formal governance structures. The Audit and Risk Committee provides independent scrutiny of risk management effectiveness and Board Assurance Framework reporting on behalf of the Board of Directors.

Risk governance is embedded through the following structures:

- Local Care Group governance arrangements, including Care Group leadership teams and clinical governance forums
- The Risk Group, chaired by the Chief Nursing Officer, providing oversight of organisational risk quality, escalation and alignment with the BAF
- The Risk Management and System Improvement Working Group, a time limited group responsible for system standards, configuration and change control
- The Quality and People Committee, a Board sub-committee chaired by a Non-Executive Director, receiving assurance on clinical and operational risk
- The Audit and Risk Committee, a Board sub-committee chaired by a Non-Executive Director, providing independent scrutiny of governance and risk management
- The Board of Directors, receiving assurance via the Board Assurance Framework and organisational risk reporting

Roles and responsibilities for Risk Owners, Risk Handlers and governance functions are defined within the Risk Management Policy (Part B) and supported by training, guidance and system controls within Datix DCIQ.

7. Risk Management Systems and Target Operating Model

Datix DCIQ is the Trust's strategic system for risk management and assurance and serves as the single authoritative source of risk information across the organisation.

The transition from Datix Web to DCIQ supports the Trust's target operating model by:

- standardising risk recording, review and escalation
- improving the quality, consistency and completeness of risk data
- strengthening auditability and assurance
- enabling effective reporting for Care Groups, Executive teams and the Board

Risk Register Structure

The Trust's risk register structure in DCIQ is designed to support clear accountability and avoid duplication. It operates across three tiers:

- **Corporate Tier:**
Strategic Risk Register (i.e. the Board Assurance Framework principal risks to achieving the organisation's strategic objectives), the Corporate Risk Register, the organisation's key risks to operational delivery), plus functional domain registers for Workplace, People, Information Governance, Digital and IT, Health and Safety, Finance, etc.
- **Care Group Tier:**
Individual operational risk registers for each Care Group, providing the primary level of operational risk governance.
- **Divisional Tier:**
Individual risk registers for operational Divisions within each Care Group (for example Surgery, Cancer Services, Paediatrics, Emergency Care). Divisional registers sit beneath the Care Group tier and feed into Care Group-level oversight and escalation.

Each risk is recorded once in a single register, with the Service/Location field used to identify where the risk originated. Escalation is managed within DCIQ through status and governance processes rather than duplication of risk records.

This structure ensures:

- a single source of truth for risk data
- clear ownership and accountability
- improved visibility across all three tiers of the register structure
- consistent reporting through Yellowfin dashboards

Target Operating Model

Under the target operating model:

- Risks are recorded using a structured, standardised format aligned to the Risk Management Policy

- Risk review, approval and escalation are supported through system workflows
- Role-based access ensures appropriate visibility and accountability
- Risk information is actively used to support decision-making at all levels
- Reporting is delivered through DCIQ and Yellowfin dashboards, supporting operational, executive and Board assurance

DCIQ enables consistent and high-quality risk management practice, but it does not replace leadership, ownership or governance. Effective risk management remains dependent on active engagement by Risk Owners, Care Groups and corporate functions, supported by robust governance oversight.

8. Capability, Culture and Continuous Improvement

Effective risk management within the Trust depends on the capability, confidence and behaviours of staff at all levels. The Trust's approach is based on the principle that risk management is integral to good clinical and operational leadership, not a separate or compliance-driven activity.

To support this, the Trust will:

- Provide clear, practical guidance on what constitutes a high-quality risk, including the cause–event–impact framework
- Deliver targeted training for Risk Owners and governance leads
- Use Datix DCIQ workflows to reinforce correct sequencing, review discipline and accountability
- Support Care Groups through data cleansing, coaching and ongoing drop-in support during and after the Datix Web to DCIQ transition
- Align training and guidance materials with RDUH equivalents where system consistency is beneficial
- Risk management capability will be supported through structured training, practical guidance and ongoing support aligned to the DCIQ implementation and transition.

The Trust recognises that sustainable improvement in risk management requires visible changes in behaviour, not just compliance with process. The following observable indicators will be used to assess whether the risk culture is changing:

- the quality and specificity of risk descriptions improving over time, as evidenced by data cleanse outcomes and Risk Group review;
- a measurable reduction in overdue reviews and stale risks (risks open more than three years without documented justification);
- evidence that risk information is actively used in committee and Care Group decision-making, not simply received and noted;
- willingness to close risks that are no longer relevant, rather than maintaining them to avoid challenge; and
- a shift from risk escalation as an act of compliance to escalation as a request for support.

Culture change will be a core discussion at the Board development session on 24 April 2026, and the Trust's approach to embedding a risk-aware culture will be developed further through the implementation phase.

Learning and improvement will be supported through regular review of themes, trends and recurring control gaps; feedback from governance forums and internal audit; and continuous refinement of

guidance, training and system configuration. This Strategy supports a culture where risks are openly identified, clearly articulated, proportionately escalated and actively managed.

9. Success Measures and Key Performance Indicators

The success of the Risk Management Strategy will be assessed through a focused set of indicators that demonstrate both delivery and impact. These measures will be monitored through the risk management system and framework and reported through established governance routes.

Domain	Measure	Target	Targets by Y1, Y2 and Y3
Risk Quality	% of risks meeting agreed quality standard (cause–event–impact, controls, assurance)	≥90%	Y1: ≥70% Y2: ≥85% Y3: ≥90%
Review Discipline	% of risks reviewed within required timescales	≥95%	Y1: ≥80% Y2: ≥90% Y3: ≥95%
Escalation Compliance	% of risks above tolerance escalated to the correct management tier	100%	Y1: ≥90% Y2: ≥95% Y3: ≥95%
Risk Age	Reduction in risks open >3 years without justification	Year-on-year reduction	Y1: Baseline est. Y2: Year on year ▼ Y3: Year on year ▼
Action Management	% of actions completed on time	≥90%	Y1: ≥75% Y2: ≥85% Y3: ≥90%
Assurance	Alignment between risk score, controls and assurance evidence	Demonstrable	Y1: Framework established Y2: Evidenced improvement Y3: Embedded
System Adoption	Active use of DCIQ for risk review and reporting	Embedded Trust-wide	Y1: DCIQ live + training Y2: Active use org-wide Y3: Embedded
Board Assurance	BAF risks supported by live, auditable risk data	≥95%	Y1: ≥80% Y2: ≥90% Y3: ≥95%
System Alignment	Risk register structure consistent with ICB reporting expectations	Annual confirmation	Y1: Confirmed Y2: Annual confirmation Y3: Annual confirmation

These measures will be reviewed periodically to ensure they remain proportionate, meaningful and aligned to the Trust's strategic priorities, regulatory expectations and system governance requirements. These measures will be monitored through DCIQ system reporting and Risk Group and governance forums.

10. Strategy Review and Version Control

This Strategy will be reviewed at least annually, or sooner if required by organisational, regulatory or system change. An early review will be undertaken within 12 months of DCIQ go-live to ensure the Strategy remains aligned with operational practice. The review will be led by the Corporate Governance team and will consider:

- Changes to the Trust's operating model or strategic objectives
- Changes to regulatory requirements or ICB system governance expectations
- Lessons learned from risk management performance data, internal audit, and external review(s)
- Changes to the Trust's partnership arrangements, including any material changes to social care (including any significant development in the Section 75 transition, a revised contractual framework, or a transfer of functions to or from Torbay Council), or system-level responsibilities

The Risk Management Strategy is owned by the Chief Executive Officer and approved by the Board of Directors. Any material changes to the Strategy require Board approval. Minor amendments may be approved by the Audit and Risk Committee and reported to the Board.

Related Documents

Part B – Core Risk Management Policy
 Part C – Risk Management Operating Manual
 Board Assurance Framework
 Risk Appetite Statement (standalone supporting document)
 Appendix 1 – Consequence Matrix (contained in Part B)
 Appendix 2 – Likelihood Matrix (contained in Part B)
 Appendix 3 – Risk Rating Matrix (contained in Part B)

Torbay and South Devon NHS Foundation Trust

Risk Management Policy

Part B – Risk Management Policy

Version 1.0 | April 2026

Document Control	
Document Title	Risk Management Policy
Part	Part B - Risk Management Policy
Version	1.0
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Owner	Chief Executive Officer
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Replaces	Previous Risk Management Policy

1. Purpose

This Policy establishes a consistent, structured and governed approach to identifying, assessing, managing and reporting risks across Torbay and South Devon NHS Foundation Trust (TSDFT).

It applies to all services, Care Groups and corporate functions and supports the delivery of the Trust’s purpose: to support the people of Torbay and South Devon to live well.

This Policy operates as Part B of the Trust’s Risk Management Manual. It sets out the rules, requirements and standards that all staff must follow when recording, reviewing and escalating risks. It is supported by the Risk Management Strategy (Part A) and the Risk Management Operating Manual (Part C), which provides practical step-by-step guidance for Risk Owners and handlers.

This Policy is operationalised through the Trust’s risk management system, Datix DCIQ, which serves as the single authoritative source for risk recording, review, escalation and reporting across the organisation.

Manual Architecture

Part A - Risk Management Strategy: Sets strategic intent, system alignment and governance principles.

Part B - Core Risk Management Policy (this document): Defines mandatory requirements, roles, standards and escalation thresholds.

Part C - Operating Manual: Provides practical, step-by-step guidance for day-to-day risk management activity.

Appendices: Consequence Matrix, Likelihood Matrix, Risk Rating Matrix.

2. Scope

This Policy applies to all Trust services, Care Groups, Corporate Services, all employees (including bank and agency staff), temporary workers, contractors and individuals working on behalf of the Trust in any capacity. All organisational risks must be recorded and managed within Datix DCIQ unless formally exempted through governance approval.

It covers all organisational risk categories, including clinical safety, operational performance, workforce, financial, digital and information governance, estates and infrastructure, legal and regulatory compliance, infection prevention and control, strategy and transformation, environmental risks, and reputation. It encompasses risks arising within Trust services, risks shared with system partners, and risks with potential impact across organisational boundaries.

The Policy applies to risks managed at all levels, from team and service level through to Care Group and Corporate registers, and to principal risks on the Board Assurance Framework (BAF).

3. Definition of Risk

Risk is defined as the effect of uncertainty on objectives. Within the Trust context, risk refers to events or circumstances that may affect the organisation's ability to:

- Deliver safe, high-quality care to patients and service users
- Achieve strategic and operational objectives
- Maintain operational performance and productivity
- Comply with legal, regulatory and contractual requirements
- Protect financial sustainability and steward resources effectively
- Safeguard organisational reputation and public confidence
- Fulfil obligations as a system partner within NHS Devon ICS

A well-described risk has three components: a cause (the source or driver of the risk), an event (what could happen), and a consequence (the impact if the event occurs). Risk Owners should use the following structure when articulating a risk: 'There is a risk that [cause] may lead to [event], resulting in [impact].'

Minimum Risk Record Requirements

A risk record must include the following as a minimum:

- A clear description using the Cause–Event–Impact framework
- A justified risk score (consequence and likelihood)
- Clearly defined current controls
- Evidence of assurance where available

- Identification of any gaps in control
- Actions in place where gaps exist

Risk records that do not meet these requirements will be identified through DCIQ quality monitoring and supported through the data cleanse and training programme. Where records remain incomplete after support has been offered, they will be referred to the relevant Care Group Lead for resolution.

Example Risk Statement

Cause: Sustained vacancies in community nursing across South Devon arising from regional workforce shortages.

Event: Inability to provide timely post-discharge clinical support to complex patients in their own homes.

Impact: Increased risk of avoidable hospital readmissions, patient deterioration and harm, with associated impact on patient experience, performance and reputation.

Formatted: *'There is a risk that sustained community nursing vacancies may lead to inability to provide timely post-discharge support, resulting in avoidable readmissions and patient harm.'*

4. Principles of Risk Management

The Trust's approach to risk management is underpinned by the following principles:

- Risk management is embedded in everyday clinical, operational and corporate decision-making, not treated as a separate compliance exercise
- Risks are owned and managed at the appropriate level, closest to where the risk arises
- Risk information supports proactive leadership, early escalation and targeted improvement
- Risk management supports learning and improvement, not bureaucracy or blame avoidance
- Risk reporting provides clear, accurate and timely visibility from frontline services through to the Trust Board
- Risk appetite is understood and applied consistently by Risk Owners at all levels
- The Trust's approach is aligned with the expectations of NHS Devon ICB and system partners, and with the risk management frameworks of partner organisations including RDUH

Risk Identification and Sources

- The organisation recognises that risks arise from a range of internal and external sources, including operational delivery, safeguarding activity, incident reporting, programme and project activity, and system interfaces.
- Risks relating to system integration or digital interfaces (for example between S1, EPIC or other systems) must be appropriately recognised and managed within the organisational risk framework to ensure visibility and oversight.
- Where risks are identified within programmes or projects, there should be appropriate alignment with the organisational risk management system to ensure that risks with wider impact are escalated and managed at the correct level.
- All risks should be clearly articulated to support consistent understanding and effective management across the organisation.

Further detail on risk identification, recording, and management processes is set out in the Risk Management Operating Manual.

5. Risk Management System (Datix DCIQ)

The Trust uses Datix DCIQ (DCIQ) as its strategic system for recording and managing organisational risks. DCIQ is the single authoritative source of risk data for the Trust and must be used for all risk recording, review and escalation activity. The use of local spreadsheets or informal lists as a substitute for DCIQ is not permitted.

DCIQ supports structured risk recording using agreed forms, standardised risk scoring, ownership and accountability, automated review notifications, escalation workflows, role-based access and Yellowfin-based reporting dashboards.

The DCIQ risk register structure operates across three tiers:

- **Corporate Tier:** Strategic Risk Register (i.e. the Board Assurance Framework principal risks to achieving the organisation's strategic objectives), the Organisational Risk Map (which forms the basis of the Corporate Risk Register, the organisation's key risks to operational delivery), plus functional domain registers for Workplace, People, Information Governance, Digital and IT, Health and Safety, Finance, etc.
- **Care Group Tier:** Individual risk registers for each operational Care Group (Planned Care, Medicine & Urgent Emergency Care, Families and Communities).
- **Divisional Tier:** Individual risk registers for each operational Division (Surgery, Cancer Services, Paediatrics etc.)

Each risk is recorded in a single register, with the Service/Location field used to capture the originating service. This prevents duplication and ensures single-source-of-truth risk data. Escalation status is recorded within DCIQ, rather than creating parallel risk entries in multiple registers.

Risk System Transition Arrangements

During the transition from DatixWeb to DCIQ, a controlled dual-system approach will be maintained for a defined period.

- All **new risks must be recorded in DCIQ** from the agreed go-live date
- DatixWeb will be retained as a **read-only repository** for legacy risks
- No new risks should be created in DatixWeb post cutover

Clear communication and system controls will be implemented to prevent duplication or parallel risk recording.

The Operating Manual (Part C) sets out:

- Transition timelines
- Data migration approach
- User responsibilities during transition

6. Risk Scoring

6.1 Consequence and Likelihood Matrices

All risks must be scored using the Trust's approved 5×5 risk matrix, which assesses two dimensions: consequence (the severity of the potential impact) and likelihood (the probability of occurrence). The matrices are aligned to NPSA standards and are set out in full in Appendix 1 (Consequence) and Appendix 2 (Likelihood).

Risk Owners must select the most appropriate consequence category for the risk type (for example, Clinical Safety, Financial, Performance, Workforce, Information Governance) and score both

consequence and likelihood on a 1 – 5 scale. The resulting risk score (consequence x likelihood) determines the risk rating and the governance and review requirements.

6.2 Risk Rating Matrix

Likelihood \ Impact →	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Risk ratings by score: 1-3 Very Low, 4 - 6 Low, 8 - 12 Moderate and 15-25 High

Risks must be scored three times: first for their initial (inherent) score without any controls in place; second for their current (residual) score reflecting existing controls; and third, a target score representing the anticipated level of risk once all planned mitigation actions have been fully implemented. The residual score is the primary score for governance, escalation and review purposes. The difference between inherent and residual scores provides a measure of control effectiveness.

Risk scoring must be supported by evidence and reflect the current effectiveness of controls and assurance arrangements.

6.3 Risk Appetite and Tolerance Thresholds

The UK Corporate Governance Code states that ‘the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives’. Risk Appetite represents risk optimisation and is a statement of strategic intent. It is set by category (Low- Very High) and represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

Risk tolerance reflects the envelope within which, the board is willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the board’s strategy and risk appetite; it is therefore articulated as number, setting an upper boundary; noting that the risk tolerance may at times exceed risk target, as a means to reaching the optimal risk position.

Risk appetite operates at two levels within the Trust:

- Strategic appetite: the Board’s overall tolerance for risk across each risk category, set out in this Statement and reviewed annually
- Operational tolerance: the specific residual risk score above which a risk must be escalated, as set out in the Operating Manual (Part C)

Overall Risk Appetite Position

The Trust operates in an inherently complex environment. Delivering integrated health and care services – acute, community and, currently, adult social care – across a dispersed geography involves unavoidable risk. The Board does not seek to eliminate risk entirely; it seeks to understand it, manage it proportionately and ensure it is always visible at the right level.

The Trust's overall risk position can be stated simply: we have the lowest tolerance for risks that could harm patients, staff or the public, and a higher tolerance for the risks that come with transforming the way we deliver care. Everything else sits between those two poles, calibrated by category.

In practice this means:

- Patient safety, infection control and legal compliance: we have very low appetite. The Trust will take all reasonable steps to eliminate or mitigate these risks. Any residual risk above the threshold must be escalated in accordance with Section 9.
- Operational and financial risks: we have low appetite. These risks are actively managed and must be escalated where controls are insufficient.
- Workforce, partnership and environmental risks: we have moderate appetite. Some risk is inherent in transforming how we work and how we collaborate across the system.
- Strategic transformation: we have a moderate appetite. Delivering our five signature moves requires bold decisions. The Trust is willing to accept well controlled risk where the benefit to patients and communities is clear.
- This position is for the year ending 31st March 2027 and is reviewed annually by the Board. The detailed appetite and tolerance thresholds for each risk category are set out in Section 5 of the Risk Appetite Statement document.

The Trust's Board-approved Risk Appetite Statement sets the acceptable residual risk level for each risk category. The Risk Appetite Statement is published as a standalone supporting document within the Risk Management Manual and sets out appetite levels and tolerance thresholds for each risk category, aligned to the NHS Devon ICS system risk appetite framework. Where a residual risk score exceeds the Trust's defined appetite threshold for its category, the risk must be escalated in accordance with Section 9. Risk appetite thresholds are reviewed annually by the Board.

Risk appetite must be actively considered in risk scoring, escalation and decision-making. Risks exceeding defined appetite thresholds must be escalated in accordance with this Policy.

It is important to note that the escalation of a risk will not negate the responsibilities of the Risk Owner or Area, Local Team, Care Group, Division or Corporate function.

The Board have agreed that the Trust's risk appetite and tolerance for **year ended 31 March 2027**, being subject to annual review, is as follows:

Risk type (as defined by the DCIQ risk category classification)	Risk appetite category (Very Low, Low, Moderate, High)	Risk target score	Risk tolerance boundary
Clinical Safety and Patient Experience	Very Low	1	Up to 3
Infection Prevention and Control	Very Low	1	Up to 3
Legal and Regulatory	Very Low	1	Up to 3

Risk type (as defined by the DCIQ risk category classification)	Risk appetite category (Very Low, Low, Moderate, High)	Risk target score	Risk tolerance boundary
Health and Safety	Low	TBC	Up to 6
Performance	Low	TBC	Up to 6
Financial	Low	TBC	Up to 6
Estates and Facilities	Low	TBC	Up to 6
Information Governance	Low	TBC	Up to 6
Communication and Reputational	Low	TBC	Up to 6
Digital, Cyber and Data †	Low	TBC	Up to 6
Business Continuity †	Low	TBC	Up to 6
Workforce, Inclusion and Education	Moderate	TBC	Up to 12
Environmental	Moderate	TBC	Up to 12
Partnership and System	Moderate	TBC	Up to 12
Health Inequalities and Population Health	Moderate	TBC	Up to 12
Organisational Transition	High	TBC	Up to 12
Strategy and Transformation	High	TBC	Up to 12

Note: Risk target scores marked 'TBC' will be confirmed through the Yellowfin reporting configuration during Q1 2026/27, with the aim of completing target score calibration before the first full BAF cycle under the new framework. Target scores for Very Low appetite categories are set at 1, representing the Trust's position that these risks should be reduced to the lowest achievable level. All scoring uses the NPSA-aligned 5x5 consequence x likelihood matrix agreed by the Risk Group (December 2025). Scores 7, 11, 13 and 14 do not exist in the 5x5 matrix.

Scoring bands: Very Low 1–3 | Low 4–6 | Moderate 8–12 | High 15–25

7. Risk Categories

All risks must be assigned to one of the Trust's agreed risk categories when recorded in DCIQ. The correct category determines which register the risk is assigned to and informs the appropriate consequence domain for scoring.

The Trust's risk categories are aligned to the DCIQ taxonomy and the Board Assurance Framework (BAF) domains. Full category definitions and mapping structures are maintained within the Risk Management Operating Manual and DCIQ configuration.

Level 1 Risk Categories will be the same categories as used for the Trust's Board Assurance Framework (BAF). This is to ensure consistent alignment across risk systems, data and reporting.

For the purposes of DCIQ configuration and reporting, Level 1 categories align to BAF domains, while Level 2 categories provide the operational risk categories used for scoring, categorisation and reporting.

Risk Category (Level 1) / BAF Domains	Scope
1. Quality, Safety, Clinical Outcomes and Patient Experience	Risks to the safety, wellbeing and quality of experience of patients and service users
2. People and Culture	Risks relating to staffing capacity, capability, culture, diversity, training and wellbeing
3. Leadership and Governance	Risks of non-compliance with legal, regulatory or contractual obligations
4. Performance	Risks to the delivery of constitutional, contractual or operational performance standards
5. Finance	Risks to financial sustainability, efficiency and resource stewardship
6. Strategy and Business	Risks associated with strategic change programmes, business continuity, environmental sustainability and organisational transformation
7. Health Inequalities and Population Health	Risks to the Trust's contribution to reducing health inequalities and improving population health outcomes for the communities it serves
8. Digital, Cyber and Data	Risks to data integrity, digital systems, cybersecurity and information governance compliance
9. Partnership and System	Risks arising from or affecting system-level delivery, ICB relationships, provider collaboration and partnership working across NHS Devon ICS
10. Organisational Transition	Risks associated with material changes to the Trust's operating model or partnership arrangements, including the Section 75 transition with Torbay Council

Level 2 categories provide further granularity within each Level 1 domain and are defined within DCIQ to support consistent categorisation and reporting.

Risk Category (Level 2)	Scope
1. Clinical Safety and Patient Experience	Risks to the safety, wellbeing and quality of experience of patients and service users
2. Performance	Risks to the delivery of constitutional, contractual or operational performance standards
3. Workforce, Inclusion and Education	Risks relating to staffing capacity, capability, culture, diversity, training and wellbeing
4. Information Governance	Risks to data integrity, digital systems, cybersecurity and information governance compliance
5. Finance	Risks to financial sustainability, efficiency and resource stewardship
6. Estates and Infrastructure	Risks relating to buildings, equipment, utilities, fire safety and business continuity
7. Environmental	Risks to environmental sustainability and regulatory compliance

Risk Category (Level 2)	Scope
8. Health and Safety	Risks to the physical safety of staff, patients and visitors
9. Strategy and Transformation	Risks associated with strategic change programmes, transformation and innovation
10. Legal and Regulatory	Risks of non-compliance with legal, regulatory or contractual obligations
11. Communication and Reputational	Risks to public confidence, stakeholder relationships and organisational reputation
12. Infection Prevention and Control	Risks relating to healthcare-associated infections and IPC compliance
13. Partnership and System	Risks arising from or affecting partnership working, ICB relationships and system delivery
14. Health Inequalities and Population Health (NEW)	Risks to population health outcomes, prevention, early intervention and equitable access to services
15. Digital, Cyber and Data (NEW)	Risks to digital infrastructure, cyber security, data integrity and digitally enabled care delivery
16. Business Continuity (NEW)	Risks to the continuity of critical services arising from major disruption including infrastructure failure, supply chain interruption or civil contingency events
17. Organisational Transition (NEW)	Risks arising from material changes to the Trust's operating model or partnership arrangements, including the Section 75 transition

Full descriptors for each risk type across all five consequence levels are set out in Appendix 1. Risk Owners should review the consequence descriptors for each applicable risk type before scoring.

8. The Risk Lifecycle

Risk management follows a structured lifecycle within DCIQ. Each stage has defined expectations and must be completed before a risk record can be considered as evidence of robust risk management.

Six steps to managing a risk

A simple, consistent process to keep our patients, staff and services safe.



9. Risk Escalation

Risks must be escalated when they exceed the Trust's defined risk appetite thresholds, when they cannot be managed effectively at the current level, when they affect multiple services or domains, or when they have potential impact at system level.

Risks will be escalated through a structured hierarchy:

- Service / Team level – locally managed risks
- Care Group / Directorate level – aggregated and higher-impact risks
- Corporate Risk Register – organisation-wide risks requiring executive oversight
- Board Assurance Framework (BAF) – principal strategic risks

The Corporate Risk Register is the executive oversight register for organisation-wide operational/cross-cutting risks, and the BAF is for principal strategic risks to objectives.

The Trust maintains a Corporate Risk Register (CRR) as the primary instrument for Executive and Board oversight of the organisation's most significant operational risks. The CRR is structured around the Trust's agreed risk categories and aligned to the Board Assurance Framework domains. It is informed by operational risk data recorded in DCIQ.

A risk may be included on the Corporate Risk Register (irrespective of its score) where it has been referred by the Risk Group, the Executive Committee, a Board sub-committee, or a named Executive Director, having regard to its score, nature and potential organisational impact. Regardless of the referral route, the Risk Group retains oversight of all risks on the Corporate Risk Register and will review each addition at its next scheduled meeting.

The Corporate Risk Register is reviewed by the Executive Committee as part of the Trust's assurance reporting cycle. Risks on the CRR that threaten delivery of the Trust's strategic objectives may be escalated to the Board Assurance Framework as principal risks.

Inclusion and removal of risks from the Corporate Risk Register is overseen by the Risk Group and confirmed by the Executive Committee. Detailed operating procedures for the CRR are set out in the Risk Management Operating Manual (Part C).

Score-based escalation and BAF inclusion are distinct processes. The hierarchy above describes the operational management tiers through which risks are escalated based on score, impact and the capacity to manage them. BAF inclusion is a separate strategic judgement. Where Risk Group and the Executive Committee assess that a risk – at any score – threatens delivery of a strategic objective, they may recommend it for inclusion on the Board Assurance Framework. A high score alone does not make a risk a principal risk; equally, a risk with strategic significance may warrant BAF consideration even where the score does not trigger automatic escalation.

Escalation decisions will consider:

- Risk score
- Proximity to risk appetite
- Strategic relevance
- Systemic impact

The Operating Manual provides detailed escalation criteria and workflows.

The following table defines the escalation requirements at each risk rating:

Score	Rating	Escalation Route
1–3	Very Low	Managed locally by service or team. Review at least every 6 months.
4–6	Low	Managed at department / Care Group level. Reviewed quarterly. Report to Care Group governance / departmental equivalent.
8–12	Moderate	Escalate to Care Group leadership. Review quarterly. Report to Care Group governance.
15–25	High	Escalate to Care Group Lead. Consider referral to Corporate Risk Register. Two governance thresholds apply within this band: scores above 15 require Executive Director sign-off; scores above 20 require Board-level awareness through ExCo or ARC reporting. Review monthly. BAF inclusion is a separate strategic judgement by Risk Group and ExCo.

Escalation of a risk to a higher-level register does not remove accountability from the originating Risk Owner. Escalated risks retain their original ownership and are jointly visible at both levels in DCIQ. There is no parallel recording of the same risk in multiple registers; escalation status is recorded within the single risk record.

Risks with potential system-level impact - including risks that may affect NHS Devon ICS delivery, RDUH shared pathways, or ICB performance oversight - should be flagged to the Chief Nursing Officer and the Corporate Governance Team for consideration of system-level reporting.

Escalation Trigger: High Risks (Score 15–25)

All risks with a residual score of 15 or above must be escalated to Care Group Lead for review. The Care Group Lead, in consultation with the relevant Executive Director, will determine whether the risk requires referral to the Corporate Risk Register based on its nature, scope and strategic significance – not solely its score.

Two additional governance thresholds apply within this band:

Scores above 15: Executive Director sign-off is required. The Executive Director takes senior responsible ownership alongside the originating Risk Owner. Risk Group oversight.

Scores above 20: Board-level awareness is required through Executive Committee or Audit and Risk Committee reporting. The Executive Director retains senior responsible ownership.

In all cases, BAF inclusion is a separate strategic judgement made by Risk Group and the Executive Committee based on whether the risk threatens delivery of a strategic objective.

10. Risk Review Frequency

All risks must be reviewed at a minimum frequency determined by their current residual score. DCIQ supports automated review notifications. Risk Owners are accountable for ensuring reviews are completed on time.

Score	Rating	Review Frequency	Governance Reporting
1–3	Very Low	At least 6-monthly	Local service governance
4–6	Low	Quarterly	Divisional governance
8–12	Moderate	Quarterly	Care group governance
15–25	High	Committee dependent frequency	Care Group / Risk Group / ExCo / Audit and Risk Committee / Board

Review activities must include an update of the risk narrative to reflect the current position, reassessment of likelihood and consequence scores based on current controls, review of action progress and evidence, and confirmation that the risk remains on the correct register and at the correct escalation level.

A risk review must not consist solely of updating a review date without substantive assessment. DCIQ quality monitoring will identify review records that do not demonstrate meaningful engagement.

11. Actions and Mitigations

Controls describe existing arrangements currently in place to mitigate the risk. Actions represent planned improvements intended to address identified control or assurance gaps. This distinction is important: controls reduce the current risk score; actions are what will reduce it further.

Where a risk record identifies gaps in existing controls or assurance arrangements, specific improvement actions must be defined and recorded in Datix DCIQ using the Risk Action Form. Actions represent planned mitigation activity intended to reduce the likelihood or impact of a risk. They must address clearly identified control or assurance gaps and must not be used to record general improvement activity unrelated to the risk.

All risk mitigation actions must:

1. Address a clearly identified control or assurance gap
2. Be assigned to a named Action Owner who is accountable for delivery
3. Include a realistic and specific due date
4. Be framed using SMART principles (Specific, Measurable, Achievable, Realistic, Time-bound)

5. Describe how the action will reduce the likelihood or impact of the risk
6. Include evidence of completion when closed
7. Be reviewed regularly as part of the risk review process to ensure they remain relevant, achievable and aligned with the current risk position

Risk Action Form

The Risk Action Form in DCIQ is a dedicated risk-specific form and must be used for actions intended to mitigate an identified risk. Generic DCIQ action forms may be used for other modules not directly linked to a specific risk. Maintaining this distinction ensures that risk mitigation activity remains clearly connected to the relevant risk record and supports effective governance oversight of whether identified control gaps are being addressed and whether risk exposure is reducing over time.

Monitoring of Actions

Overdue actions are automatically flagged through DCIQ and reviewed through governance forums, including Care Group governance meetings and the Risk Group. Persistent overdue actions, or actions that are repeatedly extended without sufficient justification, will be escalated to the relevant Executive Director for review. Completed actions must include clear evidence demonstrating that the intended mitigation has been implemented.

12. Governance Oversight, Safety and Learning

Risk management does not operate in isolation. Risk information should be actively integrated with other intelligence sources to support organisational learning and early risk identification. The Trust expects risk data to be considered alongside:

- Patient safety incidents and near misses reported via DCIQ
- Complaints, concerns and feedback from patients and the public
- Claims, inquests and legal proceedings
- Internal and external audit findings
- CQC and NHSE regulatory activity, inspections and oversight communications
- Staff survey and culture intelligence
- Workforce and financial performance data

Care Group governance forums and the Risk Group play a key role in identifying thematic risks and early warning signals that may not be visible from individual risk records alone. The Trust's Quality and Safety Committee and Audit and Risk Committee receive integrated assurance reports that draw on all these sources.

Risk management also informs and is informed by operational planning, service transformation, workforce planning, quality improvement and resource allocation.

Risk Owners are encouraged to consider emerging risks arising from change programmes and to record these in DCIQ at the earliest opportunity.



13. Roles and Responsibilities

Role / Function	Responsibilities
Trust Board	Holds ultimate accountability for risk management. Approves the Risk Management Manual, Risk Appetite Statement and Board Assurance Framework. Receives assurance through governance sub-committees.
Audit and Risk Committee	Provides independent scrutiny of risk management effectiveness and BAF reporting on behalf of the Board. Reviews Internal Audit findings on risk governance.
Quality and Safety Committee	Receives assurance on clinical and operational risk management. Reviews, themes, trends and escalated risks relevant to clinical quality and patient safety.
Executive Directors	Hold senior responsible ownership of corporate and principal risks. Champion risk management behaviours across their portfolios. Accountable for risk management within their directorates.
Chief Nursing Officer	Chairs the Risk Group. Provides executive leadership of the risk management framework. Responsible for the quality of organisational risk management practice.
Risk Group	Provides organisational oversight of the risk management framework. Reviews risk quality, escalation, alignment with BAF and compliance with this Policy. Chaired by the Chief Nursing Officer.

Role / Function	Responsibilities
Risk Mgt & DCIQ Design Authority	Governs DCIQ system standards, configuration, change control and data quality. Ensures alignment with RDUH and ICB reporting expectations.
Care Group Leadership Teams	Accountable for identifying, managing and reporting operational risks within their Care Groups. Ensure risk registers are current, accurate and appropriately reviewed.
Risk Owners	Responsible for maintaining accurate, current risk records in DCIQ. Ensure controls are documented, actions are progressed and risks are reviewed on time.
All Staff	Responsible for identifying risks relevant to their work and reporting them through agreed processes. Support a culture of openness and learning.

Full role descriptors, including guidance for Risk Owners, Risk Handlers and Care Group risk leads, are set out in the Risk Management Operating Manual (Part C).

14. Training and Capability

The Trust is committed to ensuring that all staff with risk management responsibilities have the knowledge, skills and system access to fulfil those responsibilities effectively. Risk management training will cover:

- Understanding of risk: what constitutes a risk, how to articulate a risk clearly and how to distinguish between risk, issue and action
- Risk scoring: how to apply the consequence and likelihood matrices consistently, including use of the correct risk type descriptors
- System use: how to record, review and update risk records in DCIQ, including use of the Risk Action Form and the review workflow
- Escalation: when and how to escalate risks, and how to use DCIQ escalation functionality
- Governance responsibilities: the expectations on Risk Owners, Care Group leads and governance leads

During the transition from Datix Web to DCIQ, additional training and support sessions will be provided to Care Groups to ensure risks meet the required quality standard prior to migration. Training is provided through a combination of face-to-face sessions, drop-in clinics, DCIQ system guidance, Quick Reference Guides and the Trust's intranet risk management page. Training requirements are reviewed annually. Support for DCIQ users is available through the Corporate Governance Team and the Risk Officer.

15. Monitoring and Compliance

Compliance with this Policy will be monitored through:

- DCIQ system reporting, including risk quality metrics, risk record quality (completeness of cause–event–impact structure, controls and actions), review compliance rates, escalation compliance and action completion rates
- Regular review of risk register quality at Risk Group
- Internal Audit reviews of risk management arrangements

- Governance and assurance reporting through ExCo, Quality and Safety Committee and Audit and Risk Committee
- Annual assessment against the Key Performance Indicators set out in the Risk Management Strategy

The outcomes of monitoring will be reported to the Risk Group and, where material, to the Audit and Risk Committee. Significant compliance concerns will be escalated to the Chief Nursing Officer and, where appropriate, to the Board.

16. Review of This Policy

This Policy will be reviewed every three years, or sooner where required by the circumstances set out below. An early review will be undertaken within 12 months of Datix DCIQ go-live to ensure the Policy remains aligned with operational practice and system configuration. The review will consider:

- Changes to the Trust's operating model, including any material changes to social care responsibilities or partnership arrangements
- Changes to regulatory requirements, ICB system governance expectations, or NHS England standards
- Significant changes to DCIQ or other supporting systems
- Lessons identified from internal or external review, incident investigation or regulatory feedback

This Policy is owned by the Chief Executive Officer and approved by the Board of Directors. Any material revision requires Board approval. Minor updates may be approved by the Audit and Risk Committee and reported to the Board. The Policy version history and change log are maintained in the document control register.

Related Documents

Part A – Risk Management Strategy
 Part C – Risk Management Operating Manual
 Board Assurance Framework
 Risk Appetite Statement
 Datix DCIQ Risk Register Structure Design
 Risk Action Form Guidance
 Appendix 1 – Consequence Matrix (by risk type, 5 levels)
 Appendix 2 – Likelihood Matrix (NPSA-aligned)
 Appendix 3 – Risk Rating Matrix (5×5 with colour coding)

Appendix A- Consequence Matrix

Potential Consequences					
Choose the Risk Type from the rows below, then select the Consequence from the column.					
Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
Clinical Safety and Patient Experience (Personalised Care/ Physical/ Psychological)	No physical harm or Injury. Adverse event requiring no/minimal intervention or treatment Impact prevented. Any adverse event that had the potential to cause harm but was prevented, resulting in no harm. Reduced level of patient experience not directly related to delivery of care.	Minor cuts or bruising, resulting in: - Any safety incident that required extra observation or minor treatment and caused minimal harm to one or more persons. Affects 1-2 people. Unsatisfactory patient experience, readily resolvable.	Moderate injury resulting in: - Professional intervention. - Any incident /accident that could result in a RIDDOR reportable incident. - Increase in length of hospital stay by 4-15 days. - An event which impacts on a small number of patients. - A referral to A&E. Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons. Affects 3-15 people. Mismanagement of patient care. Unsatisfactory management of patient care – local resolution (with potential to go to independent review).	Major injury resulting in: - Life changing injury/s. (e.g. disability, loss of limb). Major untoward clinical / non-clinical issue leading to significant harm / death which requires investigation with executive director involvement. Increase in length of hospital stay by 15 days plus. Mismanagement of patient care with long-term effect. Affects 16 – 50 people. Serious concerns re patient experience for a particular patient or about a particular clinical service / clinician which required executive director involvement in investigation and onward action. Significant result of misdiagnosis.	Catastrophic injuries resulting in: - Multiple permanent injuries or irreversible health effects. - Any patient safety incident that directly resulted in the death of one or more persons. - Multiple Deaths / Fatalities. Major untoward clinical issue either in a single specialty which requires executive or an independent review. Or a single clinician referred to the GMC due to clinical management. An event effecting 50 people plus. Totally unacceptable patient experience that would lead to an investigation by the CQC.

Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column. Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
Performance	Failure to meet departmental standards or KPIs.	Failure to meet Trust / local standards or KPIs.	Failure to meet National standards or KPIs. causing significant but reversible harm to patients, services, or the organisation	Failure to meet professional standards or statutory requirements. causing considerable impact or long-term consequences to patients, services, or the organisation	Sustained failure to meet professional standards or statutory requirements. causing permanent harm or devastating consequences for patients, services, or the organisation
Environmental Impact	Minimal or no impact on the environment. Minor onsite release of substance. Not directly coming into contact with patients, staff or members of the public.	Minor impact on environment. Onsite release of substance contained with potential contact with patients, staff or members of the public.	Moderate impact on environment. Onsite release of substance contained with potential contact with patients, staff or members of the public.	Major impact on environment. On-site release with potential for detrimental effect leading to off-site release with potential for detrimental effect. Involvement by the Environmental Agency	Catastrophic impact on environment. Onsite/Offsite release with realised detrimental/ catastrophic effects. Suspension of Activity by Environmental Agency.
Financial	Loss of £0 – 49k Some adverse financial impact (unplanned cost / reduced income / loss) but not sufficient to affect the ability of one or more Care Group of Corporate function to operate within its annual budget. Low value fraud: asset misappropriation (> £0 – 49k in single instance)	Loss of £50k – £99k Noticeable adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more Care Group of Corporate function to operate within its annual budget. Moderate value fraud: asset misappropriation (>£50 -99k in single instance)	Loss of £100k – £249k Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of one or more Care Group of Corporate functions to operate within their annual budget. Moderate- high value fraud: asset misappropriation (>£100k - £249k in single instance)	Loss of £250k – £499k Significant adverse financial impact (unplanned cost / reduced income / loss) affecting the ability of the organisation to achieve its annual financial control total/ deliver services as planned. High value fraud: asset misappropriation (>£250k -£499k in single instance, or multiple instances of the same type collectively totalling that amount	Loss of £500k + Significant aggregated financial impact (unplanned cost / reduced income / loss) affecting the long-term financial sustainability of the organisation/ deliver services in totality. Very high value fraud: asset misappropriation Over £500k in single instance, or multiple instances collectively totalling that amount), bribery and corruption,

Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column. Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
				leading to a concern over efficacy of internal control	and financial statement fraud
Health & Safety	No physical harm or Injury. Adverse event requiring no/minimal intervention or treatment Impact prevented. Any adverse event that had the potential to cause harm but was prevented, resulting in no harm. Impact not prevented – any adverse event that ran to completion but no harm occurred. Negligible Damage to Property, Equipment or Minor/No Injury	Minor cuts or bruising, resulting in: - No lost time or time off work. Affects 1-2 people. Non-Reportable Injury, Minor Loss of process or Slight Damage to Property	Moderate injury resulting in: - Time off work for up to 7 days. - A referral to A&E. - Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons. Affects 3-15 people. Reportable Injury, Moderate Loss of Process or Limited Damage to Property	Major injury resulting in: - Life changing injury/s. - Major injury/long term incapacity / disability (e.g. loss of limb). - More than 14 days off work. - Any incident /accident that could result in a RIDDOR reportable incident. Affects 16 – 50 people. Critical Loss of Process, Serious Damage to Property	Catastrophic injuries resulting in: - Multiple permanent injuries or irreversible health effects. - Any patient safety incident that directly resulted in the death of one or more persons. - Major untoward non-clinical issue either in a single specialty which requires executive or an independent review. An event affecting 50 people plus. Single or Multiple Fatalities, Catastrophic Loss of Business
Infection Control & Prevention	Business as usual	- Any Incident recorded for poor Infection Prevention and Control (IPC) practices - Failure to isolate a patient with an alert organism as required by IPC Isolation Policy - Sewage leaks. - Failure of Water supply. - Failure of non-critical ventilation.	- Continued lack of compliance with infection control practices. - CDT infection TSDFT Hospital onset Healthcare associated. - MRSA infection (not colonisation) TSDFT Hospital onset Healthcare associated. - Failure to isolate a patient with an Alert	- CDT infection >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - C.diff >2 TSDFT HOHA within 28 days in single clinical area. - MRSA infection (not colonisation) >2 TSDFT HOHA within 28 days in single clinical area.	- Pandemic, Swine Flu, Etc. CDT infection leading to death >2 TSDFT Hospital onset Healthcare associated - Pandemic, Swine Flu, Etc. C.diff infection leading to death >2 TSDFT HOHA within 28 days in single clinical area.

Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column.					
Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
		- Failure of Decontamination. - Estates failure leading to closure of clinical areas. - HCAI e.g. Surgical Site Infections, CVC infections, Hospital acquired pneumonia, etc.	organism in a High-Risk area.	- Seasonal flu cases 2 ward closures in TSDFT. 4 or more cases of seasonal flu on ITU leading to cancellation of surgery and transfer of patients. - Norovirus cases leading to 2 ward closures in TSDFT. 4 or more cases of Norovirus on ITU leading to cancellation of surgery and transfer of patients. - Failure to isolate a patient with an Alert organism in a Very High-Risk area. - Failure of critical ventilation.	- MRSA infection (not colonisation) leading to death >2 TSDFT Hospital onset Healthcare associated in 28 days in single clinical area. - Flu cases in hospital leading to cross infection and >2 ward closure/and increased deaths. - Staff sickness from pandemic/seasonal flu/ Norovirus leading to low staffing levels. - Norovirus cases in hospital leading to cross infection and >2 ward closure/and increased deaths. - Staff sickness from Norovirus leading to low staffing levels. - Failure to isolate >2 patient with an Alert organism in a Very High-Risk area.
Digital, Cyber & Data	Unplanned loss/interruption of service for up to 1 hour affecting one business critical system. Loss of data from a single business critical	Unplanned loss/interruption of service for up to 4 hours affecting one business critical system. Loss of data from a single business critical system	Unplanned loss/interruption of service for up to 8 hours affecting one business critical system. Loss of data from a single business critical system	Unplanned loss/interruption affecting service of one business critical IT systems for up to 24 hours.	Unplanned loss/interruption affecting service of many business-critical IT systems for up to 1 hour.

Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column.					
Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
	system that takes up to 1 hour to recover.	that takes up to 8 hours to recover.	that takes up to 24 hours to recover.	Temporary loss of data from multiple business critical systems.	Permanent loss of data from a single business critical system.
Information Governance	Exposure of non-personal or confidential information to those not covered by a data sharing agreement or otherwise unintended. Failure to meet departmental standards for Information Governance (IG).	Exposure of sensitive information to unintended recipients. Failure to meet Trust/ local standard for IG GDPR Incident raised on Datix (link to legal & regulatory risk.)	Exposure of commercially confidential information to unintended recipients. Failure to meet national IG standards or KPI.	Exposure of a single individuals' personal information to those not covered by a data sharing agreement or otherwise unintended. Failure to meet legal, professional IG/Data privacy standards or statutory requirements.	Exposure of multiple individuals' personal information to those not covered by a data sharing agreement or otherwise unintended. Sustained failure to meet legal, professional standards or statutory requirements with regard to IG
Business Continuity	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of core services or facility. Disruption to facility leading to significant "knock on" effect

Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column. Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
Workforce, Inclusion & Education	Clinical: Business as usual staffing levels: Normal staffing ratios maintained, no red flags, acuity and dependency expected within area Non-clinical: Short term reduced staffing level/levels of competence temporarily reduces service quality (1 day or less delay in service provision) Low levels of sickness and absence rates, low staff retention Locally resolved diversity or inclusion complaint via informal route of resolution High levels of attendance at mandatory/key training beginning to decrease	Clinical: patient safety and quality <u>compromised</u> <u>delivery/impact on a more than one service</u> due to staffing levels, red flags identified in all areas, acuity and dependency elevated above expectation for area. Staffing escalation plan reviewed and actioned Non-clinical: Ongoing low staffing level/levels of competence, reduces service quality (2 -7 days) Sickness and absence rates, staff retention reducing/ pattern of low morale becoming prevalent. Justified complaint in regard to non-compliance with diversity and inclusion policy and procedures- litigation unlikely, if resolved via informal route and written outcome Moderate levels of attendance at mandatory/key training	Clinical: clinically unsafe/unable to deliver a <u>service</u> due to staffing levels, red flags identified in all areas, acuity and dependency elevated above expectation for area. Staffing escalation plan in effect Non-clinical: Ongoing low staffing level/levels of competence, reduces service quality (8-30 days) Increasing sickness and absence rates, low staff retention and staff morale Justified complaint in regard to non-compliance with diversity and inclusion - litigation possible, if evidence of informal resolution explored and not successful, progression to formal investigation Poor staff attendance for mandatory/key training / minor errors arising due to insufficient training; OR identified staff not attending mandatory/ key training for a fixed agreed period due to	Clinical: significant clinical risk and inability to deliver <u>more than one service</u> due to staffing levels, red flags identified in all areas, acuity and dependency elevated above expectation for area. Staffing escalation plan in effect Non-clinical: Ongoing low staffing level/levels of competence, reduces service quality (1 month – 6 months) Sustained levels of sickness (sickness rate of 4% - 6%); Loss of key staff, lower staff morale, growing empathy fatigue Justified complaint in regard to non-compliance with diversity and inclusion - litigation expected, if formal investigation and appeal process has been unsuccessful. Case may progress to formal disciplinary requiring formal action.	Clinical: significant clinical risk and inability to deliver <u>all essential services</u> due to staffing levels, red flags identified in all areas, acuity and dependency elevated above expectation for area. Staffing escalation plan in effect Non-clinical: Ongoing low staffing level/levels of competence reduces service quality (in excess of 6 months) Sustained levels of sickness (sickness rate of 6% or more); Loss of several key staff, low staff morale, persistent empathy fatigue impacting on staff and service. Clear non-compliance of diversity and inclusion legislation – litigation expected or received. Where formal action has resulted in end of employment and progress to an Employment Tribunal or Public Interest

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			organisational requirements	No staff attending mandatory/ key training for a fixed agreed period due to organisational requirements	No staff attending mandatory training /key training on an ongoing basis.
Potential Consequences					
Choose the Risk Type from the rows below, then select the Consequence from the column.					
Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
Strategy & Transformation	New programmes: Key stakeholders largely supportive/strategy Delivery: Insignificant cost increase or schedule slippage on projects or improvements Negligible reduction in scope or quality of programme design/ delivery or innovation Minor delay to milestones (< 2 weeks) with negligible effect on related deliverables/ programme Minimal disruption; no impact on strategic goals or clinical services.	New programmes: 20% of key stakeholders unhappy with proposals/strategy Delivery: Above 5 per cent over project or improvement budget Schedule slippage Minor reduction in quality/scope. Delay to critical milestones (2-4 weeks) but overall project is recoverable, Plans in place for majority of milestones Negligible effect on service delivery and no change to outcomes or patient care.	New programmes: 20% - 50% of key stakeholders unhappy with proposals/strategy Delivery: 5–10 per cent over project or improvement budget Schedule slippage: leading to service delay/improvement Reduction in scope or quality Delay to critical milestones (1-3 months) but overall project is recoverable. Plans in place for critical milestones Some impact on clinical workflows / may affect local service quality.	New programmes: 50% of key stakeholders unhappy with proposals/strategy Delivery: 10–25 per cent over project or improvement budget Schedule slippage: leading to significant service delay/improvement Failure to meet secondary objectives. Critical milestones missed >3 months). Plans in place to manage and mitigate impact of slippage/interdependencies Significant disruption to programme delivery or system performance; affects patient care or Trust reputation.	New programmes: Active organised resistance to proposals/ strategy Delivery: Incident leading to more than 25 per cent over project or improvement budget Schedule slippage: leading to lack of certainty for delivery in whole or part Key objectives not met Milestones missed that will have a significant impact on the deliverability of the project and are not recoverable Failure of critical services, severe patient safety risk, major strategic failure

Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column. Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
Communication & Reputational	Complaint / Rumours. Derogative posts on social media, (Facebook/Twitter/Instagram). Potential for public concern. Informal/locally resolved complaint.	Local media coverage, short-term reduction in public confidence. Shared derogative posts on social media, (Facebook/Twitter/Instagram). Elements of public expectation not being met. Overall treatment/service substandard. Formal justified complaint Minor implication for patient safety if unresolved.	Local media coverage. Long-term reduction in public confidence. Sustained postings of derogative posts on social media, (Facebook/Twitter/Instagram). Justified complaint involving lack of appropriate care. Major implications for patient safety if unresolved.	National media coverage with <3 days service well below reasonable public expectation. Petition raised on Change.org or other social media platform. Multiple justified complaints leading to independent review. Noncompliance with National standards with significant risk to patients if unresolved.	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House.) Total loss of public confidence. Multiple justified complaints - Single major claim - Inquest/ombudsman inquiry
Legal & Regulatory	Locally resolved complaint Minor non-compliance with standards Minor recommendations from regulator, inquiry or other oversight body Fines, damages, or costs below £100,000: where covered by NHSR insurance Fines, damages, or costs below £10,000: where not covered by NHSR insurance	Justified complaint peripheral to patient care Litigation unlikely Non-compliance with standards Recommendations given Fines, damages, or costs: £100,000 - £499,000: where covered by NHSR insurance Fines, damages, or costs: up to £10,000 - £25,000: where not covered by NHSR insurance	Justified complaint involving a lack of patient care Litigation/enforcement action possible Reduced rating Challenging recommendations Non-compliance with core standards or legislation Fines, damages, or costs: £500,000-£2,500,000: where covered by NHSR insurance Fines, damages, or costs: £25,000 - £100,000: where not covered by NHSR insurance	Multiple justified complaints Litigation/enforcement expected Low rating Enforcement action HSE intervention Critical report from regulatory body Major non-compliance with core standards or legislation Fines, damages, or costs: £2,500,000 - £10million: where covered by NHSR insurance Fines, damages, or costs: £100,000 - £1million: where not	Multiples claims or single major claim Litigation/prosecution certain Zero rating Prosecution Severely critical report from regulatory body Loss of contracts Public Inquiry Trust put into Special Administration/Suspension of CQC registration Fines, damages, or costs above £10 million: where covered by NHSR insurance Fines, damages, or costs: above £1million: where not covered by NHSR insurance

				covered by NHSR insurance	
Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column.					
Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
Health Inequalities and Population Health	Isolated, short-term variation in access or uptake affecting a small cohort within a single locality. No measurable change in health outcomes. Identified through routine monitoring and addressed through business-as-usual activity.	Localised access barrier or demographic gap in service uptake identified in one care group or neighbourhood. Minor, reversible impact on prevention or early intervention activity. Addressed through targeted operational action within existing resources.	Sustained inequity in access, uptake or health outcomes across one or more population groups (e.g. by deprivation, ethnicity or geography). Evidence of widening gap in a measurable health outcome. Place-based care delivery or population health management programme materially disrupted. Requires senior management intervention and dedicated resource to resolve.	Significant, measurable deterioration in health outcomes for one or more population groups. Failure to deliver against a national or ICS health inequalities priority. Multiple access barriers affecting a substantial proportion of the local population. External scrutiny from ICB, NHSE or OHID likely. Reputational and regulatory consequences if not addressed.	Systemic failure to address health inequalities resulting in demonstrable excess morbidity or mortality in underserved populations. Complete failure of place-based care model or prevention programme. National regulatory intervention or public inquiry. Trust unable to demonstrate compliance with its statutory duties under the Health and Care Act 2022 in respect of health inequalities.
Organisational Transition	Minor, contained delay or administrative issue affecting a single workstream within the transition programme. No impact on service continuity, workforce or contractual obligations. Resolved within existing project governance.	Short-term disruption to one element of the transition (e.g. delayed milestone, minor workforce redeployment issue, single contract amendment required). Limited impact on service users. Managed within existing programme governance	Material delay or disruption affecting service continuity in one or more service areas during the transition period. Workforce uncertainty affecting recruitment, retention or morale in transitioning services. Contractual or financial sustainability issue	Significant service disruption affecting multiple service areas or a large staff group. Contractual or financial model for the revised operating arrangement unresolved with material financial exposure. Regulatory or legal risk crystallising (e.g. breach of Section 75	Complete failure of the transition process resulting in unplanned service cessation, mass workforce displacement or contractual collapse. Fundamental breakdown in the partnership with Torbay Council.

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		with no escalation required.	requiring renegotiation or additional resource. Co-design process with the local authority stalled or at risk. Requires Executive Director intervention.	obligations, employment law challenge). Partnership relationship with the local authority materially damaged. National or regional scrutiny from NHSE, DHSC or CQC.	Legal proceedings or regulatory enforcement action. Direct harm to service users arising from service discontinuity. Board-level intervention and external review required. Trust placed in formal oversight or equivalent.
Potential Consequences Choose the Risk Type from the rows below, then select the Consequence from the column.					
Consequence (Impact) Score and Examples of Descriptor					
Score >	1	2	3	4	5
Risk Type	Minimal	Minor	Moderate	Major	Catastrophic
Organisational Transition	Minor, contained delay or administrative issue affecting a single workstream within the transition programme. No impact on service continuity, workforce or contractual obligations. Resolved within existing project governance.	Short-term disruption to one element of the transition (e.g. delayed milestone, minor workforce redeployment issue, single contract amendment required). Limited impact on service users. Managed within existing programme governance with no escalation required.	Material delay or disruption affecting service continuity in one or more service areas during the transition period. Workforce uncertainty affecting recruitment, retention or morale in transitioning services. Contractual or financial sustainability issue requiring renegotiation or additional resource. Co-design process with the local authority stalled or at risk. Requires Executive Director intervention.	Significant service disruption affecting multiple service areas or a large staff group. Contractual or financial model for the revised operating arrangement unresolved with material financial exposure. Regulatory or legal risk crystallising (e.g. breach of Section 75 obligations, employment law challenge). Partnership relationship with the local authority materially damaged. National or regional scrutiny from NHSE, DHSC or CQC.	Complete failure of the transition process resulting in unplanned service cessation, mass workforce displacement or contractual collapse. Fundamental breakdown in the partnership with Torbay Council. Legal proceedings or regulatory enforcement action. Direct harm to service users arising from service discontinuity. Board-level intervention and external review required. Trust placed in formal oversight or equivalent.

Notes

1. Health Inequalities and Population Health is a new TSDFT-specific category aligned to the ICS BAF 2026/27 and linked to the Trust's signature move "Living well in our neighbourhoods." The catastrophic descriptor references the Health and Care Act 2022 statutory duties on health inequalities.

2. Organisational Transition is a time-limited category created to give Board-level visibility of the Section 75 transition and other material operating model changes. Descriptors reference the specific context of the Torbay Council partnership. This category and its descriptors should be reviewed at the end of the transition period.

Appendix B – Likelihood Matrix

Score	Descriptor	Detailed description	Frequency	Probability
1	Rare	Highly unlikely, may occur in exceptional circumstances	Not expected for years	1–5%
2	Unlikely	Slight possibility of occurring	At least annually	6–25%
3	Possible	Might occur at some time	At least monthly	26–50%
4	Likely	Strong possibility, frequent occurrences	At least weekly	51–75%
5	Almost Certain	Expected in most circumstances	At least daily	76–100%

Appendix C – Risk Rating Matrix

Likelihood \ Impact →	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

Risk ratings by score: 1-3 Very Low, 4 - 6 Low, 8 - 12 Moderate and 15-25 High

Risks must be scored three times: first for their initial (inherent) score without any controls in place; second for their current (residual) score reflecting existing controls; and third, a target score representing the anticipated level of risk once all planned mitigation actions have been fully implemented. The residual score is the primary score for governance, escalation and review purposes. The difference between inherent and residual scores provides a measure of control effectiveness.

Risk scoring must be supported by evidence and reflect the current effectiveness of controls and assurance arrangements.

Torbay and South Devon NHS Foundation Trust

Risk Appetite Statement

Document Title	Risk Appetite Statement
Part	Supporting document - Risk Management Strategy
Version	1.2 (Draft for approval)
Status	Draft
Author	Corporate Governance Team
Owner	Board of Directors (owner); Chief Executive Officer (executive lead)
Approved by	Board of Directors
Approval date	May 2026
Review date	May 2027 (or earlier if required)

1. Purpose

This Risk Appetite Statement sets out the level of risk Torbay and South Devon NHS Foundation Trust (TSDFT) is willing to accept in pursuit of its strategic objectives. It is a Board-approved document and forms an integral part of the Trust's Risk Management Manual, operating alongside:

- Part A: Risk Management Strategy, which sets out the Trust's strategic intent and system alignment
- Part B: Risk Management Policy, which defines the mandatory requirements for risk recording, scoring, escalation and review
- Part C: Risk Management Operating Manual, which provides practical day-to-day guidance for Risk Owners

This Statement provides the reference point against which risk scores are interpreted, escalation decisions are made, and Board assurance is framed. It is used by Risk Owners, Care Group leads, Executive Directors and governance forums to determine whether identified risks are being managed within acceptable boundaries.

2. Definition of Risk Appetite and the Trust's Position

Risk appetite is defined as the amount and type of risk that the Trust is prepared to pursue, retain or accept in pursuit of its strategic objectives. It represents a deliberate balance between the potential benefits of innovation and improvement and the risks that change inevitably brings.

The UK Corporate Governance Code states that 'the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'. Risk Appetite represents risk optimisation and is a statement of strategic intent. It is set by category (Low- Very High) and represents a balance between the potential benefits of innovation and the threats that change inevitably brings.

Risk tolerance reflects the envelope within which, the board are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the board's strategy and risk appetite; it is therefore articulated as number, setting an upper boundary; noting that the risk tolerance may at times exceed risk target, as a means to reaching the optimal risk position.

Risk appetite operates at two levels within the Trust:

- Strategic appetite: the Board's overall tolerance for risk across each risk category, set out in this Statement and reviewed annually
- Operational tolerance: the specific residual risk score above which a risk must be escalated, as set out in the Risk Management Policy (Part B) and Operating Manual (Part C)

Risk appetite is not the same as risk tolerance

Risk appetite describes the type and level of risk the Trust is willing to accept in principle. It is expressed as a qualitative descriptor: Very Low, Low, Moderate or High.

Risk tolerance describes the maximum residual risk score acceptable within a given category before escalation is required.

Both are set out in this Statement and applied consistently through the risk management system (Datix DCIQ) and the Organisational Risk Map.

Overall Risk Appetite Position

The Trust operates in an inherently complex environment. Delivering integrated health and care services – acute, community and, currently, adult social care – across a dispersed geography involves unavoidable risk. The Board does not seek to eliminate risk entirely; it seeks to understand it, manage it proportionately and ensure it is always visible at the right level.

The Trust’s overall risk position can be stated simply: *we have the lowest tolerance for risks that could harm patients, staff or the public, and a higher tolerance for the risks that come with transforming the way we deliver care. Everything else sits between those two poles, calibrated by category.*

In practice this means:

- **Patient safety, infection control and legal compliance:** we have very low appetite. The Trust will take all reasonable steps to eliminate or mitigate these risks. Any residual risk above the threshold requires Board visibility.
- **Operational and financial risks:** we have low appetite. These risks are actively managed and must be escalated where controls are insufficient.
- **Workforce, partnership and environmental risks:** we have moderate appetite. Some risk is inherent in transforming how we work and how we collaborate across the system.
- **Strategic transformation:** we have high appetite. Delivering our five signature moves requires bold decisions. The Trust is willing to accept well-controlled risk where the benefit to patients and communities is clear. This position is for the year ending 31st March 2027 and is reviewed annually by the Board. The detailed appetite and tolerance thresholds for each risk category are set out in Section 5 of this Statement.

3. System and Regulatory Alignment

3.1 NHS Devon Integrated Care Board

TSDFT operates as a provider within the NHS Devon Integrated Care System (ICS) under the strategic oversight of NHS Devon Integrated Care Board (ICB). This Risk Appetite Statement aligns with the system-level appetite framework proposed for 2026/27 by the South West Peninsula Board at the qualitative level – using the same five appetite descriptors (Very Low, Low, Moderate, High and Very High) and covering the same strategic domains, including Health Inequalities and Digital and Data, as required by the ICS BAF. The Trust’s operational scoring uses the NPSA-aligned 5×5 consequence × likelihood matrix, which is the national standard for NHS risk management and differs from the ICS 5-point score bands in structure but not in intent.

Note on scoring

Risk Owners score risks in Datix DCIQ using the NPSA-aligned 5×5 consequence × likelihood matrix agreed by the Trust’s Risk Group (December 2025). The possible scores and their bands are:

Very Low: 1, 2, 3 Low: 4, 5, 6 Moderate: 8, 9, 10, 12 High: 15, 16, 20, 25

Scores 7, 11, 13 and 14 do not exist in a 5×5 matrix. This is a feature of the NPSA matrix structure, not an error.

The tolerance thresholds in this Statement are set at the top of each band. Where a risk score exceeds the threshold for its category, escalation is required in accordance with the Risk Management Policy. Where there is any uncertainty, the more cautious interpretation should be applied.

4. Risk Appetite Scale

The following four-level scale describes the Trust's appetite across each risk category, using the NPSA-aligned scoring bands applied in Datix DCIQ. The tolerance threshold is the score above which escalation is required for that appetite level.

Appetite	Score Band	Possible Scores	Tolerance Threshold	What this means in practice
Very Low	1–3	1, 2, 3	Score >3	The risk must be managed and escalated in accordance with the Risk Management Policy.
Low	4–6	4, 5, 6	Score >6	The Trust will actively manage this risk to reduce it. Residual risk within this band (4–6) is acceptable only where all proportionate controls are in place.
Moderate	8–12	8, 9, 10, 12	Score >12	The Trust accepts a defined level of risk in this area, recognising that some risk is inherent to delivering services. Controls must be documented and regularly reviewed.
High	15–25	15, 16, 20, 25	Score >15: ED sign-off Score >20: Board escalation	The Trust is willing to accept elevated risk in pursuit of strategic objectives where benefit outweighs risk. Two governance thresholds apply: risks scoring above 15 require Executive Director sign-off; risks scoring above 20 require Board-level awareness through Executive Committee or Audit and Risk Committee reporting. Executive Director takes senior responsible ownership.

Note: The High band spans scores 15–25. Within this band, two governance thresholds apply to reflect the significant difference between a score of 15 and a score of 25.

5. Risk Appetite

Risk Appetite Categories and Thresholds

Risk appetite thresholds are governance triggers, not substitutes for professional judgement. In categories where the potential operational consequence of failure is severe – patient safety, estates, business continuity – the Trust will supplement score-based escalation with named overarching risks on the Corporate Risk Register that receive Board-level scrutiny at every cycle regardless of their current score.

The following table sets out the Trust's Board-approved risk appetite for each agreed risk category.

All tolerance thresholds use the TSDFT NPSA-aligned scoring bands. The Board have agreed that the Trust's risk appetite and tolerance for **year ended 31 March 2027**, being subject to annual review, is as follows:

Risk Category (DCIQ Classification)	Appetite	Band	Tolerance	Risk Appetite Statement
Clinical Safety and Patient Experience BAF: Quality, Safety and Patient Experience	Very Low	1–3	>3	The Trust has a very low appetite for risks to the clinical safety and quality of care it provides, and to the quality of patient experience, and adopts a zero-tolerance position for avoidable harm . The Trust will take all reasonable steps to eliminate, transfer or mitigate them. While some residual risk is inherent in complex healthcare delivery, no patient safety risk should be managed at service level without appropriate clinical leadership oversight. Quality and People Committee will maintain robust oversight of this risk

Risk Category (DCIQ Classification)	Appetite	Band	Tolerance	Risk Appetite Statement
				category, providing assurance to Board in line with its Terms of Reference.
Infection Prevention and Control BAF: Quality, Safety and Patient Experience	Very Low	1–3	>3	The Trust has a very low appetite for risks arising from failures in infection prevention and control. The spread of infection poses a direct threat to patient safety, staff wellbeing and regulatory compliance. The Trust will endeavour to maintain the highest standards of IPC practice across all settings and will not accept avoidable lapses in compliance with its IPC framework. Any risk scoring above the tolerance threshold (>3) must be escalated in accordance with the escalation thresholds set out in the Risk Management Policy.
Legal and Regulatory BAF: Leadership and Governance	Very Low	1–3	>3	The Trust has a very low appetite for risks arising from non-compliance with its CQC registration, NHS England provider oversight obligations, Foundation Trust licence conditions or statutory duties. Compliance is a foundational requirement, not a discretionary activity. Any risk scoring above the tolerance threshold (>3) requires immediate escalation and Executive Director ownership.
Health and Safety BAF: Quality, Safety and Patient Experience	Low	4–6	>6	The Trust has a low appetite for risks to the physical safety of patients, staff and visitors arising from its estate, equipment or working practices. Health and safety obligations are non-negotiable in law and in practice. The Trust will actively manage all identified H&S risks and ensure statutory compliance is maintained. Residual risk within the Low band (4–6) is acceptable only where all proportionate controls are in place and documented.
Communication and Reputational BAF: Leadership and Governance	Low	4–6	>6	The Trust has a low appetite for risks to its reputation and public standing, including risks arising from media scrutiny, stakeholder relationships, political interest or organisational communications. The Trust recognises that sustained reputational damage affects its ability to recruit, retain and partner effectively. Active management of reputational risk is expected at all levels, with escalation to the Executive Committee where reputational impact is assessed as significant.

Risk Category (DCIQ Classification)	Appetite	Band	Tolerance	Risk Appetite Statement
Performance BAF: Performance	Low	4–6	>6	The Trust has a low appetite for risks to the delivery of constitutional performance standards and patient access commitments. Patient access is a core statutory duty, and any material deviation requires immediate management attention and Board visibility. Residual risk within the Low band (4–6) is acceptable only where all proportionate controls are in place and documented.
Estates and Facilities BAF: Performance	Low	4–6	>6	The Trust has a low appetite for risks to the operational integrity of its estate and facilities, including risks arising from backlog maintenance, infrastructure condition or inadequate facilities management. The Trust recognises the significant capital challenge it faces. Given the known challenges of the physical estate, score-based escalation alone is not sufficient assurance in this category – the Finance and Operations Committee maintains active oversight of the Trust's estate risk position, with assurance provided to the Board through the BAF.
Financial BAF: Finance	Low	4–6	>6	The Trust has a low appetite for risks to financial sustainability or compliance with its statutory financial duties. It prioritises the delivery of a balanced financial position and responsible stewardship of public resources, while recognising that some financial risk is inherent in transformation. Residual risk within the Low band (4–6) is acceptable only where all proportionate controls are in place.
Information Governance BAF: Digital and Data (system-aligned)	Low	4–6	>6	The Trust has a low appetite for risks to information governance compliance, data integrity and the lawful management of personal information. The Trust will maintain robust information governance standards in line with its statutory obligations under GDPR, the Data Security and Protection Toolkit and NHS England requirements. Residual risk within the Low band (4–6) is acceptable only where all proportionate controls are in place.
Digital, Cyber and Data BAF: Digital and Data (system-aligned)	Low	4–6	>6	The Trust has a low appetite for risks to its digital infrastructure, cyber resilience and data management capability. The Trust will maintain a secure, stable and resilient digital environment.

Risk Category (DCIQ Classification)	Appetite	Band	Tolerance	Risk Appetite Statement
				Following Epic go-live in April 2026, the Trust will prioritise the protection of clinical systems, patient data and digital infrastructure. Residual risk within the Low band (4–6) is acceptable only where all proportionate controls are in place.
Workforce, Inclusion and Education BAF: People and Culture	Moderate	8–12	>12	The Trust has a moderate appetite for risks associated with workforce sustainability, culture, inclusion and education. The Trust recognises that maintaining the status quo is itself a risk; it is willing to accept calculated risk in transforming workforce models, skill mix and ways of working. Residual risk within the Moderate band (8–12) is acceptable where controls are documented and regularly reviewed. NB: The Trust has a Low appetite specifically for EDI and inclusion risks, which is encompassed within this risk category.
NEW: Business Continuity BAF: Strategy and Business	Low	4–6	>6	The Trust has a low appetite for risks to organisational and service continuity arising from system failure, cyber incidents, supplier failure or major incidents. The Trust will maintain a proportionate business continuity framework and will accept some level of residual continuity risk where full mitigation is disproportionate or impractical. Critical patient safety services must be protected.
Environmental BAF: Strategy and Business	Moderate	8–12	>12	The Trust has a moderate appetite for risks to its environmental sustainability obligations and Green Plan delivery. It is willing to accept some risk in piloting innovative approaches to carbon reduction and sustainable healthcare delivery, while ensuring compliance with statutory environmental obligations. The Trust's 2040 Net Zero commitment provides the strategic boundary within which this appetite is applied.
Partnership and System BAF: Partnership and System	Moderate	8–12	>12	The Trust has a moderate appetite for risks arising from partnership working within the NHS Devon ICS, with RDUH, UHP and local authority partners. The Trust is willing to accept some risk in moving beyond traditional organisational boundaries where this supports population health

Risk Category (DCIQ Classification)	Appetite	Band	Tolerance	Risk Appetite Statement
NEW: Health Inequalities and Population Health BAF: Health Inequalities and Population Health	Moderate	8–12	>12	outcomes and system sustainability. The Trust has a moderate appetite for risks associated with its contribution to reducing health inequalities. The Trust recognises that traditional service models have not consistently closed the equity gap, and it is willing to accept calculated risks in piloting targeted, place-based interventions for underserved populations. This appetite is aligned to the NHS Devon ICS system-level appetite for health inequalities.
NEW: Organisational Transition BAF: Organisational Transition	High	15-25	Score >15: ED sign-off Score >20: Board escalation	The Trust has a moderate appetite for risks associated with material changes to its operating model, including its adult social care responsibilities. The Trust recognises the governance and financial complexity of this transition and will manage it actively, with dedicated Board-level visibility through the Organisational Transition BAF domain. Note — Adult Social Care Transition: The Board's March 2026 decision to serve notice on the Section 75 agreement with Torbay Council creates a period of elevated risk. During the 12-month transition period the appetite position will be actively monitored. The Board will maintain oversight through the BAF.
Strategy and Transformation BAF: Strategy and Business	High	15-25	Score >15: ED sign-off Score >20: Board escalation	The Trust has a high appetite for risks associated with strategic transformation, service redesign and innovation. The Trust's integrated model of care requires bold clinical and organisational change. The Trust accepts a defined level of risk in this area and is willing to accept calculated risk in driving strategic transformation and service redesign where there is a clear patient or population benefit. Controls must be documented and regularly reviewed.

6. Applying Risk Appetite in Practice

6.1 Risk Owners

Risk Owners should consult this Statement when scoring and reviewing risks in Datix DCIQ. Where the current (residual) risk score of a risk exceeds the tolerance threshold for its category, the risk must be escalated in accordance with the Risk Management Policy (Part B, Section 9).

Risk appetite does not prevent risks from being recorded at any score level. It determines the governance response: who must be informed, at what frequency the risk must be reviewed, and what level of assurance is required.

6.2 Escalation Triggers

Where a residual risk score exceeds the tolerance threshold for its category, the risk must be escalated in accordance with the Risk Management Policy (Part B, Section 9).

Two additional governance thresholds apply within the High band: risks scoring above 15 require Executive Director sign-off, and risks scoring above 20 require Board-level awareness through Executive Committee or Audit and Risk Committee reporting.

BAF inclusion is a separate strategic judgement made by Risk Group and the Executive Committee based on whether a risk threatens delivery of a strategic objective, not an automatic consequence of any score threshold.

6.3 Risks to Patient Safety – Avoidable Harm

Patient safety – the Trust's clearest statement of appetite

The Trust has a very low appetite for risks to patient safety and clinical quality. This means the Trust will take all reasonable steps to eliminate or mitigate these risks.

The Trust has zero tolerance for avoidable harm and for unmanaged risks to patient safety. While some residual risk is inherent in complex healthcare delivery, no risk to patient safety should be managed at service level without appropriate clinical leadership oversight.

7. Board Assurance Framework Alignment

The Trust's Board Assurance Framework (BAF) maps directly to its strategic objectives. This Risk Appetite Statement is the reference point for assessing whether principal risks on the BAF are being managed within acceptable boundaries. Five of the ten BAF domains are anchored to one of the Trust's five signature moves.

BAF Objective Domain	Primary Risk Categories	Primary Committee	Appetite	Status
1. Quality, Safety, Clinical Outcomes and Patient Experience <i>Signature Move → "Reimagining acute and specialist care"</i>	Clinical Safety and Patient Experience Infection Prevention and Control Health and Safety	Quality and People Committee	Very Low / Low	CONFIRMED
2. People and Culture <i>Signature Move → "Caring, skilled people ready for tomorrow"</i>	Workforce, Inclusion and Education	Quality and People Committee	Moderate	CONFIRMED
3. Leadership and Governance	Legal and Regulatory Communication and Reputational	ExCo / Audit and Risk Committee	Very Low / Low	CONFIRMED
4. Performance	Performance Estates and Facilities	Finance and Operations Committee	Low	CONFIRMED
5. Finance	Financial	Finance and Operations Committee	Low	CONFIRMED
6. Strategy and Business	Strategy and Transformation Business Continuity**	Finance and Operations Committee	High	CONFIRMED

BAF Objective Domain	Primary Risk Categories	Primary Committee	Appetite	Status
	Environmental			
7. Partnership and System <i>Signature Move →</i> "Joined-up care, every step of the way"	Partnership and System	Finance and Operations Committee	Moderate	CONFIRMED
8. Health Inequalities and Population Health <i>Signature Move →</i> "Living well in our neighbourhoods"	Health Inequalities and Population Health	Quality and People Committee	Moderate	CONFIRMED
9. Digital and Data (system-aligned) <i>Signature Move →</i> "Smart use of technology for better care"	Information Governance Digital, Cyber and Data	Finance and Operations Committee	Low	CONFIRMED
10. Organisational Transition	Organisational Transition	ExCo / Board (direct)	High	CONFIRMED

The BAF domains for Health Inequalities and Population Health, Digital and Data, Partnership and System, and Organisational Transition have been added to align with the NHS Devon ICS system BAF for 2026/27.

** Business Continuity has a Low appetite (tolerance >6), distinct from the High appetite applied to Strategy and Transformation and Environmental within this BAF domain.

8. Governance and Review

This Risk Appetite Statement is owned by the Board of Directors and approved annually. The Chief Executive Officer is the executive lead responsible for its maintenance and implementation between annual reviews.

Forum	Frequency	Role
Board of Directors	Monthly	Approves and reviews the Risk Appetite Statement annually. Receives assurance on risks exceeding appetite through the BAF.
Audit and Risk Committee	Quarterly	Provides independent scrutiny of risk appetite alignment and the effectiveness of the risk management framework. Reviews escalated risks and BAF reporting on behalf of the Board.
Quality and People Committee	Monthly	Monitors risks to patient safety, clinical quality, IPC, health and safety, workforce and health inequalities against agreed appetite thresholds.
Finance and Operations Committee	Monthly	Monitors risks to performance, finance, estates, strategy, digital and partnership against agreed appetite thresholds.
Trust Executive Group	Monthly	Reviews cross-cutting risks, transformation risks and organisational transition risks against appetite.
Risk Group	Agreed frequency	Monitors organisational risk scoring against appetite thresholds. Reviews escalation compliance and reports to the Audit and Risk Committee.

9. Review and Version Control

This Statement will be reviewed at least annually, or sooner if required by organisational, regulatory or system change. An early review will be undertaken within 12 months of Datix DCIQ go-live to ensure appetite levels and tolerance thresholds remain appropriate.

Trigger conditions for an unscheduled review include:

- Material changes to the Trust's operating model, including any change to adult social care responsibilities
- Material changes to the NHS Devon ICS system risk appetite framework
- Regulatory action, significant audit finding or adverse CQC inspection outcome
- Significant change to the Trust's financial position or provider oversight rating
- Formal ratification of proposed additional risk categories, requiring appetite positions to be confirmed by the Board

Related Documents

Part A — Risk Management Strategy

Part B — Risk Management Policy

Part C — Risk Management Operating Manual

Board Assurance Framework

DCIQ Risk Type Taxonomy — Three-Level Configuration (working document)

Appendix 1 — Consequence Matrix (NPSA-aligned, Risk Group 02 December 2025)

Appendix 2 — Likelihood Matrix (NPSA-aligned, Risk Group 02 December 2025)

Appendix 3 — Risk Rating Matrix (5×5)

NHS Devon ICS / South West Peninsula Board BAF Paper (March 2026)

Strategic Objectives and Deliverables, Principal Risks and the Board Assurance Framework

Torbay and South Devon
NHS Foundation Trust
Board of Directors – May 2026



Introduction



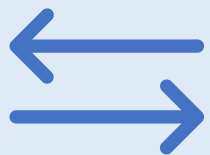
This pack provides an overview of the Trust's draft strategic objectives aligned to its five signature moves, the associated deliverables, the principal risks to achieving these objectives, and the proposed new Board Assurance Framework (BAF) structure.

Introduction



The pack also provides an overview of our shared vision, guiding principles, the five signature moves that define our strategic direction, and the risk management framework that underpins Board-level assurance.

Why we must change



Torbay and South Devon NHS Foundation Trust

We serve one of the most complex and rapidly ageing populations in England, with many people living longer with multiple long-term conditions.

Pressures on urgent care, elective recovery and community services are growing, while workforce challenges continue to shape how services operate.

Our hospitals face rising demand and constrained capacity. Financially, we must be realistic and disciplined, with an underlying deficit at the start of 2026 of almost £100m.

We must redesign how care is organised and delivered, shifting our focus towards prevention, neighbourhood-based care and supporting people to live well for longer.

Our shared vision

To support every person, family and community we serve to live well.

This means enabling everyone to start well, live well, age well and die well in a place where care feels connected, personal and compassionate.

What we will become

We will act in three complementary roles:

Provider Delivering excellent clinical, community and remote services with safety, quality and compassion.	Convener Bringing partners together around shared purpose and outcomes, connecting information, pathways and people so care feels seamless.	Enabler Supporting communities, colleagues and volunteers to play their part in improving wellbeing and creating the right conditions for partners to thrive.

Our guiding principles

Our five commitments guide every decision:

	Value and sustainability Using our resources wisely to deliver financial, workforce and environmental sustainability
	People, purpose and partnership Placing human connection at the centre of everything we do
	Research, learning and innovation Continuously improving and adapting
	Safety and responsible care Protecting people while acting responsibly to improve
	Equity and inclusion Ensuring equity, belonging and trust for all our people and communities

Drivers



Torbay and South Devon NHS Foundation Trust

We serve one of the most complex and rapidly ageing populations, with many people living longer with multiple long-term conditions and high-levels of suicide and self-harm

Pressures on urgent care, elective recovery and community services are growing, while our hospitals face rising demand and constrained capacity

An underlying financial deficit of almost £100m, we must be realistic and disciplined, making significant changes so that the care we provide is affordable and sustainable

The Peninsula will move towards shared services and infrastructure, including digital and data, with success depending on partnership, leadership and trust

National NHS plans call for more prevention, neighbourhood-based care and digital transformation – we aim to drive and support these changes locally

How we will get there

Three overlapping stages of change:

1

Stabilising and building foundations

Strengthen core services, improve flow, reduce waiting times and strengthen financial discipline and digital capability. Create the space, capability and confidence for change.



2

Transforming care together

Design and test neighbourhood models of joined-up care, improve co-ordination between hospital and community services and embed learning, digital and innovation into everyday work.



3

Realising the health and care community we aspire to become

Achieve joined-up, adaptive and compassionate care that enables people to stay well, live independently and access specialist care when they need it.



Torbay and South Devon NHS Foundation Trust

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OUR FIVE SIGNATURE MOVES

Five major shifts in how we design and deliver care

1. Living well in our neighbourhoods

Working with communities to make care easy to reach and part of everyday life

2. Reimagining acute and specialist care

Modernising hospital services, strengthening links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably

3. Joined-up care, every step of the way

Supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout

4. Smart use of technology for better care

Using digital tools and fresh thinking to make care more personal, easier to access and better connected

5. Caring, skilled people ready for tomorrow

Creating a great place to work, supporting people to be their best selves, and building an agile, inclusive workforce for the future

System alignment



The Trust's risk management framework has been designed to work on two levels – at Trust level and at system level.

System alignment – South West Peninsula Board

South West Peninsula Board (SWPB) is the joint governance arrangement overseeing the NHS Devon and NHS Cornwall and Isles of Scilly (CIOS) ICB cluster.

The Trust's risk management framework has been designed to work on two levels. Locally, it is anchored to the five signature moves in the Trust Strategy approved by the Board in March 2026, so that every principal risk on the BAF connects directly to what the Trust is trying to achieve.

At system level, it uses the same risk platform (DCIQ) as other Trusts (i.e. RDUH), scoring methodology and risk description format as other Devon providers, and has added two new BAF domains – Health Inequalities and Digital and Data – specifically to align with the system BAF proposed by the South West Peninsula Board for 2026/27. Where the Trust's appetite positions differ from those in the system framework, this reflects its context as an integrated care provider with direct patient-facing responsibilities, rather than a departure from system alignment.

System alignment – South West Peninsula Board

Summary and key divergences

South West Peninsula Board (SWPB) is the joint governance arrangement overseeing the NHS Devon and NHS Cornwall and Isles of Scilly (CIOS) ICB cluster.



Where TSDFT aligns with the SWPB framework

BAF structure
Controls–assurances–gaps–mitigating actions architecture mirrors the SWPB BAF format used by both Devon and CIOS
Risk description format
Cause–Event–Impact maps directly to the IF–THEN–RESULTING IN structure used in both SWPB BAFs
System BAF domains
Health Inequalities and Digital and Data domains added specifically to align with SWPB system BAF for 2026/27
Risk scoring matrix
5×5 consequence × likelihood matrix shared across TSDFT, Devon, CIOS and RDUH
DCIQ and Yellowfin
Shared risk system and reporting platform with RDUH supports system-level risk comparison



Key divergences requiring Board narrative

Appetite framework labels
SWPB uses GGI 6-level (Avoid → Mature). TSDFT uses a 5-level scale (Very Low → Very High). Labels and number of levels do not directly correspond.
People and Culture
TSDFT: Moderate (>12). Devon: Seek (20–25). A workforce risk scoring 16 breaches TSDFT tolerance but sits comfortably within Devon's.
Leadership and Governance
TSDFT: Very Low/Low (>3/>6). Devon: Seek (20–25). The widest gap — TSDFT is far more conservative than the system position. This can be attributed to NHSE oversight and continued regulatory compliance focus.
Health Inequalities
TSDFT: Moderate (>12). Devon: Avoid (8–12). Devon is more conservative here, reflecting the ICB's statutory duties.
Scoring band boundaries
Devon treats a score of 12 as "High"; TSDFT groups it as "Moderate" (8–12). Same risk, different classification at system level.

Recommendation: Where appetite positions differ from the SWPB system BAF, the covering paper should explain that divergences reflect the Trust's specific provider context and risk profile and are a legitimate local adaptation of the system framework.



Risk appetite framework alignment — TSDFT to Good Governance Institute (GGI)

The SWPB BAFs (Devon and CIOs) use the Good Governance Institute 6-level framework. TSDFT has adopted a 5-level scale described as system-aligned.

TSDFT appetite level(s)	Nearest GGI appetite level(s)	GGI definition (summary)	TSDFT (proposed) tolerance	NHS Devon examples
Very Low	Avoid	Avoidance of uncertainty is a key organisational objective	> 3	Quality (8–12)
Low	Minimal / Cautious	Minimal (ALARP): Ultra-safe options, low risk, limited reward Cautious: Safe options, low inherent risk, limited reward potential	> 6	<i>Not currently used by Devon</i>
Moderate	Open	Willing to consider all options providing acceptable reward and value for money	> 12	Finance (15) Local Priorities (15) BAU (15)
High	Seek	Eager to innovate; choosing options with higher business rewards despite greater inherent risk	> 20	People (20–25) Leadership (20–25)
Very High	Mature	Confident in setting higher risk appetite because controls, forward scanning and responsiveness systems are robust	<i>Not defined</i>	<i>Not currently used by Devon</i>



GGI distinguishes Minimal (ALARP) from Cautious. TSDFT's "Low" collapses both into a single band. The practical difference is narrow, but the ALARP language carries specific regulatory connotations in health and safety contexts that may be relevant to Estates and Health and Safety risk categories.



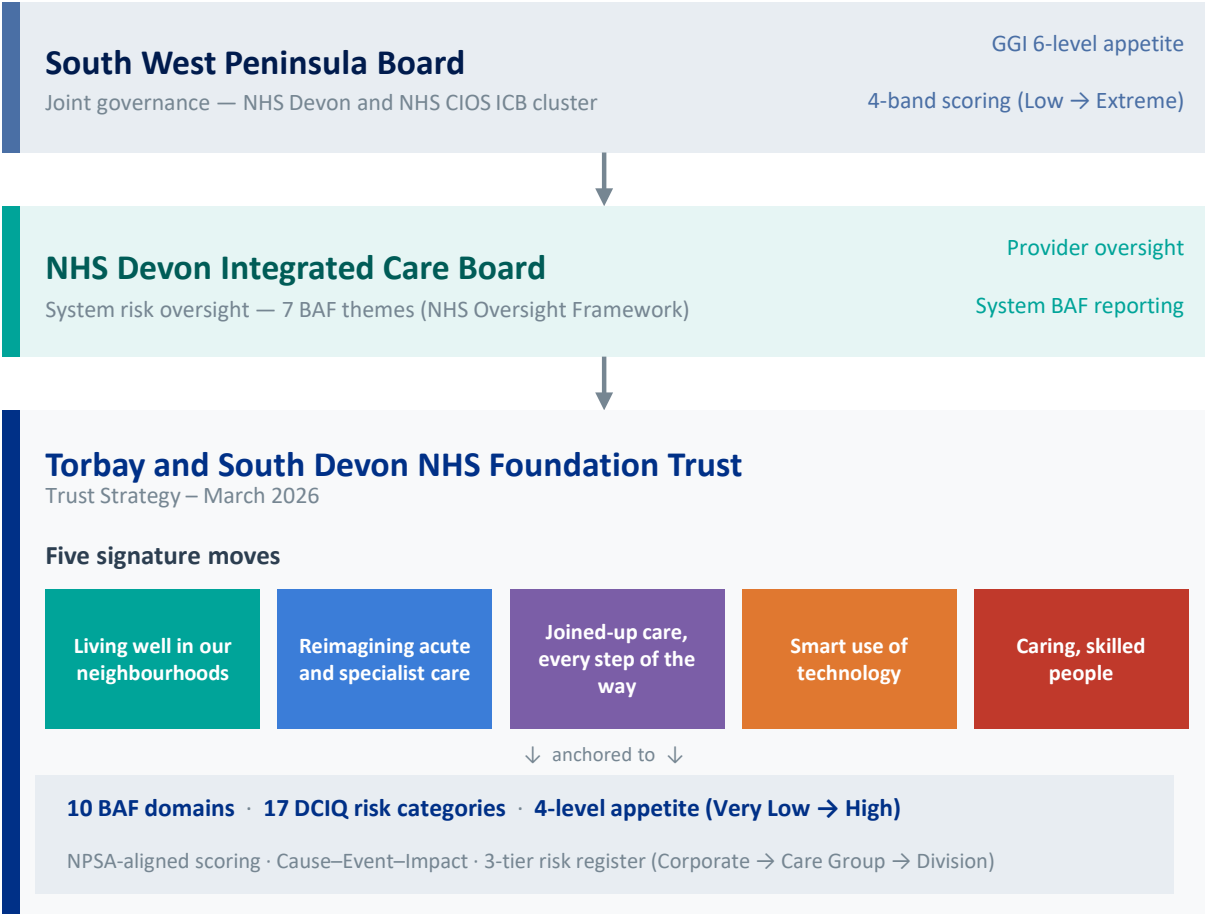
BAF domain cross-reference – TSDFT to SWPB system BAFs

Mapping TSDFT's proposed 10 BAF domains to NHS Devon and NHS CIOs BAF themes (SWPB, December 2025)

TSDFT BAF domain	TSDFT appetite	NHS Devon BAF theme	Devon appetite	NHS CIOs BAF objective	Alignment
Quality, Safety and Patient Experience	Very Low / Low	1. Quality of Care, Access and Outcomes	Avoid	RECOVER (Quality, patient safety)	Aligned
People and Culture	Moderate	4. People	Seek ▲	RECOVER / TRANSFORM (Workforce elements)	Divergent
Leadership and Governance	Very Low / Low	5. Leadership and Capability	Seek ▲	<i>Embedded across objectives</i>	Divergent
Performance	Low	1. Quality of Care, Access and Outcomes (Performance elements)	Avoid	RECOVER (Constitutional standards)	Aligned
Finance	Low	3. Finance and Use of Resources	Open ▲	IMPROVE VALUE	Partial
Strategy and Business	High	7. Delivering BAU in 2025/26 + Local Strategic Priorities	Open	TRANSFORM	Partial
<i>Partnership and System (pending)</i>	<i>Moderate</i>	<i>No standalone equivalent (Embedded across themes)</i>	—	<i>Embedded — system focus across objectives</i>	Trust-specific
<i>Health Inequalities and Population Health (pending)</i>	<i>Moderate</i>	<i>2. Preventing Ill-Health and Reducing Inequalities</i>	Avoid ▲	TRANSFORM (PHM and inequalities)	Partial
<i>Digital and Data (pending)</i>	<i>Low</i>	<i>No standalone equivalent (Digital/cyber within other themes)</i>	—	TRANSFORM (Digital infrastructure, cyber)	System-aligned
<i>Organisational Transition (pending)</i>	<i>High</i>	<i>6. Reducing ICB Running Costs (Transition elements)</i>	Open	DELIVER + Proposed cluster capacity risk	Partial

▲ = material divergence in appetite position between TSDFT and Devon for the equivalent domain. *Pending* items are subject to ExCo and Risk Group approval.

System context – from Trust strategy to system assurance



Shared across the system

- Datix DCIQ**
Same platform as RDUH — single risk data architecture
- Yellowfin reporting**
Aligning reporting dashboards with RDUH for system-level comparison
- 5x5 NPSA matrix**
Consequence × likelihood scoring shared across Devon providers
- IF – THEN – RESULTING IN**
Risk description format used in all SWPB BAFs
- System BAF domains**
Health Inequalities and Digital & Data aligned to SWPB 2026/27

Adapted for the Trust

- Appetite labels**
4-level (Very Low → High) vs GGI 6-level (Avoid → Mature)
- Scoring bands**
Score 12 = Moderate at TSDFT vs High at Devon
- BAF structure**
10 domains anchored to signature moves vs NHS Oversight themes

Delivery of our Signature Moves



The key measures set out in this document are intended as draft indicators of strategic direction. They show what success looks like for each signature move and provide a starting point for Board and committee assurance.

Delivery of our Signature Moves

The key measures set out in this document are intended as draft indicators of strategic direction. They show what success looks like for each signature move and provide a starting point for Board and committee assurance.

Before these measures are embedded in programme reporting and BAF oversight, they will need to be developed into fully specified performance measures using the SMART framework – specific in what they track and where the data comes from, measurable with defined baselines and data sources, achievable given the Trust's current position and capacity, relevant to whether the signature move is being delivered and the associated risk managed, and time-bound with clear reporting frequencies and target dates.

This work will be led by the relevant SRO and workstream lead for each signature move, supported by the PMO, during Q1 2026/27. Baselining will take place in the same period so that targets are grounded in the Trust's actual starting position rather than set in the abstract. A standard template will be used across all workstreams to ensure consistency in how measures are defined, reported and assured.

1. Living well in our neighbourhoods

Working with communities to make care easy to reach and part of everyday life

SRO: CPSO

BAF: Health Inequalities & Pop. Health

Appetite: Moderate (>12)

Year 1 deliverables (OPFBC Year 2)

Workstream	Deliverables
Frailty Hub	Expand The Harbour community frailty hub incl. fracture liaison service
Bed-based care	Review bed-based offer for reablement; promote independence; delay unnecessary long-term bed-based care
Virtual ward	Expand virtual wards, MAAT and Hospital@Home services
Neighbourhood infrastructure	Re-establish 5 locality forums; LCP funding bid; upgrade IT for risk stratification; community estate review
Adult Social Care	Possible workstream post Board Section 75 decision (March 2026)

Draft key measures

- Reduction in non-elective admissions from neighbourhood populations (baseline Q1)
- Virtual ward / Hospital@Home occupied bed days per month
- Fracture liaison service operational with monthly activity reporting
- 5 neighbourhood forums re-established with named clinical leads
- % of high-risk patients with risk stratification in place
- Ambulance conveyance rate to ED (reduction target TBC)
- Community bed-based care: average length of stay and reablement outcome rate

Subject to executive, PMO and workstream lead approval. Measures will be baselined in Q1 2026/27.

2. Reimagining acute and specialist care

Modernising hospital services; focusing specialist care where we deliver the highest quality sustainably

SRO: CNO (triumvirate)
BAF: Quality, Safety & Patient Exp.
Appetite: Very Low / Low (>3 / >6)

Year 1 deliverables (OPFBC Year 2)

Workstream	Deliverables
Clinical services reviews	Review top 6 specialties against service viability criteria (quality, safety, workforce, value)
Fragile services	Progress legacy projects for fragile services incl. dermatology, urology
Productivity including best practice	SLR rollout; GIRFT standards; trust-wide productivity programme (theatres, outpatients, coding); productivity tools for clinical service reviews

Draft key measures

- 6 specialty reviews completed with Board-ready recommendations by Q4
- Service line reporting live across all specialties
- Theatre utilisation rate (target: upper quartile vs. Model Hospital peers)
- Outpatient PIFU rate and advice & guidance conversion rate
- Elective waiting list trajectory (52-week and 65-week breaches)
- Independent sector spend reduction trajectory
- Fragile services: number with confirmed sustainable delivery model

Subject to executive, PMO and workstream lead approval. Measures will be baselined in Q1 2026/27.

3. Joined-up care, every step of the way

Supporting people through every stage of care so transitions feel smooth

SRO: CMO

BAF: Partnership and System

Appetite: Moderate (>12)

Year 1 deliverables (OPFBC Year 2)

Workstream	Deliverables
Pathway review and redesign	All pathways reviewed against best-practice evidence; preventative elements implemented; new advice and guidance pathways

Draft key measures

- Number of pathways reviewed against best-practice evidence (target: all high-volume pathways by Q4)
- % of pathways with embedded prevention element
- Advice and guidance utilisation rate by specialty
- Emergency readmission rate within 30 days
- Virtual ward capacity (occupied beds) and step-down conversion rate
- MYCARE patient registrations and active users
- Patient-reported experience of care transitions (FFT / survey metric TBC)

Subject to executive, PMO and workstream lead approval. Measures will be baselined in Q1 2026/27.

4. Smart use of technology for better care

Using digital tools and fresh thinking to make care more personal, easier to access and better connected

SRO: COO
BAF: Digital and Data (system-aligned)
Appetite: Low (>6)

Year 1 deliverables (OPFBC Year 2)

Workstream	Deliverables
Digital First	AI triage tools (e.g. Skin Analytics); community tech incl. wearables; BI and data strategy; clinical leadership group for digital
EPIC implementation	Acute and community EPR go-live April 2026; digital skills programme; benefits realisation
MY CARE	Roll out of MYCARE online patient portal

Draft key measures

- EPR go-live delivered to plan (April 2026) with stabilisation metrics
- EPR adoption rate: clinician logins, order entry compliance, documentation completion
- Digital skills training completion rate across all staff groups
- MYCARE registrations and monthly active users
- AI triage pilot: referral accuracy and time-to-decision
- DSPT compliance score
- Reduction in duplicate data entry / paper-based processes (baseline Q1)

Subject to executive, PMO and workstream lead approval. Measures will be baselined in Q1 2026/27.

5. Caring, skilled people ready for tomorrow

Creating a great place to work, supporting people to be their best selves, building an agile inclusive workforce

SRO: CPO

BAF: People and Culture

Appetite: Moderate (>12)

Year 1 deliverables (OPFBC Year 2)

Workstream	Deliverables
Cultural transformation	Health and wellbeing offer; Learning Academy launch; renewed leadership programme (ethics, inclusion, partnership, transformation); remodel people and education services; culture charter; policy review for just and learning culture
Workforce plan and transformation	E-rostering dashboard and medical e-rostering; People digital; on-call review; corporate services review incl. methodology for workforce reduction plans

Draft key measures

- Staff sickness absence rate (reduction target vs. 2025/26 outturn)
- Staff turnover rate (voluntary) — quarterly trend
- Learning Academy operational with enrolment numbers by role group
- Leadership programme: completion rate and participant feedback scores
- Staff survey: engagement, morale and recommendation scores
- E-rostering coverage: % of rosters managed through system
- Agency and bank spend as % of total pay bill (reduction trajectory)
- Culture charter: awareness and adoption survey

Subject to executive, PMO and workstream lead approval. Measures will be baselined in Q1 2026/27.

Strategic themes (signature moves) mapped to BAF domains

Signature Move	Linked BAF Domain / Principal Risk	Linked Risk Categories (DCIQ)	Risk Appetite	Primary Committee for Assurance and Oversight
1. Living well in our neighbourhoods	Health Inequalities and Population Health	Health Inequalities and Population Health †	Moderate	Quality and People Committee
2. Reimagining acute and specialist care	Quality, Safety, Clinical Outcomes and Patient Experience	Clinical Safety & Patient Experience IPC Health and Safety	Very Low / Low	Quality and People Committee
3. Joined-up care, every step of the way	Partnership and System	Partnership and System	Moderate	Finance and Operations Committee
4. Smart use of technology	Digital and Data (system-aligned)	Information Governance Digital, Cyber and Data †	Low	Finance and Operations Committee
5. Caring, skilled people	People and Culture	Workforce, Inclusion and Education	Moderate	Quality and People Committee

Full BAF domain mapping – ten proposed domains

BAF Domain (10 proposed domains)	Risk Categories (17 reporting categories aligned to BAF domains)	Appetite	Tolerance	Primary Committee	Status
Quality, Safety, Clinical Outcomes and Patient Experience	1. Clinical Safety & Patient Experience 2. IPC 3. Health and Safety	Very Low / Low	>3 / >6	Quality and People Committee	Existing BAF Domain
People and Culture	1. Workforce, Inclusion and Education 2. and Education	Moderate	>12	Quality and People Committee	Existing BAF Domain
Leadership and Governance	1. Legal and Regulatory 2. Communication and Reputational	Very Low / Low	>3 / >6	ExCo / Audit and Risk Committee	Existing BAF Domain
Performance	1. Performance 2. Estates and Facilities	Low	>6	Finance and Operations Committee	Existing BAF Domain
Finance	1. Financial	Low	>6	Finance and Operations Committee	Existing BAF Domain
Strategy and Business	1. Strategy and Transformation 2. Business Continuity (Low) 3. Environmental	High	>15	Finance and Operations Committee	Existing BAF Domain
Partnership and System	1. Partnership and System	Moderate	>12	Finance and Operations Committee	Proposed additional BAF Domain
Health Inequalities and Population Health	1. Health Inequalities and 2. Population Health	Moderate	>12	Quality and People Committee	Proposed additional BAF Domain
Digital and Data	1. Information Governance 2. Digital, Cyber and Data	Low	>6	Finance and Operations Committee	Proposed additional BAF Domain
Organisational Transition	1. Organisational Transition (Section 75 — time-limited)	High	>15	ExCo / Board	Proposed additional BAF Domain

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Principal risks



The following slides provide the proposed principal risks for the Trust, mapped to the ten BAF domains and the five signature moves.

Principal risks are the most significant threats to delivery of the Trust's strategic objectives. They are managed through the BAF and overseen by the Board and its committees.

Board Assurance Framework – summary of proposed principal risks aligned to strategic moves / foundations

Signature Move / Domain	BAF Domain / Principal Risk	Overarching Risk Wording (Draft – for executive review and amendment)	Committee	Director Lead
Reimagining acute and specialist care	Quality, Safety, Clinical Outcomes and Patient Experience	There is a risk that the Trust fails to provide consistently safe, high-quality care due to workforce pressures, demand and capacity constraints	QPC	Chief Nurse / Medical Director
Caring, skilled people	People and Culture	There is a risk the Trust cannot recruit, retain and develop the workforce needed to deliver safe and effective services	QPC	Chief People Officer
Living well in neighbourhoods	Health Inequalities and Population Health (NEW)	There is a risk that the Trust's plans do not sufficiently address health inequalities across its population	QPC	Chief Strategy and Planning Officer
Joined-up care	Partnership and System (NEW)	There is a risk that the Trust fails to develop effective partnerships within the ICS and with local authorities	F&OC	Chief Executive
Smart use of technology	Digital and Data (NEW)	There is a risk that digital infrastructure is insufficient to support transformation and is vulnerable to cyber threats	F&OC	Chief Digital and Information Officer
Foundation - Finance	Finance	There is a risk the Trust does not achieve financial sustainability given the underlying deficit of c.£100m	F&OC	Chief Finance Officer
Foundation - Performance	Performance	There is a risk the Trust does not meet constitutional standards for access, waiting times and quality	F&OC	Chief Operating Officer
Foundation – Leadership and Governance	Leadership and Governance	There is a risk the Trust does not maintain compliance with statutory and regulatory requirements	ARC	Chief of Staff
Foundation – Strategy and Business	Strategy and Business	There is a risk that the Trust's transformation programmes do not deliver the required scale of change within the planned timescales	F&OC	Chief Strategy and Planning Officer
Foundation – Organisational Transition	Organisational Transition (NEW)	There is a risk that the transition of Section 75 services impacts on service continuity and quality	Board	Chief Executive

How the risk framework works in practice

Score-based escalation thresholds

Risk Management Policy (Section 9) and Risk Appetite Statement (Section 4)

Score	Band	Managed at	Escalation requirement
1 - 3	Very Low	Local / service level	No automatic escalation required
4 - 6	Low	Divisional level	Report to Care Group governance forum
8 - 12	Moderate	Care Group level	Managed within Care Group governance
15 - 25	High	Corporate / Executive / Board	Escalate to Care Group Lead and Risk Group. Consider referral to Corporate Risk Register. >15: Executive Director sign-off >20: Board-level awareness through ExCo/ARC reporting BAF inclusion is a separate strategic judgement by Audit and Risk Committee and ExCo — not an automatic score trigger.

From identification to Board assurance

01

Risk Owner identifies the risk, describes it using Cause–Event–Impact, scores it using the 5×5 matrix and records it in DCIQ.

02

The risk is managed at the appropriate tier — local, divisional, Care Group or Corporate — with controls and actions in place.

03

The risk is reviewed at defined intervals. Where the score exceeds the tolerance threshold for its category, or where strategic impact is identified, the risk escalates to the next tier.

04

Risks escalated to Corporate level are reviewed by the relevant Board committee (QPC, F&OC or ExCo/ARC) and by the Risk Group.

05

Where Risk Group and ExCo judge that a risk threatens delivery of a strategic objective, it is recommended for BAF inclusion via the Audit and Risk Committee. The Board uses the BAF to assure itself that principal risks to the strategy are managed within appetite.

Key principles

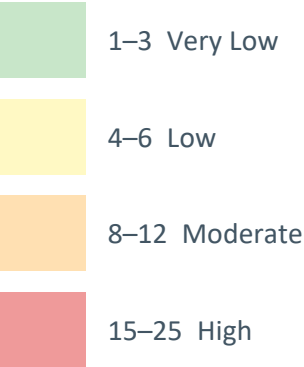
- Risk appetite thresholds are governance triggers, not substitutes for professional judgement.
- In categories where the consequence of failure is severe (patient safety, estates, business continuity), appropriate committee oversight is required.
- Escalation does not transfer ownership – the original Risk Owner retains accountability unless agreed otherwise via an appropriate authority; escalation ensures visibility and oversight at senior level.
- Risks are recorded once in a single register. Escalation is achieved by updating the status of the existing record, not by creating duplicate entries.

Risk scoring matrix

Risk Score = Impact / Consequence × Likelihood (I × L)

Impact ↓ Likelihood →	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk grading:



Use of NPSA approach aligned scoring bands (Approved Risk Group, December 2025):

Very Low: scores 1–3 (tolerance >3) | **Low:** scores 4–6 (tolerance >6)

Moderate: scores 8–12 (tolerance >12) | **High:** scores 15–25 (tolerance >20 for Board escalation)

Scores 7, 11 13 and 14 do not exist in a 5×5 NPSA matrix.

Risk appetite – TSDFT four-level scale

Board-approved (tbc) appetite levels applied to each risk category, using NPSA-aligned scoring bands

Appetite	NPSA Band	Possible Scores	Tolerance	What this means in practice
Very Low	1–3	1, 2, 3	>3	The Trust will take all reasonable steps to eliminate or mitigate these risks.
Low	4–6	4, 5, 6	>6	Preference for safe delivery options with low degree of inherent risk. Risks are actively managed and must be escalated where controls are insufficient.
Moderate	8–12	8, 9, 10, 12	>12	Some risk is inherent in transforming how we work and collaborate across the system. Acceptable where controls are in place and the risk is actively managed.
High	15–25	15, 16, 20, 25	>20	Delivering the five signature moves requires bold decisions. The Trust is willing to accept elevated risk where the benefit to patients and communities is clear.

Scores 7, 11, 13 and 14 do not exist in a 5×5 NPSA matrix. Tolerance thresholds are set at the top of each band. Where a risk score exceeds the threshold for its category, escalation is required via the appropriate processes as defined in the Risk Management Policy and Risk Management Operating Manual.

Appendix A - Board Assurance Framework Template

A draft BAF template with 10 key principal risks has been populated in a new proposed BAF format for Torbay and South Devon NHS Foundation Trust.

The template draws on best practice from NHS England, the Good Governance Institute, and comparable NHS Trusts.

See Appendix A for more information.

Proposed next steps

13th April 2026 - Completed

Submit papers to Executive Committee to review and approve (subject to any feedback) the draft Risk Management Strategy, Policy, Risk Appetite Statement, updated risk taxonomy, and proposed BAF structure aligned to the strategy and five Signature Moves. A proposal to align the Organisational Risk Map and the Corporate Risk Register will also be shared for consideration.

20th and 30th April 2026 - Completed

Updated documents with feedback from the Executive Committee to be reviewed with Nicola McMinn and Mark Greaves for review prior to Audit and Risk Committee submission for meeting on 30th April 2026. ARC will be asked to approve documents and recommend to Board for approval.

7th May 2026

Board of Directors will be asked to approve the Risk Management Strategy, Policy, Risk Appetite Statement, BAF and strategic alignment to Signature Moves, and to note the status of the DCIQ migration works progress, and interim reporting arrangements whilst risks are being transferred and Yellowfin dashboards / reports are being built.

Q1 2026/27

Complete DCIQ configuration, launch formally and introduce a formal cutover from DatixWeb, with supporting guides, training materials and the finalised Risk Management Operating Manual.

Q2 2026/27

Organisational Risk Map and Corporate Risk Register migration to DCIQ taxonomy complete; first full BAF cycle under new framework.

Appendix A – Planning Update Paper presented at March Board Meeting

Board of Directors

Planning 2026/27 – March Update

Date of meeting	Date report produced
Tuesday 17 th March 2026	Thursday 12 th March 2026

Author(s)		Report approved by	
Name and title:	Alan Welch, Business Director for Planning and Productivity Andrea Wright, Director of Operational Finance	Name and title:	Simon Tapley, Chief Planning and Strategy Officer

Date: Thursday 12th March 2026

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

Executive summary

Following consideration by the Trust Board, a second formal plan submission was submitted on the 12th February 2026. This report provides an update and details of the proposed third submission due 18th March 2026.

The Trust has continued to undertake further planning work following the second formal submission as described in previous reports.

Meetings have been held between the ICB and the Trust to close financial alignment issues on the contract and agree specific areas such as Growth, Commissioning Intentions, Continuing Healthcare, RTT funding and Cost Improvement Plans. Assurance meetings have also been held between the NHS region, ICB and Trusts to agree the overall Devon position ahead of the March submission.

The latest changes proposed and described in this paper seek to address the ongoing financial challenge and call for greater savings, the need to further reduce headcount whilst also achieving compliance with performance standards.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Whole report	Limited	No Change

Appendices

Appendix A – Workforce Plan Paper

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

Finance and Operations Committee/ Board

Key recommendations and actions requested

-
- **Note** the ongoing work to mature the detail underpinning the plan
- **Note** the Trust will continue to work with the ICB and other partners to address the financial deficit and assure the CIP plan.
- **Note** the contract negotiation process is ongoing

How does this report further our Trust strategy?

- The delivery of the Trust strategy is included in the transformation plan

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	The plan development is incorporating strategic shifts towards prevention, integrated neighbourhood teams and community-based frailty models, directly supporting population health objectives.
Quality of services provided	Delivering quality services is built on good planning. Triangulation across finance, activity, and workforce maintains quality as a central planning principle.
Sustainable and efficient use of resources	Planning is fundamental to delivering Trust strategy. The establishment of stringent financial principles and high efficiency targets is key to achieving financial sustainability and efficiency.

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	
Leadership and Governance	
Performance	The Operating Plan, refined through Care Group Demand & Capacity modelling and triangulation checkpoints, will describe how challenging performance standards will be met.
People and Culture	
Strategy and Business Intelligence	The Operating Plan will translate the new Trust strategy into deliverable, quantified operational plans.
Finance	Planning is fundamental to delivering Trust strategy. The implementation of a two-stage financial planning process, focusing on baseline clarity and aggressive CIP targets is central to achieving financial sustainability.
Risk	
Risks lodged on Datix:	
N/A	
External Standards affected by this report and associated risks	
A robust plan will support delivery of performance targets and quality standards.	
No issues relevant to External Standards have been raised in this report.	

1. Introduction and background

Following consideration by the Trust Board, a second formal plan submission was submitted on the 12th February 2026. This report provides an update and detail of the proposed third formal submission due by 18th March 2026.

2. Progress Update

Final adjustments have been made to the formal planning submission due on 18th March so that it can be approved for submission by the Trust Board.

Finance Plan

The February Plan Submission had a plan deficit of £72.2m reflecting:

- Underlying deficit exiting from 2025-26 of £99.5m
- In-year cost pressure (costs of delivery exceeding funding) of £12.8m
- Cost Improvement Plans (CIP) of £40m

The February plan included several key areas of uncertainty, which the Trust has worked with corporate and operational colleagues, as well as NHS England and the ICB, to reassess and refine assumptions.

Most issues have now been resolved, with changes agreed on the following three key areas.

- Commissioning Intentions: the Trust did not include any expectation of reduction in funding associated with Commissioner plans to withdraw £8.1m of activity funding. The Trust recognises the intentions as valid and has agreed to accept a smaller reduction to funding reflecting more modest changes. The exact changes have yet to be settled but are likely to centre around reduction in outpatient follow-ups with no procedure and increased SDEC/0 Day LOS activity. The Trust has accepted a £2.4m reduction to funding.
- CHC funding: the Trust has been pursuing £3.6m as a step change towards full cost recovery on CHC activity. The ICB has agreed to fund at this level.
- Demand Growth: The ICB has reassessed demand growth using national data on population growth, adjusted for age profile and health needs. This has reduced the Trust's income allocation by £0.8m.
- RTT Funding: The ICB has maintained the initial offer for RTT of £4.9m (to reduce waiting list backlogs to 40 weeks) however they have signalled an intention to review how this achievement can be achieved in the most cost-effective way, which may be different than the Trust initial submission to equalise all waits evenly.
- CIP: the Trust has been pressed to agree a more ambitious CIP target at 6%. The Trust has agreed to this and added an additional £10m of CIP to the Trust financial plan.

The net impact of these changes removes any contract misalignments and improves the Trust's planned deficit by £10m to £62.2m deficit.

Summary of key movements between 2025-26 Planned Deficit and 2026-27 Plan Deficit, with adjustments from previous plan submission.

		Feb Submission		Adjustment		March Submission	
		Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)	Surplus / (Deficit)
		£M	£M	£M	£M	£M	£M
2025-26 Planned Deficit		(8.0)	(8.0)		0.0	(8.0)	(8.0)
Loss of Non-Recurrent Funding	DSF	(30.8)				(30.8)	
Loss of Non-Recurrent Funding	Regional Surplus Redistribution	(18.9)				(18.9)	
Loss of Non-Recurrent Funding	System Flex	(8.4)				(8.4)	
Loss of Non-Recurrent Funding	System Support	(4.5)				(4.5)	
Loss of Non-Recurrent Funding	Other NR Income	(2.4)				(2.4)	
Loss of Non-Recurrent Funding	Loss of Non-Recurrent Funding Total		(65.0)		0.0		(65.0)
Efficiency	Planned Non-Recurrent CIP	(8.8)	(8.8)		0.0	(8.8)	(8.8)
2025-26 Planned Recurrent Deficit		(81.8)	(81.8)	0.0	0.0	(81.8)	(81.8)
Efficiency	Recurrent efficiency under delivery	(10.1)	(10.1)		0.0	(10.1)	(10.1)
In-Year Cost Pressures	Pay Cost Pressures Incl Pay Award	(1.3)				(1.3)	
In-Year Cost Pressures	Adult Social Care Cost Pressure	(3.5)				(3.5)	
In-Year Cost Pressures	UEC Demand Growth/ Escalation	(1.0)				(1.0)	
In-Year Cost Pressures	Other FYE Cost Pressures	(1.8)				(1.8)	
In-Year Cost Pressures	In-Year Cost Pressures Total		(7.6)		0.0		(7.6)
2025-26 Forecast Recurrent Underlying Deficit		(99.5)	(99.5)	0.0	0.0	(99.5)	(99.5)
Inflation	Adult Social Care and Continuing Healthcare Costs above funding	(1.4)				(1.4)	
Inflation	Other inflationary impacts above funding	(1.7)				(1.7)	
Inflation	Inflation Total		(3.1)		0.0		(3.1)
Demand	Demand Growth - Unfunded Adult Social Care & Continuing Healthcare	(4.7)				(4.7)	
Demand	Demand Growth - Other funding growth, cost pressures and investments	1.1				1.1	
Demand	Reduced Activity Growth Expectations to DALY			0.9		0.9	
Demand	Reduced Activity Funding Growth to DALY			(0.9)		(0.9)	
Demand	Reduced Activity on Commissioning Intentions			2.4		2.4	
Demand	Reduced Funding on Commissioning Intentions			(2.4)		(2.4)	
Demand	Demand Total		(3.6)		0.0		(3.6)
PDC Dividend Change	Impact PDC Capital Allocations and PDC Revenue Support	(3.2)	(3.2)		0.0	(3.2)	(3.2)
Funding Adjustments	Funding Adjustments - Efficiency in tariff	(10.1)				(10.1)	
Funding Adjustments	Funding Adjustments - ICB Surplus and Other Allocations	7.3				7.3	
Funding Adjustments	Total Funding Adjustments		(2.8)		0.0		(2.8)
Other	Provision for Redundancy			(2.5)		(2.5)	
Other	Non-recurrent funding			2.5		2.5	
Other	Total Other				0.0		0.0
2026-27 Pre-Efficiency Planned Deficit		(112.2)	(112.2)	0.0	0.0	(112.2)	(112.2)
Efficiency of £40m	Efficiency	40.0	40.0		0.0	40.0	40.0
Efficiency - Additional £10m				10.0	10.0	10.0	10.0
2026-27 Planned Deficit		(72.2)	(72.2)	10.0	10.0	(62.2)	(62.2)

The key issues, risks and mitigations from the latest draft plan are:

- Underlying Deficit** – The Trust forecast included expectations on CIP delivery and emergent cost pressures based on M6 financial position. These assumptions have been reviewed with latest financial information. A variety of changes have been identified, but overall, these are neutral to the plan position. The ULP is considered a balanced risk position.
- Deficit Support Funding (DSF)** – NHS England have indicated that DSF of £22.8m will be withdrawn if the Trust cannot meet the requirement to breakeven. The March plan submission excludes DSF.
- Demand and Performance Costs and Funding** – The Trust has agreed the funding settlement expected from the ICB in terms of baseline, demand growth and RTT performance. Provision is held within the plan to cover incremental costs of meeting these demand and performance requirements. More detailed decisions regarding allocation of funds to services to be determined following internal business case processes. There is risk to the Trust as the demand growth in contract is lower than the demand growth expected by the Trust, but there is some risk mitigation available where demand exceeds contracted activity levels in variable or semi-variable points of delivery.
- Commissioning Intentions** – The Trust has agreed a £2.4m contract reduction for Commissioning Intentions. The exact form of these contract deductions has not yet been agreed, but, dependent on whether they are set

against variable, semi-variable or fixed contract components may provide the Trust with some mitigation for activity above plan.

- **Continuing Health Care** – The Trust has a baseline overspend of £7.2m on CHC budgets. The Trust has accepted an ICB offer to reduce this by 50% with additional income of £3.6m.
- **CIP risk** – Work is continuing to improve maturity and reduce risk on the CIP programme, to date c£22.8m (46%) is red rated (noting that this includes a very recent addition of £10m of additional CIP schemes).

The financial plan is based on the following assumptions:

- Recurrent underlying position (ULP) is based on month 6 forecast outturn adjusted for material non recurrent items (Non recurrent CIP and deficit support funding) and full year effects of recurrent CIP delivery and investments started in 2025/26.
- The recurrent cost base includes the recurrent running costs of EPR, with an additional non-recurrent cost provision of £0.5m, reflecting that cost reductions will be part year due to timing of legacy contracts end dates and other factors.
- Income has been set per ICB allocation schedule, with all income disputes resolved, but noting remaining risk about activity above plan and application of contract terms (such as proposals to apply hard cut-off on SUS activity submissions and not honouring previous agreements on drugs switches).
- CFHD has been removed from cost and income base in Year 1, due to proposed transfer to DPT, all other services have been treated as continuing services, with the exception of ASC which is shown as a service divestment in Year 2 of the plan.
- There is a neutral movement in the financial plan (but reduction in the workforce plan) reflecting the planned One Devon TUPE for payroll and parts of finance to be hosted by RDUH.
- The plan has a non-recurrent fund set aside for the costs of a redundancy programme of £2.4m, which will support achievement of the increased CIP target.
- Income Growth:
 - Income Cost Uplift Factor (CUF) 2.03% - per ICB schedule
 - Income Efficiency (2.00%) - per ICB schedule
 - Activity growth - £7.8m
 - RTT funding - £4.9m
 - Commissioning Intentions – -£2.4m deduction to contract.
 - Other operating income - inflation applied at 2%, almost CUF (2.03%)
 - Council income increased to £70.7m - per S75 (£68.165m + £2.55m) plus £1m ASC client contributions.
 - CHC – (2.81% - demographic growth)
- Expenditure Growth
 - ASC - £8m (£4m activity & £4m inflation) & CHC £4m

- Specialist Commissioning inflation / growth estimated/matched based on 26/27 M6 ULP
- Inflation: Pay +2.10%, Non-Pay +2.20%, High cost / PTP Drugs +5.90% (matched to income inflation), Cost of capital +1.66%, Unallocated CNST +0.52%
- Business cases included: SCBU Safer Staffing £47k, Biosimilars (Rheum) £251k, Finance restructure £262k
- Demand Growth has been provided for at £4.3m (c50% of demand funding growth)
- RTT - added in £4.9m income and expenditure to meet RTT performance improvement of 7% and reduce all waiting lists to 40 weeks.
- DSF not included as plan does not meet breakeven requirement
- Bank and agency plan set at cap limits (£17,014k and £4,053k respectively for 26/27)

The Trust considers that there is c£41.8m gross risk to plan delivery, with £29.9m CIP classed as amber or red risk as well as risks around the application of freeze dates on SUS activity of c£5m and risks to activity delivery of c£1.9m (where activity plans assumes no loss of productivity relating to EPR implementation) and a potential cost pressure on a band 5 nursing role profile review.

The Trust mitigations include an expectation that amber-rated risks of £7.1m will progress to full maturity and delivery relatively quickly and that the potential loss of £5m of tariff income due to missing freeze deadlines can be mitigated by additional investment in coding capacity and agreeing a pragmatic approach to retrospective data corrections with the ICB and that there will be national funding available to meet the costs of the nurse profile review.

The Trust assessment, taking risks and mitigations together is that there is £24.7m net risk in the Trust plan. This is £13.7m higher than the net risk in 2025-26 plan (£11m) mainly due to CIP target being higher (£50m in 2026-27, £41.5m in 2025-26) as well as the additional risk around EPR implementation and variable contract income

The Trust will continue to liaise with ICB to reduce risks around income and to progress CIP plan to minimise delivery risk.

	Feb Submisison	Change	Mar Submission
	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations
	£M	£M	£M
Commissioning Intentions	(8.1)	8.1	0.0
CHC Funding	(0.6)	0.6	0.0
CIP low maturity/red rated	(17.0)	(5.8)	(22.8)
CIP medium maturity/amber rated	(11.9)	4.8	(7.1)
Application of Freeze Dates for SUS submissions		(5.0)	(5.0)
Implementation of EPR		(1.9)	(1.9)
Nurse Profiles - Band 5		(5.0)	(5.0)
Plan Risks	(37.6)	(4.2)	(41.8)
Commissioning Intentions	0.0		0.0
CHC Funding	0.0		0.0
CIP low maturity/red rated	0.0		0.0
CIP medium maturity/amber rated	11.9	(4.8)	7.1
Application of Freeze Dates for SUS submissions		5.0	5.0
Implementation of EPR			0.0
Nurse Profiles - Band 5		5.0	5.0
Plan Mitigations	11.9	5.2	17.1
Plan net Risk	(25.7)	1.0	(24.7)

Years 2 and 3 of the medium-term financial plans are summarised below. These values may change slightly as the recurrent impact of the latest CIP additions are worked through fully, however in broad terms it is expected that the additional £10m CIP will improve the underlying position by £10m (down to £66m deficit) that the Trust will continue to recognise inflationary, demand and RTT costs and funding consistent with current year expectations, to withdraw from (or receive additional funding toward the costs) of Adult Social Care and to continue to make progress in reducing the underfunding gap in the ICB contract at £7m pa.

This plan reflects an expectation to breakeven over a three year planning horizon.

	Year 2	Year 3
	£M	£M
ULP	- 66	- 27
Inflation Funding	9	9
Inflation Costs	- 13	- 14
Demand Growth Funding	8	8
Demand Growth Costs	- 5	- 6
RTT Funding	5	5
RTT Costs	- 5	- 5
Efficiency in Tariff	- 9	- 9
ASC Service Transfer	21	
Funding Adjustment	7	7
Pre-CIP Plan	- 48	- 32
Recurrent CIP	21	32
Non-Recurrent CIP	3	3
Draft Surplus/(Deficit)	- 24	3
Draft Recurrent Surplus/(Deficit)	- 27	-

Transformation Programme and CIP Plans

Incorporated within the plan is the Trusts proposed Transformation Programme and CIP plans. A summary of the current programme status is given in the table below showing the expected impact in terms of finances and workforce.

Delivery Assessment (Transformation Review Group) – Programme Summary

Programme	£m's				WTE			
	Green	Amber	Red	Total (£m's)	Green	Amber	Red	Total (WTE)
CHC	2.61		0.39	3.00	0.00			0.00
CIP - Medicines Rationalisation	2.00	0.60		2.60	0.00	0.00		0.00
CIP - Adult Social Care	6.20	0.00	0.00	6.20	0.00			0.00
CIP - Adult Social Care			5.19	5.19			0.00	0.00
CIP - Commercial Income	0.10	0.04	0.05	0.19		0.00		0.00
CIP- Procurement	0.20	0.98	0.50	1.68	0.00	0.00	0.00	0.00
CIP- Procurement	0.24			0.24				0.00
CIP - technical finance review	1.00			1.00	0.00			0.00
CIP- Care Group CIP schemes - Families & Communities	0.98	0.05	0.08	1.11	4.90	0.96		5.86
CIP- Care Group CIP schemes - Governance & Legal			0.03	0.03				0.00
CIP- Care Group CIP schemes - Medicine & Urgent Care	0.49	0.45	0.73	1.67	10.80	3.79	4.36	18.95
CIP- Care Group CIP schemes - Nursing & Quality		0.03		0.03		0.00		0.00
CIP- Care Group CIP schemes - People	0.67			0.67	10.68			10.68
CIP- Care Group CIP schemes - Planned Care	0.49	0.51	2.15	3.15	3.60	0.00	0.00	3.60
CIP- Care Group CIP schemes - Strategy	0.06			0.06				0.00
CIP- Care Group CIP schemes - Workplace	0.68	0.15	0.10	0.93	0.00	13.00	0.00	13.00
CIP- Income Contract Management			2.00	2.00			0.00	0.00
CIP- Income Contract Management Improving Patient Records		1.00		1.00		0.00		0.00
CIP- Temporary Staffing	1.30	0.20		1.50	4.14	0.00		4.14
Clinical Service Review				0.00				0.00
Clinical Service Review				0.00				0.00
Corporate Services & Management Review		1.20	1.20	2.40		28.18	28.18	56.36
Diagnostics		0.45		0.45		0.00		0.00
Education Income	0.20			0.20				0.00
EPIC	0.12	0.25	3.00	3.37	4.35	14.35	0.00	18.70
Estates utilisation and rationalisation		0.32		0.32		1.48		1.48
Neighbourhood Teams			0.96	0.96			32.48	32.48
Neighbourhood Teams		1.23	0.00	1.23		30.06	0.00	30.06
Private Patients Income				0.00				0.00
Research & Development Income			0.25	0.25				0.00
Safe Staffing			1.04	1.04			26.08	26.08
Stretch CIP Target	2.95		4.59	7.54			90.00	90.00
Totals	20.29	7.45	22.26	50.00	38.47	91.82	181.10	311.39

Total CIP plans now total £50m across red/amber/green schemes and 311 WTE. This has increased from the £40m included in the last formal plan submission and responds to the call from NHSE region and NHS Devon ICB for additional savings.

Detailed plans continue to be progressed, and the value of green schemes has increased. However, £22.26m of red rated schemes represent higher risk and will require robust management. The Executive Team is establishing a Finance Delivery Group to provide increased focus on CIP delivery and management of the overall financial position.

Performance

The performance levels reflected in the plan are summarised in the table below.

Performance Submission March				
 Torbay and South Devon NHS Foundation Trust				
Metric	Dec 25	2026-27	2027-28	2028-29
RTT incomplete%	67.5%	73.8%	83.45%	92%
RTT PTL	32,825	29235	24,808	22,288
UEC 4 hours	70.7%	82%	83%	85%
Cancer 28 days	78.7%	80.8%	80.9%	80.9%
Cancer 62 Days	80.3%	80.75	82.5	85.1
Diagnostics DM01	30.4%	15.5%	9.94%	1%
Acute Beds	390	390	390	390
1st Op Growth		5.4%	2.9%	2.9%
f/up growth		4%	2.6%	2.6%
DC Growth		9%	1.3%	1.3%
IP Growth		12%	1.7%	1.7%
ED Growth		4%	3.5%	3.5%
UEC 0 LOS		4%	2.5%	2.5%
UEC 1+ LOS		1%	1%	1%

UEC 4-hour performance

- The refreshed plan has been updated to being compliant in year one by reaching 82% at FYE 26/27. The starting trajectory has been updated to reflect the current plan to sprint to 74% by the end of 25/26. It should be noted that the national metric changes in year 2 and year three with compliance being measured the average performance over the year, rather than meeting a performance standard at the end of the financial year.
- Our current plan is based on managing a certain level of demand growth (3.6%) and by factoring an improvement assumption from the plans developed.
- If demand growth exceeds this level, then there is clear potential to impact on performance improvement. This has been well communicated with the ICB and a request for support with demand management programmes.

- Continued ambulance growth has clear risk. We have seen 15%/20% ambulance growth since Timely Handover Protocol (THP) go live. There is a call before convey programme planned across the system for 26/27 with leadership being provided by our Trust. The continued increase in ambulance demand poses a risk for all UEC performance metrics, not just ambulance handover times and our plan is predicated on an improved management of demand alongside SWASFT and system partners.
- We have a UEC plan refresh due for review and sign off on the 5th Feb to support our sprint for 74% but will also need factoring into the figures for next year and could support improvement.

The other issue to note is that 27/28 and 28/29 plan expectations require average performance throughout year and not an end of year number. This will be an issue to manage given seasonal fluctuation.

RTT

- The Trust RTT plan is based on the year-on-year delivery required to meet the 92% RTT position at the end of year three.
- Our plan has been developed on the speciality level activity delivery required to meet the expected levels of demand and reduce existing backlogs. The plan for year 1 is based on a reduction to the waiting list of ~4000 patients, a reduction in wait to first appointment to 26 weeks, and a reduction to the longest waiters to 40 weeks.
- Each care group has been asked to develop speciality level plans to identify the levels of capacity required to deliver their plan and what they can provide through core capacity and expected productivity gains. Identifying the gaps in capacity to deliver the plan will enable us to clearly understand the levels of WLI, insourcing or alternative levels of activity required to deliver the plan.
- The Trust is currently developing a more robust productivity plan based on new to follow up ratios, conversion rates, elective and non-elective LoS, re-admission rates. This level of detail still requires quantification at that this point.
- As part of planning for 26/27 the Trust was asked to model and quantify the level of additional activity required to meet performance compliance in 26/27. This is the level of activity required to reduce long waiters in line with our plan. This level of additional activity funding equated to ~£4.1m and the Trust team had invested time in walking the ICB team through the model and outputs to ensure alignment.
- At the beginning of March, the ICB altered their position on RTT planning and are asking plans to be modified to reduce the costs associated with the backlog clearance across the system. The ICB method is asking providers to focus on outpatient activity over 18 weeks and admitted activity for patients who would be waiting over 52 weeks by year end only. Initial modelling internally has raised concerns if we were taking this approach and at the time of writing, this change of approach has not been agreed and therefore our RTT plan remains as per previous method undertaken.

- The impact of EPIC activity reductions required over go live have been modelled and included within the plan. An expected and a worst-case position has been developed which will show the loss of between 2500 and 3400 clock stops across the go live period. This number of clock stops will need to be recovered through the remainder of the year to ensure the Trust meets its end of year RTT and waiting list position. There are various methods available to recover this activity including; validation, productivity gains, converting follow up activity to new, converting non-RTT activity to RTT, converting SPA and admin sessions to clinical.

Cancer and Diagnostics

- The Trust plans to meet the cancer and diagnostics performance position as required by national planning guidance.
- There is a risk to cancer positions through go live related to levels of activity lost, particularly in dermatology. Cancer activity will continue to be prioritised through this period to limit the impact to cancer performance. Other mitigations are being sourced such as insourcing, AI based solutions and alternative pathways.
- The diagnostic position remains challenged approaching the new year, particularly in non-obstetric ultrasound, DEXA scanning and flexi cystoscopy. Plans are in place for non-obstetric ultrasound and flexi cystoscopy which will enable the meeting of next year's improvement trajectory.
- The meeting of the year three diagnostic performance requirement will be challenging. Demand management and reducing the levels of diagnostic requests will be required. Modelling shows that to meet current demand growth, a third MRI scanner may be needed in year 3, which could be used to support the move of frailty from acute to community, as well as other services.

Workforce

The TSDFT Workforce Plan 2026/27 outlines a significant reset of the Trust's workforce position following a higher-than-planned 2025/26 outturn. This variance was largely driven by undelivered redundancy schemes, externally funded posts remaining in place, and delays to planned service reconfiguration.

For 2026/27, the Trust's underlying workforce baseline increases by 124 WTE compared with the 2025/26 outturn. However, the plan includes workforce reductions totalling 531 WTE, reflecting organisational change and service transformation. Key changes include the TUPE transfer of 294 WTE to DPT, alongside a further 60 WTE transfer associated with the One Devon model. The plan also incorporates budget rebasing, the conversion of some outsourced activity into substantive roles, and the introduction of a Voluntary Redundancy Scheme to support the delivery of required reductions.

Overall, the plan delivers a 221 WTE workforce Cost Improvement Programme (CIP) for 2026/27, with an additional 90 WTE reduction expected through the Voluntary Redundancy Scheme.

To support long-term sustainability, the Trust will implement a range of workforce improvement initiatives. These include enhanced e-rostering, organisational change programmes, strengthened health and wellbeing support, expanded education pipelines, apprenticeships, widening participation routes, and strengthened retention and leadership development frameworks. Together, these measures aim to stabilise the workforce, improve efficiency, and ensure staffing levels align with future service delivery models.

A more detailed workforce paper is provided at Appendix A.

Board Assurance Position

The extraordinary Board meeting in February approved Board Assurance Statements that assessed planning maturity across demand and capacity analysis, clinical leadership involvement, productivity assumptions and equality impact assessments. No changes are proposed.

3. Next Steps

The internal work to mature the detail behind the Trusts plan will continue in order to manage risk and increase confidence in delivery.

Contract negotiations with the ICB will continue to finalise the contractual terms for 2026/27.

4. Summary

A third formal plan submission is proposed.

The Trust continues to work positively to reconcile the challenges of the planning and contract negotiation process.

5. Assurance recommendations and summary

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Whole report	Limited	No Change

It is recommended the Committee take limited assurance given the challenges of delivering the latest plan.

- **Note** the ongoing work to mature the detail underpinning the plan
- **Note** the Trust will continue to work with the ICB and other partners to address the financial deficit and assure the CIP plan.
- **Note** the contract negotiation process is ongoing

Appendix A – Workforce Plan

TSDFT Workforce Plan 2026/27 Update – March 2026 Subject to change following 19th March Submission

1. Summary WTE position

2025/26 Plan	6389
2025/26 Outturn	6644
2026/27 Underlying position	6768
2026/27 Plan year end	6237

- The total WTE outturn position is 255 WTE above plan
- There is a 15 WTE adjustment between the PWR (255) and PFR (240) due to variances in reporting
- The 2026/27 underlying position is a 124 WTE increase compared to the 2025/26 outturn WTE.
- The WTE reduction planned in 2026/27 is 531

The key drivers for the increased 2025/26 outturn position are:

- *Undelivered compulsory redundancy scheme*
- *Externally funded posts not included in the original plan which do not impact on our financial position*
- *Other undelivered CIP schemes related to clinical service reconfiguration*

The key drivers for the increased 2026/27 underlying position are:

- *Non-recurrent vacancies added back in to meet safe staffing establishment levels (currently under review)*
- *CFHD WTE in budget held pre-Tupe transfer*

Key points to note:

- 294 WTE will be transferred under Tupe to DPT in 2026/27 (CFHD)
- 60 WTE will be transferred under TUPE as part of One Devon

2. Detailed Workforce Bridge from 2025-26 plan to 2026-27 workforce plan

Workforce Plan	Total	Substantive	Bank	Agency
	WTE	WTE	WTE	WTE
2025-26 Plan (Excluding CIP)	6,843	6,471	308	63
CIP - Compulsory Redundancy	(205)	(205)	0	0
CIP - A&E and SDEC	(22)	(22)	0	0
CIP - Elective	(31)	(31)	0	0
CIP - Other Acute Activity	(91)	(91)	0	0
CIP - Service Reconfiguration (Community Hospitals)	(94)	(94)	0	0
CIP - Outpatients	(6)	(6)	0	0
CIP - Workplace	(5)	(5)	0	0
2025-26 CIP	(454)	(454)	0	0
2025-26 Plan (Including CIP)	6,389	6,018	308	63
Undelivered CIP - Compulsory Redundancy	205	205	0	0
Undelivered CIP - Other, incl Service Reconfiguration	104	104	0	0

Externally funded posts - including EPR, Health Education and Capital	133	133	0	0
Unfunded escalation beds	34	34	0	0
Additional costs of ERF/RTT delivery	20	20	0	0
Use of non-substantive staff	0	(20)	8	12
Other vacancy treated as recurrent vacancy factor	(145)	(145)	0	0
Other non-recurrent vacancy	(111)	(111)	0	0
2025-26 Forecast Variances to Plan	240	220	8	12
2025-26 Forecast Outturn (per M10 PWR Workforce Actuals)	6,629	6,237	317	75
Additional worked WTEs excluded from PWR contractual WTE reporting	15	15	0	0
2025-26 Forecast Outturn (adjusted from PWR)	6,644	6,252	317	75
Other non-recurrent vacancy (*memo below)	111	111	0	0
Gross up CFHD budgets ahead of transfer	13	13	0	0
Error - to be adjusted in final submission	0	0	0	0
Non-Recurrent vacancies and adjustments	124	124	0	0
Recurrent Underlying Position 2026-27 Plan	6,768	6,376	317	75
One Devon TUPE	(60)	(60)	0	0
Convert temp staffing costs and outsourcing to substantive delivery models	40	137	(64)	(33)
Transfer of Services (CFHD)	(294)	(294)	0	0
RTT Backlog	26	26	1	0
Demand Growth and Approved Business Cases	68	68	0	0
2026-27 Plan Workforce Changes	(219)	(123)	(64)	(33)
2026-27 Plan (Excluding CIP)	6,548	6,253	253	42
CIP - £40m	(221)	(215)	0	(6)
CIP - Additional £10m (workforce impact TBC)	(90)	(90)	0	0
2026-27 CIP Plan	(311)	(305)	0	(6)
2026-27 Plan (Including CIP)	6,237	5,948	253	36

Summary overview:

- 205 WTE were in the 2025/26 plan for CR which was never delivered due to no funding/approval support
- 133 WTE of externally funded posts increases WTE but hasn't impacted budget
- 40 posts will be converted from outsourcing to WTE at a cheaper cost so will reduce cost
- All growth is being absorbed in 2026/27 with only 81 additional WTE (1% WTE growth compared to a 3% demand growth)
- 13 WTE were put back in to pass CFHD over at full budget
- There is a CIP plan of a 311 WTE reduction (see below)
- Of the 111 vacancies going back into the plan, all are clinical or patient facing posts.

Multi-Year Planning Workforce Change 2026-27

Year 1 (26-27)							
Substantive change	Substantive % change	Bank change	Bank % change	Agency change	Agency % change	Total change	Total % change
-434	-6.8%	-64	-20.2%	-33	-44%	-531	-7.8%

Points to note:

This is subject to change following final submission on 18 March. The following changes currently being finalised:

- Removal of 46 WTE from an error in the Feb submission
- 90 WTE will be removed for an additional £10m CIP
- 35 WTE to be added back in to pre-existing CIP schemes to recognise latest data

- Removal of 60 WTE to reflect further TUPEs confirmed for 2026-27

3. Workforce Plan Schemes 2026/27

The Trust is planning a WTE reduction CIP scheme of 256.93 WTE. To deliver the workforce CIP in 2026/27 a number of key CIP schemes have been identified.

Care Group/Scheme	WTE	CIP Schemes
Families & Children	35.52	• Management review • Community hospital bed configuration • Budget alignment to contract income
MUEC	77.51	• Ward closure • Safer staffing • MIU closure • Vacancy factor
Planned Care	12.30	• EPIC benefits • Pool closure
Workplace	15.88	• Rationalisation of Estate • Catering revised target operating model • Cleaning revised target operating model
People Services	10.68	People Digital
Trust wide	69.5	• Temporary Staffing • Corporate and Management Review • EPIC
Voluntary Redundancy	90	• Additional funds added in for March submission
Total	311.39	

Additional information:

- Care Group budgets have been re-based to meet bank and agency reduction target requirements – an additional opportunity of 4 WTE has been identified
- The Trust has just received formal approval from NHSE to run a Voluntary Redundancy scheme which is a key enabler to deliver the WTE reductions (more details below)
- Care Groups and Corporate Directors continue to have check and challenge workshops with the CEO and executive team.
- There are weekly updates from the PMO to the executives to monitor progress with the development of detailed plans to deliver the WTE reduction schemes
- Executive led vacancy control process and approval will continue and has been strengthened with monitoring and oversight by the CPO and CEO.
- Some CIP schemes are reliant on ICB decisions in relation to clinical services/hospitals closures.
- Weekly meetings between Finance, PMO and Workforce to review CIP plans covering both finances and WTE.

4. Workforce strategies in the plan

4.1 Voluntary Redundancy Scheme

The purpose of the Voluntary Redundancy Scheme is to:

- Support the delivery of the Trust's financial recovery and workforce plans
- Enable workforce change in a fair, transparent, and non-compulsory manner
- Minimise, and where possible avoid, the need for compulsory redundancies
- Ensure workforce reductions are aligned to future service delivery models
- Deliver value for money while protecting patient safety and service continuity

The Voluntary Redundancy Scheme will operate as a controlled scheme, rather than a fully open scheme, to ensure affordability, service continuity, and compliance with the 2025 National Model Voluntary Redundancy Scheme.

Subject to service impact and workforce risk assessment, applications for Voluntary Redundancy may be considered from the following staff groups:

- Administrative and Clerical staff
- Non-clinical staff within Corporate Services
- Non-clinical operational staff at Agenda for Change Band 5 and above

Approvals has been given for up to £3m (approx. 56 WTE based on an average salary of £53k) to be invested in Voluntary Redundancy payments.

4.2 AfC E-Rostering Improvements

Review of AFC rostering policy, process and practice to include training and development of managers and staff and implementation of a new rostering dashboard to identify opportunities.

The dashboard has been designed to support the following outcomes:

- Provide weekly dashboard updates, ensuring the Trust has current, decision-ready information to support operational grip, workforce governance and improvement, and financial oversight.
- Deliver an integrated finance and workforce view, bringing together funded establishment, vacancy position, costs and WTE to enable more transparent workforce planning, stronger financial oversight and improved workforce efficiency.
- Replicate existing manual reporting within the dashboard, helping to reduce the internal reporting burden and streamline processes.
- Support routine use across relevant teams, underpinned by clear governance arrangements, a regular refresh cadence, and prioritised development actions where required.

4.3 Medical E-Rostering

The implementation of medical e-rostering, alongside strengthened governance around the approval of additional hours, will deliver a number of organisational and workforce benefits. These include:

- Improved workforce planning and visibility through real-time oversight of medical staffing levels, enabling better alignment of workforce deployment with service demand and patient need.

- Enhanced governance and financial control through a strengthened approval process for additional hours, ensuring appropriate oversight, consistency of decision-making, and alignment with workforce controls.
- Reduced reliance on temporary staffing by optimising the use of substantive medical staff and improving the management of internal capacity before external locum cover is considered.
- Improved data and reporting capability, enabling more effective monitoring of workforce utilisation, additional hours activity, and staffing gaps to support operational and strategic workforce planning.

4.4 Organisational change

A programme of organisational change is being undertaken to ensure management and administrative structures are aligned to the Trust's strategic priorities, operational requirements, and the benefits associated with digital transformation. This includes an administrative and clerical review to ensure roles, structures and ways of working are aligned with the efficiencies and opportunities arising from the implementation of EPIC, supporting improved productivity and streamlined processes.

In addition, a Trust-wide management review is being progressed to ensure leadership and management capacity is appropriately aligned to organisational priorities. This review includes consideration of the Executive Director structure, corporate management arrangements, and operational management structures. The programme is being delivered in phases, with Phase 1 already implemented, Phase 2 commencing in April, and Phase 3 scheduled to begin in May. The review will support the development of a sustainable organisational structure that strengthens leadership, improves efficiency, and supports delivery of the Trust's operational and financial plans.

4.5 Health and Well-being

Strengthen the health and wellbeing plan and supporting resources to proactively address sickness absence, with a focus on reducing absence rates and associated costs. This will support improved staff wellbeing and attendance, while also contributing to a reduced reliance on temporary staffing through increased workforce availability and stability.

4.6 Pipeline Development

A structured and coordinated pipeline is essential to ensure a continuous flow of people into hard-to-recruit roles and support long-term workforce sustainability. Key elements include:

- Structured 16–18 pathways to build early interest in clinical and non-clinical NHS careers.
- Coordinated work-experience programmes across departments, enabling young people to understand NHS roles and expectations.
- T-Level placement capacity with clear supervision models, ensuring the Trust is an active and reliable partner for local technical education.
- Targeted engagement with local schools to raise awareness of the wide range of NHS careers.
- Support for under-represented groups, enabling equitable access and widening participation.

- Stepping-stone routes into apprenticeships, HCA roles, further education or healthcare degrees.
- Development of “grow-our-own” career pathways to reduce reliance on temporary staffing and overseas recruitment.

This approach builds a sustainable supply chain for future staffing needs and strengthens TSDFT’s role as an anchor institution.

4.7 Apprenticeships

Apprenticeships are a key mechanism for upskilling our workforce and developing future talent. Priorities include:

- Strengthening clinical apprenticeships in key areas such as Nursing Associate, Registered Nurse and AHP pathways.
- Growing non-clinical apprenticeships, including leadership & digital.
- Optimising the apprenticeship levy, including levy transfer opportunities with system partners.
- Linking apprenticeships to career pathways and succession plans, ensuring apprentices move into permanent roles upon completion.
- Ensuring robust supervision, pastoral support and protected learning time to maximise programme success.

This strategy strengthens internal progression routes and contributes to vacancy reduction.

4.8 Widening Participation and “Grow-Our-Own” Routes (OU Programme and Local Access)

Recognising that traditional higher education pathways are not accessible for all, TSDFT continues to invest in widening participation initiatives:

- The TSDFT Open University Nursing Programme supports local people to enter the nursing profession, contributing to retention and continuity of care.
- Plans to expand pathways into children’s nursing, AHP professions, and mental health nursing in partnership with Devon Partnership Trust (DPT).

Continued development of local entry routes and blended learning models tailored to the needs of our rural and coastal communities.

These initiatives support a stable locally sourced workforce and improve long-term recruitment and retention outcomes.

4.9 Partnership with South Devon College (SDC) and other local providers

TSDFT’s strengthened partnership with SDC provides an integrated local education pipeline. Areas of collaboration include:

- Joint curriculum planning aligned to current and future NHS workforce demand.
- Expansion of health, care, digital and technical programmes that support clinical and non-clinical roles.
- Shared facilities and simulation-based learning, enriching the quality of training and practice-based education.

- Clear progression routes from Levels 2–7, enabling long-term career development.
- Community-based recruitment and widening participation, using SDC's reach to attract local residents.
- Collaboration to build the educator workforce, supporting the national emphasis on educator capability across all professions.

This partnership ensures alignment between education supply and workforce needs, while embedding NHS careers within the local community.

4.10 CPD Investment for Specialist Roles (Aligned to Workforce Planning)

Targeted CPD investment is critical for developing specialist capability and retaining skilled staff. Focus areas include:

- Developing specialist clinical skills, including AHP advanced practice, critical care, diagnostics, and theatres.
- Leadership development for clinical supervisors and aspiring leaders.
- Support for professional accreditation, credentialing and revalidation requirements.
- Succession planning for high-risk and hard-to-recruit roles.
- Ensuring equitable access to CPD across all staff groups to promote fairness and inclusion.

This supports service transformation, role redesign and long-term workforce stability.

4.11 Postgraduate Medical Education (PGME) – Expansion Opportunities

PGME is a cornerstone of medical workforce supply and retention. Priorities include:

- Maintaining high-quality training environments that meet NHS England standards.
- Ensuring effective clinical supervision, protected teaching time and compliant rota design.
- Acting on GMC trainee feedback to make responsive improvements.
- Exploring expansion of training posts to support service models and future consultant workforce supply.
- Strengthening transition pathways from training into local consultant and SAS roles.

Enhancing PGME strengthens recruitment, retention and TSDFT's reputation as an excellent training provider.

4.12 Cultural Ambassadors – Recruitment

The Cultural Ambassador programme supports fairness, inclusion and transparency in recruitment:

- Trained Cultural Ambassadors will participate in recruitment panels and review key processes.
- Ensuring bias-aware, fair decision-making in high-risk selection processes.
- Improving the diversity of appointments and supporting inclusive recruitment practices.
- Enhancing candidate experience and reinforcing EDI commitments.

This aligns with NHS workforce equality standards and helps reduce disparities in recruitment outcomes.

4.13 Retention Strategy

A robust retention approach is essential for stabilising the workforce. Key components include:

- Improved induction and early-years support, particularly for AHPs and Nursing, to reduce early attrition.
- Greater access to flexible working, internal mobility and career development pathways.
- Health and wellbeing support, including psychological safety, Freedom to Speak Up and access to occupational health.
- Compassionate, inclusive leadership development aligned to national frameworks.
- Focused interventions in hotspot areas identified through turnover data and the Cultural Insights Review Group.
- Embedding career conversations, talent development and progression planning.

These actions aim to reduce turnover, improve staff experience and strengthen organisational culture.

4.14. Leadership and Management Development

A comprehensive leadership and management development approach underpins all workforce transformation efforts:

- A structured programme aligned to the NHS Leadership Competency Framework.
- Development of leaders' capability to manage change, support new roles and navigate workforce redesign.
- Clear expectations for accountability, compassionate leadership and inclusive behaviours.

This ensures leaders are equipped to drive cultural, operational and workforce transformation.

4.15 Resident Doctor 10 Point Plan

Maintain full compliance with the Resident Doctor 10-Point Plan, ensuring the Trust continues to meet national expectations in relation to safe working, training quality, supervision, wellbeing and working conditions for resident doctors. This will include ongoing monitoring of key standards such as rota management, exception reporting, safe staffing levels, rest facilities, and access to appropriate educational and clinical supervision.

Appendix B – Finance Plan Update Slide deck presented to Finance & Operations Committee


Torbay and South Devon
NHS Foundation Trust

Finance Plan Updates

Working with you, for you

Finance Plan Update


Torbay and South Devon
NHS Foundation Trust

The Trust submitted a finance plan in March for 2026-27 of Breakeven (£57.8m deficit excluding DSF) reflecting:

- Underlying deficit exiting from 2025-26 of £99.5m
- In-year cost pressure (costs of delivery exceeding funding) of £12.7m
- Non-recurrent Deficit Support Funding (DSF) of £57.8mm
- Cost Improvement Plans (CIP) of £54.4m

This is an improvement on the previous submission of £62.2m deficit plan, reflecting additional NHSE funding of £57.8m DSF and a commitment to increased CIP of £4.4m.

Updated bridge with movements to previous submission included on following slide

Finance Plan Update – Bridge Analysis									
NHS Torbay and South Devon NHS Foundation Trust									
		1st March Submission		Adjustment		Final March Submission			
		Surplus / (Deficit) £M	Surplus / (Deficit) £M	Surplus / (Deficit) £M	Surplus / (Deficit) £M	Surplus / (Deficit) £M	Surplus / (Deficit) £M		
2025-26 Planned Deficit		(18.0)	(18.0)	0.0	0.0	(18.0)	(18.0)		
Loss of Non-Recurrent Funding	CIP	(16.0)				(16.0)			
Loss of Non-Recurrent Funding	Regional Surplus Redistribution	(18.0)				(18.0)			
Loss of Non-Recurrent Funding	System Flex	(8.4)				(8.4)			
Loss of Non-Recurrent Funding	System Support	(4.5)				(4.5)			
Loss of Non-Recurrent Funding	Other NH Income	(2.4)				(2.4)			
Loss of Non-Recurrent Funding	Loss of Non-Recurrent Funding Total	(49.3)		0.0	0.0	(49.3)			
Efficiency	Planned Non-Recurrent CIP	(18.0)	(18.0)	0.0	0.0	(18.0)	(18.0)		
2025-26 Forecast Recurrent Deficit		(18.0)	(18.0)	0.0	0.0	(18.0)	(18.0)		
Efficiency	Recurrent efficiency under delivery	(18.0)	(18.0)	0.0	0.0	(18.0)	(18.0)		
In-Year Cost Pressures	Pay Cost Pressures (incl Pay Award)	(3.3)				(3.3)			
In-Year Cost Pressures	Adult Social Care Cost Pressures	(3.5)				(3.5)			
In-Year Cost Pressures	VED Demand Growth/ Escalation	(3.0)				(3.0)			
In-Year Cost Pressures	Other FYE Cost Pressures	(3.8)				(3.8)			
In-Year Cost Pressures	In-Year Cost Pressures Total	(13.6)	(13.6)	0.0	0.0	(13.6)	(13.6)		
2025-26 Forecast Recurrent Underlying Deficit		(18.0)	(18.0)	0.0	0.0	(18.0)	(18.0)		
Inflation	Adult Social Care and Continuing Healthcare Costs above funding	(3.4)				(3.4)			
Inflation	Other inflationary impacts above funding	(3.7)				(3.7)			
Inflation	Inflation Total	(7.1)	(7.1)	0.0	0.0	(7.1)	(7.1)		
Demand	Demand Growth - Unfunded Adult Social Care & Continuing Healthcare	(4.7)				(4.7)			
Demand	Demand Growth - Other funding (EPR, front processors and investments)	3.1				3.1			
Demand	Reduced Activity Growth Expectations to DASH	0.9				0.9			
Demand	Reduced Activity Funding Growth to DASH	(0.3)				(0.3)			
Demand	Reduced Funding on Commissioning Intentions	2.4				2.4			
Demand	Reduced Funding on Commissioning Intentions	(2.4)				(2.4)			
Demand	Demand Total	(3.0)	(3.0)	0.0	0.0	(3.0)	(3.0)		
PDC Dividend Change	Impact PDC Capital Allocations and PDC Revenue Support	(3.2)	(3.2)	0.0	0.0	(3.2)	(3.2)		
Funding Adjustments	Funding Adjustments - Efficiency in care	(13.0)				(13.0)			
Funding Adjustments	Funding Adjustments - RSB Surplus and Other Allocations	7.3				7.3			
Funding Adjustments	Funding Adjustments - Deficit Support Funding			57.8	57.8		55.8		
Funding Adjustments	Total Funding Adjustments	(2.0)	(2.0)			(2.0)			
Other	Provision for Redundancy	2.5				2.5			
Other	Non-recurrent funding	2.5				2.5			
Other	Total Other	0.0	0.0	0.0	0.0	0.0	0.0		
2025-26 Plan Efficiency Planned Deficit		(112.2)	(112.2)	57.8	57.8	(112.2)	(112.2)		
Efficiency	Initial Efficiency of £40m	(40.0)				(40.0)			
Efficiency	Efficiency - Additional Search	(10.0)				(10.0)			
Efficiency	Efficiency Total	(50.0)				(50.0)			
2026-27 Planned Deficit		(62.2)	(62.2)	62.2	62.2	(124.4)	(124.4)		

Finance Plan Update – Key Risks and Mitigations									
NHS Torbay and South Devon NHS Foundation Trust									
		Mar Submission	(Risks) / Mitigations						
			£M						
CIP low maturity/red rated		(23.9)							
CIP medium maturity/amber rated		(8.5)							
Application of Freeze Dates for SUS submissions		(5.0)							
Implementation of EPR		(1.9)							
Resident Doctor Strikes		(1.5)							
Nurse Profiles - Band 5		(5.0)							
Plan Risks		(45.8)							
CIP low maturity/red rated		0.0							
CIP medium maturity/amber rated		8.5							
Application of Freeze Dates for SUS submissions		5.0							
Implementation of EPR		0.0							
Resident Doctor Strikes		1.5							
Nurse Profiles - Band 5		5.0							
Plan Mitigations		20.0							
Plan net Risk		(25.8)							

The Trust reported plan delivery risks of £25.8m (£45.8m gross risk offset with £20.0m mitigation) of which:

- CIP Risk is £23.9m*** (£32.4m gross risk on all low and medium maturity plans offset with an expectation that all medium maturity plans (£8.5m) would reach delivery quickly)
- Application of freeze dates for SUS submissions is £0m** (gross risk on uncoded backlog is c£5.0m, offset with £5.0m mitigation that Trust is investing in coding staff and will negotiate contract terms to avoid application of non-payment rules).
- EPR Implementation risk of £1.9m** (unmitigated risk reflecting potential for loss of productivity in EPR implementation phase)
- Resident Doctor Strikes risk of £0m** (gross risk of £1.5m reflecting a continuation of impact recognised in 2025-26, offset with a mitigation of £1.5m assuming additional national funding to meet costs).
- Band 5 Nurse Job Profiles risk of £0m** (gross risk of £5m relating o change in profiles and banding, offset with a mitigation of £5m assuming additional national funding to meet these costs).

*This risk assessment was based on CIP maturity at the point of plan submission on 31st March, the Trust is rapidly progressing CIP maturity with the target of achieving 75% Green delivery.

Finance Plan Update - Assumptions	
NHS Torbay and South Devon NHS Foundation Trust	
Financial Plan underlying assumptions are unchanged from previous plan submission, except DSF, which has been included at an uplifted value to latest NHSE offer. - Recurrent underlying position (ULP) is based on month 6 forecast outturn adjusted for material non recurrent items (Non recurrent CIP and deficit support funding) and full year effects of recurrent CIP delivery and investments started in 2025/26. - The recurrent cost base includes the recurrent running costs of EPR, with an additional non-recurrent cost provision of £0.5m, reflecting that cost reductions will be part year due to timing of legacy contracts end dates and other factors. - Income has been set per ICB allocation schedule except for income disputes totalling £8.7m, against which a risk provision of £3.8m has been maintained in the plan, consistent with the initial proposal for a convergence deduction, which was subsequently withdrawn. - CFHD has been removed from cost and income base in Year 1, due to transfer to DPT, all other services have been treated as continuing services, with the exception of ASC which is shown as a service divestment in Year 2 of the plan. - Income Growth: - Income CUF 2.03% - per ICB schedule - Income Efficiency (2.00%) - per ICB schedule - Activity growth - £8.6m - Convergence deduction - £3.8m (maintained in plan as a risk provision, although this was subsequently withdrawn and replaced by the ICB with a proposal to remove £8.1m contract income as Commissioning Intentions). - Other operating income - inflation applied at 2%, almost CUF (2.03%) - Council income increased to £70.7m - per S75 (£68.165m + £2.55m) plus £1m ASC client contributions - CHC - (2.81% - demographic growth) - Expenditure Growth - ASC - £8m (£4m activity & £4m inflation) & CHC £4m - Spec Comm inflation / growth estimated/matched based on 2627 M6 ULP - Inflation: Pay +2.10%, Non Pay +2.20%, High cost / PTP Drugs +5.90% (matched to income inflation), Cost of capital +1.66%, Unallocated CNST +0.52% - Business cases included: SCBU Safer Staffing £47k, Biosimilars (Rheum) £251k, Finance restructure £262k - Demand Growth has been provided for at £4.3m (c50% of demand funding growth) - RTT - added in £4.940k income and expenditure to meet RTT - DSF has been included at latest NHSE offer value of £57.8m - Bank and agency plan set at cap limits (£17,014k and £4,053k respectively for 26/27)	

Finance Plan Update - Medium Term Plan



Torbay and South Devon
NHS Foundation Trust

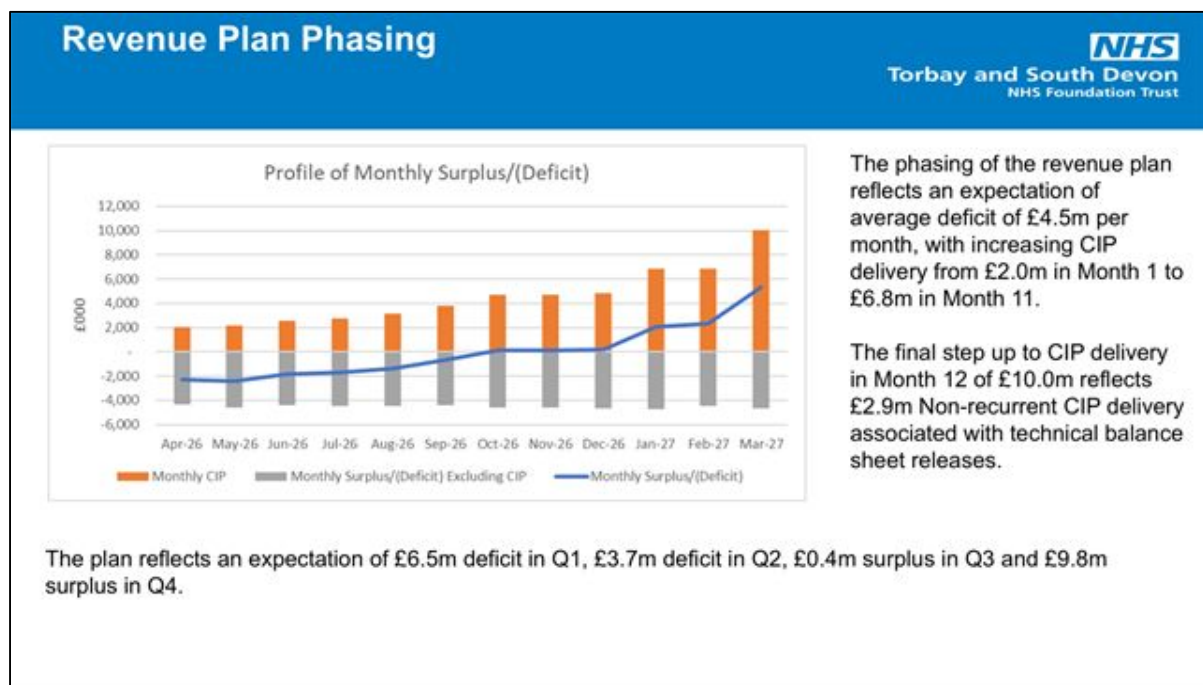
Amended Submission		
	Year 2	Year 3
	£M	£M
ULP	(66)	(22)
Inflation Funding	9	9
Inflation Costs	(13)	(14)
Demand Growth Funding	8	8
Demand Growth Costs	(8)	(8)
RTT Funding	5	5
RTT Costs	(5)	(5)
Efficiency in Tariff	(9)	(9)
ASC Service Transfer	21	
Funding Adjustment	7	7
Non-Recurrent Costs of Transformation		(10)
Non-Recurrent DSF	22	10
Pre-CIP Plan	(29)	(29)
Recurrent CIP	29	29
Non-Recurrent CIP		
Draft Surplus/(Deficit)	(0)	0
Draft Recurrent Surplus/(Deficit)	(22)	0

The Trust has made assumptions for Year 2 and 3 of the financial plan consistent with expectations in Year 1:

- Inflation pressure largely relates mainly to expectations of CHC costs rising above general inflationary trends, assumed at 2% pa on costs and income, 6% on high cost drugs (fully funded), contributes net £4-5m deficit pa.
- Demand growth on key points of delivery expected to continue at the same rates modelled for Year 1, between 1-3% dependent on point of delivery, with costs of meeting demand equivalent to the investment (neutral to plan) with opportunities to meet demand growth at less than full cost included in CIP.
- Plan assumes that the RTT trajectory for years 1 and 2 is consistent with Year 1 and that gross cost investment matches tariff funding - Net £0m impact pa. Opportunities to meet demand growth at less than full cost included in CIP.
- 2% efficiency toplice assumed each year from contract, contributing £9m loss.
- Withdrawal from ASC assumed for Year 2, improving position by £21m
- The Trust assumes that the contract underfunding position will be resolved over the 3 year plan horizon, improving the bottom line by £7m pa.
- Provision for £10m Non-recurrent cost to implement transformational change in Year 3
- Nonrecurrent DSF included at value proposed by NHSE in Years 2 and 3
- £29m CIP assumed in each year in recurrent savings to meet in year and breakeven and recurrent breakeven by end of Year 3.

Revenue Plan														 Torbay and South Devon NHS Foundation Trust	
Statement of comprehensive income	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	2026-27		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
Operating income from patient care activities (Excluding DSF)	53,280	53,715	53,339	53,766	53,825	53,413	53,981	53,569	54,001	54,078	52,826	54,110	643,903		
Other operating income	3,128	3,130	3,135	3,138	3,143	3,141	3,168	3,168	3,169	3,178	3,176	6,133	40,807		
Employee expenses	(31,443)	(31,696)	(31,486)	(31,389)	(31,344)	(30,768)	(30,801)	(30,812)	(30,804)	(30,522)	(30,511)	(30,496)	(372,072)		
Operating expenses excluding employee expenses	(31,365)	(31,611)	(30,873)	(31,295)	(31,041)	(30,500)	(30,310)	(29,850)	(30,256)	(28,721)	(27,213)	(28,483)	(361,518)		
OPERATING SURPLUS/(DEFICIT)	(6,400)	(6,462)	(5,885)	(5,780)	(5,417)	(4,714)	(3,962)	(3,925)	(3,890)	(1,987)	(1,722)	1,264	(48,880)		
FINANCE COSTS															
Finance income	135	135	131	133	131	134	131	129	134	130	127	122	1,572		
Finance expense	(990)	(184)	(184)	(184)	(184)	(186)	(184)	(184)	(186)	(184)	(183)	(186)	(3,019)		
PDC dividend expense	(630)	(629)	(630)	(629)	(630)	(629)	(630)	(629)	(630)	(629)	(630)	(629)	(7,554)		
NET FINANCE COSTS	(1,485)	(678)	(678)	(680)	(683)	(681)	(683)	(684)	(682)	(683)	(686)	(693)	(9,001)		
Corporation tax expense	(3)	(3)	(3)	(3)	(3)	(2)	(3)	(3)	(2)	(3)	(3)	(2)	(15)		
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	(7,886)	(7,141)	(6,569)	(6,461)	(6,101)	(5,397)	(4,646)	(4,610)	(4,574)	(2,671)	(2,409)	569	(57,896)		
Adjustments for impact donated assets and PFI accounting	766	(58)	(58)	(58)	(57)	(59)	(58)	(59)	(59)	(59)	(59)	(60)	122		
Adjusted financial performance surplus/(deficit) Excluding DSF	(7,120)	(7,199)	(6,627)	(6,519)	(6,158)	(5,456)	(4,704)	(4,669)	(4,633)	(2,730)	(2,468)	509	(57,774)		
Deficit Support Funding (DSF)	4,814	4,814	4,814	4,814	4,814	4,814	4,814	4,814	4,814	4,814	4,814	4,820	57,774		
Adjusted financial performance surplus/(deficit) Including DSF	(2,306)	(2,385)	(1,813)	(1,705)	(1,344)	(642)	110	145	181	2,084	2,346	5,329	0		

The Trust plan reflects a breakeven plan including DSF, £57.8m deficit excluding DSF.
The Trust includes £0.1m transactions not included in assessment of financial performance relating to accounting adjustments related to PFI accounting and donated asset depreciation and income.



Cash Plan  Torbay and South Devon NHS Foundation Trust												
Cashflow Plan	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cash flow from operating activities												
Operating surplus/(deficit)	(1,586)	(1,646)	(1,071)	(966)	(805)	100	852	889	924	2,827	3,062	6,064
Non-cash income and expenses												
Depreciation and amortisation	2,225	2,227	2,230	2,122	2,209	2,092	2,094	2,094	2,069	2,099	2,134	2,232
Income recognised in respect of capital donations (cash and non-cash)	(30)	(30)	(31)	(30)	(30)	(31)	(30)	(30)	(31)	(30)	(31)	(31)
(Increase)/decrease in receivables	(2,188)	(478)	(477)	(478)	(478)	(477)	(478)	(479)	(478)	(479)	770	1,500
Increase/(decrease) in other current assets	27,730											
Increase/(decrease) in trade and other payables	5,522	(4,517)	(941)	(2,429)	1,744	2,317	(5,542)	1,747	1,236	(1,907)	(941)	(3,882)
Increase/(decrease) in other liabilities	2,850	(1,650)	(1,650)	2,750	(2,750)	2,500	(2,000)	(2,000)	(2,267)	2,233	(2,296)	
Increase/(decrease) in provisions	(7)	(7)	(7)	(7)	(7)	(8)	(7)	(8)	(7)	(7)	(8)	
Corporation tax (paid) / received	(1)	(0)	(1)	(1)	(1)	(2)	(1)	(1)	(2)	(1)	(1)	(2)
Net cash generated from / (used in) operations	34,825	(6,196)	(1,428)	971	1,806	2,281	(612)	2,223	1,722	255	7,869	4,542
Cash flow from investing activities												
Interest received	135	135	131	131	131	134	131	129	134	130	127	132
Purchase of intangible assets	0	(1,898)	(576)	(523)	(579)	(523)	(523)	(850)	(930)	(850)	(850)	(850)
Proceeds from sales of intangible assets												
Purchase of property, plant and equipment and investment property	(21,271)	(311)	(330)	(381)	(780)	(781)	(580)	(961)	(1,270)	(1,287)	(1,280)	(1,645)
Receipt of cash donations to purchase capital assets	30	11	30	11	10	11	30	11	30	11	30	30
Net cash generated from/(used in) investing activities	(21,126)	(2,060)	(765)	(769)	(1,118)	(1,139)	(960)	(1,470)	(1,736)	(1,896)	(1,799)	(2,158)
Cash flow from financing activities												
Public dividend capital received	0	4,680	1,813	1,705	1,344	941	0	80	86	250	628	994
Public dividend capital repaid	0	0	0	0	0	0	0	0	0	(2,524)	(1,347)	(5,322)
Loans from Department of Health and Social Care – repaid	0	(847)	(270)	0	0	(263)	0	(447)	(270)	0	0	(264)
Capital element of lease liability repayments	(262)	(262)	(262)	(262)	(262)	(262)	(262)	(262)	(262)	(262)	(262)	(262)
Capital element of PFI, LIFT and other service concession payments	(96)	(97)	(96)	(97)	(96)	(97)	(96)	(97)	(96)	(97)	(96)	(96)
Interest paid	(127)	(127)	(126)	(127)	(127)	(126)	(127)	(127)	(126)	(127)	(126)	(126)
Interest element of lease liability repayments	(130)	(130)	(130)	(130)	(130)	(130)	(130)	(130)	(130)	(130)	(130)	(130)
Interest element of PFI, LIFT and other service concession obligations	(117)	(117)	(116)	(117)	(117)	(116)	(117)	(116)	(117)	(117)	(117)	(117)
PDC dividend (paid)/refunded						(1,776)						
Net cash generated from/(used in) financing activities	(593)	3,708	1,008	1,170	809	(1,936)	(593)	(900)	(739)	(1,800)	(2,270)	(5,632)
Cash flow from/(used in) other financing activities												
Increase/(decrease) in cash and cash equivalents	13,104	(4,548)	(1,185)	1,181	587	(2,812)	(2,108)	(150)	(734)	(4,141)	3,809	(7,248)
Cash and cash equivalents at start of period	13,692	24,806	26,306	28,121	29,502	23,999	18,787	16,179	16,029	11,715	11,095	14,898
Cash and cash equivalents at end of period	26,806	20,258	25,121	29,302	24,089	18,287	16,179	16,029	15,295	11,895	14,898	7,650

- The plan includes an assumption that the Trust will require Revenue PDC support of £10m to support the monthly deficits in Q1-2, which will be repaid in Q4 as the Trust moves into surplus.
- The Trust cash plan assumes full achievement of the revenue plan and reflects a closing cash balance that does not fall below £18m in Q1-2, therefore the Trust should be able to maintain cash balances without drawing on PDC Revenue support.
- The Trust will closely monitor cash position and forecast to avoid any unnecessary PDC Revenue support and minimise impacts on PDC Dividends.

Capital Plan  Torbay and South Devon NHS Foundation Trust												
Gross capital expenditure	£000											
Property, land and buildings	9,088											
Plant and equipment	3,330											
IT	8,985											
Other	2,643											
Gross capital expenditure	24,046											
Less PFI capital (IFRIC12)	(727)											
Gross capital expenditure (excluding PFI/IFRIC12 impact)	23,319											
Less grants, donations and peppercorn leases	(125)											
Plus PFI capital charges on a UK GAAP basis (e.g. residual interest)	464											
Total CDEL (Including National PDC)	23,658											
Capital CDEL Limits	£000											
Trust Limit CDEL	22,278											
PFI capital charges on a UK GAAP basis	464											
Trust Limit CDEL	22,742											
National PDC: Community Diagnostics Centres	750											
National PDC: Endoscopy	166											
National PDC Funded CDEL	916											
Total CDEL	23,658											
Capital Cash Sources	£000											
National PDC Funding	916											
Capital Support PDC	1,102											
Depreciation	25,307											
Lease funding	3,632											
Lease capital repayments	(3,138)											
PFI Capital repayments	(1,885)											
Repayment of Borrowing	(1,962)											
Donations	125											
Other	(51)											
Total Funding Sources	24,046											

Capital Programme

- The Trust plan submission includes total capital expenditure of £24.0m, of which £23.7m is classed as CDEL spend.
- This includes spend on major service development schemes:
 - Theatres (£2m),
 - Aseptic Suite (£2.3m)
 - Cardiac Cath Lab (£1.2m)
- The plan includes ongoing commitment to IM&T, estates backlog and medical equipment programmes as well as final phases of EPR.

Capital CDEL Limits

- The Trust plan has a total CDEL limit of £23.7m, of which £0.9m is from nationally funded PDC schemes, £0.5m relates to PFI capital charges and £22.7m relates to Trust-funded capital spend.
- It is likely that additional national PDC funding will be awarded during the year for specific schemes.

Capital Cash Sources

- The Trust capital programme of £24m is mainly funded by depreciation cover of £25.3m, but has a net shortfall of cash sources of £1.1m (reflecting the extent that capital repayments exceed depreciation cover and new lease funding).
- The Trust will need to submit a request for Capital Support PDC to cover the cash shortfall to meet spend up to approved CDEL Limits.
- If Capital Support PDC is not approved the Trust will need to consider reducing the capital programme or maximising leasing acquisitions to maintain cash balances.

CIP Target Allocation														 Torbay and South Devon NHS Foundation Trust	
Plan Submission	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2026-27		
£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Trust Total	2,045	2,177	2,563	2,780	3,143	3,775	4,684	4,732	4,850	6,826	6,833	10,032	54,420		
Care Group - CIP Plans															
£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Adult Social Care Torbay	506	544	634	655	781	793	1,121	1,132	1,163	1,330	1,329	1,402	11,390		
Placed People (OHC)	57	100	149	179	213	232	280	296	306	368	363	424	3,000		
Families & Communities	89	89	90	216	217	217	229	229	230	231	231	231	2,298		
Medicine and Urgent Care	188	188	206	206	309	445	445	445	445	445	445	445	4,396		
Planned Care and Surgery	227	239	272	312	357	363	528	533	548	608	611	633	5,231		
Executive Directors	234	250	293	301	359	388	550	557	570	660	664	683	5,516		
Workplace Team	141	142	143	123	125	125	102	103	103	144	144	145	1,539		
Total CIP Plans	1,443	1,562	1,877	2,082	2,360	2,563	3,257	3,296	3,395	3,766	3,787	3,974	33,372		
Care Group - Shortfall															
£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Adult Social Care Torbay	-	0	0	0	0	0	0	0	0	0	0	0	0		
Placed People (OHC)	37	38	42	43	48	75	86	88	90	187	187	187	1,295		
Families & Communities	331	136	150	152	171	265	312	314	318	664	665	1,318	4,595		
Medicine and Urgent Care	334	108	119	121	135	210	247	248	252	525	526	1,044	3,638		
Planned Care and Surgery	251	260	285	291	326	505	594	598	606	1,266	1,269	2,514	8,763		
Executive Directors	30	31	35	35	39	61	72	72	73	153	153	304	1,059		
Workplace Team	49	50	55	56	63	98	115	116	117	245	246	487	1,608		
Total CIP Plans	602	625	687	688	782	1,212	1,427	1,436	1,455	3,040	3,046	6,037	21,044		
Care Group - CIP Target															
£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Adult Social Care Torbay	506	544	634	655	781	793	1,121	1,132	1,163	1,330	1,329	1,402	11,390		
Placed People (OHC)	54	138	191	222	261	307	366	386	425	555	550	796	4,256		
Families & Communities	220	226	240	268	387	481	541	543	547	895	896	1,550	6,893		
Medicine and Urgent Care	292	296	415	417	444	655	680	684	697	971	972	1,489	8,034		
Planned Care and Surgery	478	499	558	603	683	967	1,122	1,131	1,154	1,873	1,879	3,147	13,995		
Executive Directors	265	282	327	336	398	449	622	629	643	813	817	907	6,577		
Workplace Team	190	192	198	179	188	223	218	218	220	389	390	632	3,236		
Total CIP Plans	2,045	2,177	2,563	2,780	3,143	3,775	4,684	4,732	4,850	6,826	6,833	10,032	54,419.77		

The Trust has planned CIP of £54.4m, of which:

- £33.4m are supported by Care Group plans detailed down to a cost centre level
- £21m relate to opportunities that have been assessed at a Trust-level but do not have cost centre level delivery (this includes a major workforce schemes for voluntary redundancy).
- The full target (in financial and WTE terms) has been allocated to Care Groups and Exec Directorates in budgets to identify the full CIP requirement at the outset of the financial year, based on influenceable spend.
- WTE impacts are included on the following slide.

CIP Target Allocation (WTE)														 Torbay and South Devon NHS Foundation Trust	
Plan Submission - WTE Reduction	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2026-27		
WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE		
Trust Total	99	99	125	149	149	275	293	293	293	311	311	311	311		
Care Group - CIP Plans WTE Reduction															
WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE		
Adult Social Care (incl OHC)	-	-	-	-	-	-	-	-	-	-	-	-	-		
Families & Communities	6	6	6	35	35	35	36	36	36	36	36	36	36		
Medicine and Urgent Care	19	19	45	45	45	78	78	78	78	78	78	78	78		
Planned Care and Surgery	-	-	-	-	-	-	12	12	12	12	12	12	12		
Executive Directors	7	7	7	7	7	11	16	16	16	21	21	21	21		
Workplace Team	8	8	8	3	3	3	3	3	3	16	16	16	16		
Total CIP Plans	39	39	66	89	89	128	144	144	144	162	162	162	162		
Care Group - Shortfall in WTE Reduction Plans															
WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE		
Adult Social Care (incl OHC)	4	4	4	4	4	11	11	11	11	11	11	11	11		
Families & Communities	9	9	9	9	9	23	23	23	23	23	23	23	23		
Medicine and Urgent Care	1	1	1	1	1	1	3	3	3	3	3	3	3		
Planned Care and Surgery	40	40	40	40	40	101	101	101	101	101	101	101	101		
Executive Directors	7	7	7	7	7	18	18	18	18	18	18	18	18		
Workplace Team	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total CIP Plans	60	60	60	60	60	150	150	150	150	150	150	150	150		
Care Group - WTE Reduction Target															
WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE		
Adult Social Care (incl OHC)	4	4	4	4	4	11	11	11	11	11	11	11	11		
Families & Communities	15	15	15	44	44	57	58	58	58	58	58	58	58		
Medicine and Urgent Care	18	18	44	44	44	74	74	74	74	74	74	74	74		
Planned Care and Surgery	40	40	40	40	40	101	113	113	113	113	113	113	113		
Executive Directors	14	14	14	14	14	28	33	33	33	36	36	36	36		
Workplace Team	8	8	8	3	3	3	3	3	3	16	16	16	16		
Total CIP Plans	99	99	125	149	149	275	293	293	293	311	311	311	311		

The Trust has planned CIP WTE reduction of 311 (consistent with the workforce plan), of which:

- 162 are supported by Care Group plans detailed down to a cost centre level
- 150 relate to opportunities that have been assessed at a Trust-level but do not have cost centre level delivery (this includes a major workforce schemes for voluntary redundancy).
- The full target (in WTE terms) has been allocated to Care Groups and Exec Directorates in budgets to identify the full CIP requirement at the outset of the financial year.

Workforce					 Torbay and South Devon NHS Foundation Trust	
Workforce Plan	Total	Mar Submission				
	WTE	WTE	Bank	Agency		
	WTE	WTE	WTE	WTE		
2025-26 Plan (Excluding CIP)	6,843	6,471	308	63		
CIP - Compulsory Redundancy	(205)	(205)	0	0		
CIP - A&E and SDEC	(22)	(22)	0	0		
CIP - Elective	(91)	(91)	0	0		
CIP - Other Acute Activity	(91)	(91)	0	0		
CIP - Service Reconfiguration (Community Hospitals)	(94)	(94)	0	0		
CIP - Outpatients	(6)	(6)	0	0		
CIP - Workplace	(5)	(5)	0	0		
2025-26 CIP	(454)	(454)	0	0		
2025-26 Plan (Including CIP)	6,389	6,018	308	63		
Undelivered CIP - Compulsory Redundancy	205	205	0	0		
Undelivered CIP - Other, incl Service Reconfiguration	104	104	0	0		
Externally funded posts - including EPR, Health Education and Capital	133	133	0	0		
Unfunded escalation beds	34	34	0	0		
Additional costs of ERF/RTT delivery	20	20	0	0		
Use of non-substantive staff	0	(29)	8	12		
Other vacancy treated as recurrent vacancy factor	(145)	(145)	0	0		
Other non-recurrent vacancy	(111)	(111)	0	0		
2025-26 Forecast Variances to Plan	240	220	8	12		
2025-26 Forecast Outturn (per M10 PWR Workforce Actuals)	6,629	6,237	317	75		
Additional worked WTEs excluded from PWR contractual WTE reporting	15	15	0	0		
2025-26 Forecast Outturn (adjusted from PWR)	6,644	6,252	317	75		
Other non-recurrent vacancy (memo below)	111	111	0	0		
Gross up CFMD budgets ahead of transfer	13	13	0	0		
Error - to be adjusted in final submission	0	0	0	0		
Non-Recurrent vacancies and adjustments	124	124	0	0		
Recurrent Underlying Position 2026-27 Plan	6,768	6,376	317	75		
One Devon TUBE	(60)	(60)	0	0		
Convert temp staffing costs and outsourcing to substantive delivery models	40	137	(64)	(33)		
Transfer of Services (CFMD)	(294)	(294)	0	0		
RTT Backlog	26	26	1	0		
Demand Growth and Approved Business Cases	68	68	0	0		
2026-27 Plan Workforce Changes	(219)	(123)	(64)	(33)		
2026-27 Plan (Excluding CIP)	6,548	6,253	253	42		
CIP - E&O	(221)	(215)	0	(6)		
CIP - Additional Staff	(90)	(90)	0	0		
2026-27 CIP Plan	(311)	(305)	0	(6)		
2026-27 Plan (Including CIP)	6,237	5,948	253	36		

The Trust has submitted a workforce plan with closing workforce WTEs of 6,237 WTEs, including 311 WTE reduction relating to CIP.

This is triangulated with the finance plan and establishment budgets have been set at a corresponding level, including a target reduction relating to unallocated CIP target (as per previous slide).

Our People
AT THEIR BEST

NHS

Torbay and South Devon
NHS Foundation Trust



OUR STRATEGY

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Foreword

We are shaped by the unique character of our place and our people. We are proud to serve many vibrant and diverse communities—spanning coastal towns, rural villages, and market centres—each with its own history, strengths, and challenges. Ours is a region of natural beauty and deep-rooted pride, but also one where inequalities persist and where health is shaped as much by housing, work and social connection as by access to care.

Our community services, neighbourhood teams, clinics and hospitals are woven into the fabric of local life - trusted and valued, thanks to the compassion and commitment of our colleagues, volunteers, and partners. Every day, they demonstrate extraordinary skill and kindness, supporting people through moments of vulnerability and change.

We stand at a pivotal moment.

Across the NHS, organisations like ours are being called to support the 10-year NHS plan, shifting care: from sickness to prevention, from analogue to digital, from hospital to community. For us this is not a new direction, but a natural evolution - building on our legacy of innovation, integration and partnership.

As one of the largest employers and anchor institutions in our region, we recognise our role in shaping not only the health of our population but the wellbeing of our communities. This means investing in education and skills, supporting local economic growth, promoting fair employment and working with partners across the NHS, local authorities, GPs and the voluntary sector to ensure our actions deliver benefits far beyond our organisational boundaries.

We face enormous challenges: rising demand, an ageing population, workforce pressures, the need to renew our buildings and technology and our current financial position is unsustainable. Yet we also have real strengths - dedicated colleagues and volunteers, pioneering neighbourhood teams, expert hospital services and a strong community and voluntary sector.

This strategy builds on those strengths. It sets out how we will stabilise and strengthen the services people rely on today, while creating the conditions for everyone we serve to start well, live well, age well and die well. It invites us to look beyond organisational boundaries, to act as one NHS and to put human relationships at the heart of everything we do.

Central to this vision is our commitment to strong clinical input, including primary care, into all our decision making. We believe that those closest to care - our clinicians and teams and care partners - should have greater autonomy and the support to shape services, lead change and take responsibility for the outcomes that matter most to our communities. By empowering clinical leaders across our services and fostering a culture of shared accountability, we will ensure our strategy is grounded in real experience and delivers lasting impact while also supporting us to take the difficult decisions that we face.

Given the context which we currently face, we will make brave, transparent decisions to disinvest in services that do not deliver enough impact. We will strive for clinical consensus but accept that this will not always be possible and we will evaluate our choices using the most up to date clinical evidence.

This isn't about mapping every step – it's about establishing and sharing the principles that will shape our future direction and guide our decision making.

This is a strategy of renewal. We believe change is possible when we unite around a common purpose and listen to the voices and hopes of those we serve.

We are proud of what has already been achieved: the resilience shown through the pandemic, the creativity and dedication of our teams and the countless acts of kindness that define our daily work. Building on these foundations, our collective task now is to make integrated care not just an ambition, but a lived reality in every street, village and town.

This is not a strategy for one organisation alone. It is an open invitation to everyone with a stake in the health and wellbeing of Torbay and South Devon - our people and communities, our colleagues, partners and volunteers - to play their part in shaping a future that is compassionate, inclusive and sustainable.

Thank you to everyone who has contributed to this vision - colleagues, partners, community representatives and local residents. Your insights and voices have shaped this strategy and will continue to guide its delivery.

Together, let's create a future where everyone in Torbay and South Devon has the chance to live well, supported by a local NHS at place that reflects the best of who we are and the best of what we can become.

Let's move forward with confidence, optimism and a shared commitment to making a difference.

Martin Beaman
Chair

Joe Teape
Chief Executive

Executive Summary

A strategy to help people live well in Torbay and South Devon

Why we must change

We stand at a turning point. We serve one of the most complex and rapidly ageing populations in England, with many people living longer with multiple long-term conditions. Levels of suicide and self harm are high, and the number of cared for children within the local authority remains among the highest in England.

Pressures on urgent care, elective recovery and community services are growing, while the cost of living, housing and workforce challenges continue to shape both health outcomes and the way services operate.

Our hospitals face rising demand and constrained capacity – a situation mirrored across the wider health and care system, including primary care. Our workforce is under sustained pressure. Our buildings and technology need renewal. Financially, we must be realistic and disciplined, with an underlying deficit at the start of 2026 of almost £100m. This means we must prioritise, focus on value and ensure every pound delivers the greatest possible benefit for our population.

At the same time, there is opportunity. Across our communities there is resilience, creativity and compassion. New science, data and digital technology are changing what is possible in care.

The new Devon, Cornwall and Isles of Scilly Cluster Integrated Care System provides a platform for genuine partnership and the experience and commitment of our colleagues and volunteers remain our greatest strength.

To meet the needs of the future, we cannot simply work harder within the existing model. Incremental improvement alone will not be enough.

Continuing to respond to rising demand in the same way would place further strain on our people and would not deliver the outcomes our communities need. We must redesign how care is organised and delivered, shifting our focus towards prevention and independence, neighbourhood-based care and supporting people to live well for longer, while keeping hospital care for when it is most needed.

Our shared vision

Our vision is simple:

To support every person, family and community we serve to live well.

This means enabling everyone to start well, live well, age well and die well in a place where care feels connected, personal and compassionate. It means supporting people not only to recover from illness, but to live meaningful, healthy and connected lives, with greater independence and quality of life.

To achieve this, we will act in three complementary roles:

- as a **provider**, delivering excellent clinical, community and remote services with safety, quality and compassion.
- as a **convener**, bringing partners together around shared purpose and outcomes, then connecting information, pathways and people so care feels seamless.
- as an **enabler**, supporting communities, colleagues and volunteers to play their part in improving wellbeing and creating the right conditions for partners to thrive.

What we will become

We will transform from being primarily a service provider to becoming a strong place-based partner with a leading role in how care works together across Torbay and South Devon. This reflects the national direction of travel, with Foundation Trusts playing a broader role in aligning care, prevention and population health improvement with partners across place.

This means:

- organising around people and relationships, not organisational boundaries
- building stronger neighbourhood and community-based care, supported by digital and data systems that connect seamlessly with hospitals
- working with partners across health, care, voluntary, academic and community sectors to align around shared outcomes
- investing in prevention and early intervention to reduce avoidable illness and future demand
- acting as an anchor institution, supporting the social, economic and environmental wellbeing of our area and beyond.

How we will get there

Transformation will not happen all at once. We will balance immediate stabilisation with long-term redesign, staying credible now while building a sustainable future. We describe this through three overlapping stages of change.

1. Stabilising and building foundations

Strengthen core services, improve flow, reduce waiting times and strengthen financial discipline and digital capability. Create the space, capability and confidence for change.

2. Transforming care together

Design and test neighbourhood models of joined-up care, improve co-ordination between hospital and community services and embed learning, digital and innovation into everyday work.

3. Realising the health and care community we aspire to become

Achieve joined-up, adaptive and compassionate care that enables people to stay well, live independently and access specialist care when they need it.

These stages overlap, allowing early innovations while core services are strengthened, ensuring that change is both realistic now and sustainable in the long term.

Our guiding principles

Our five commitments guide every decision:

- **value and sustainability** – using our resources wisely to deliver financial, workforce and environmental sustainability
- **people, purpose and partnership** – placing human connection at the centre of everything we do
- **research, learning and innovation** – continuously improving and adapting
- **safety and responsible care** – protecting people while acting responsibly to improve
- **equity and inclusion** – ensuring equity, belonging and trust for all our people and communities.

These principles guide our decisions, priorities and relationships. They ensure that change is grounded in shared purpose and integrity, not just operational change.

Our signature moves

Our strategy brought to life through five major shifts in how we design and deliver care:

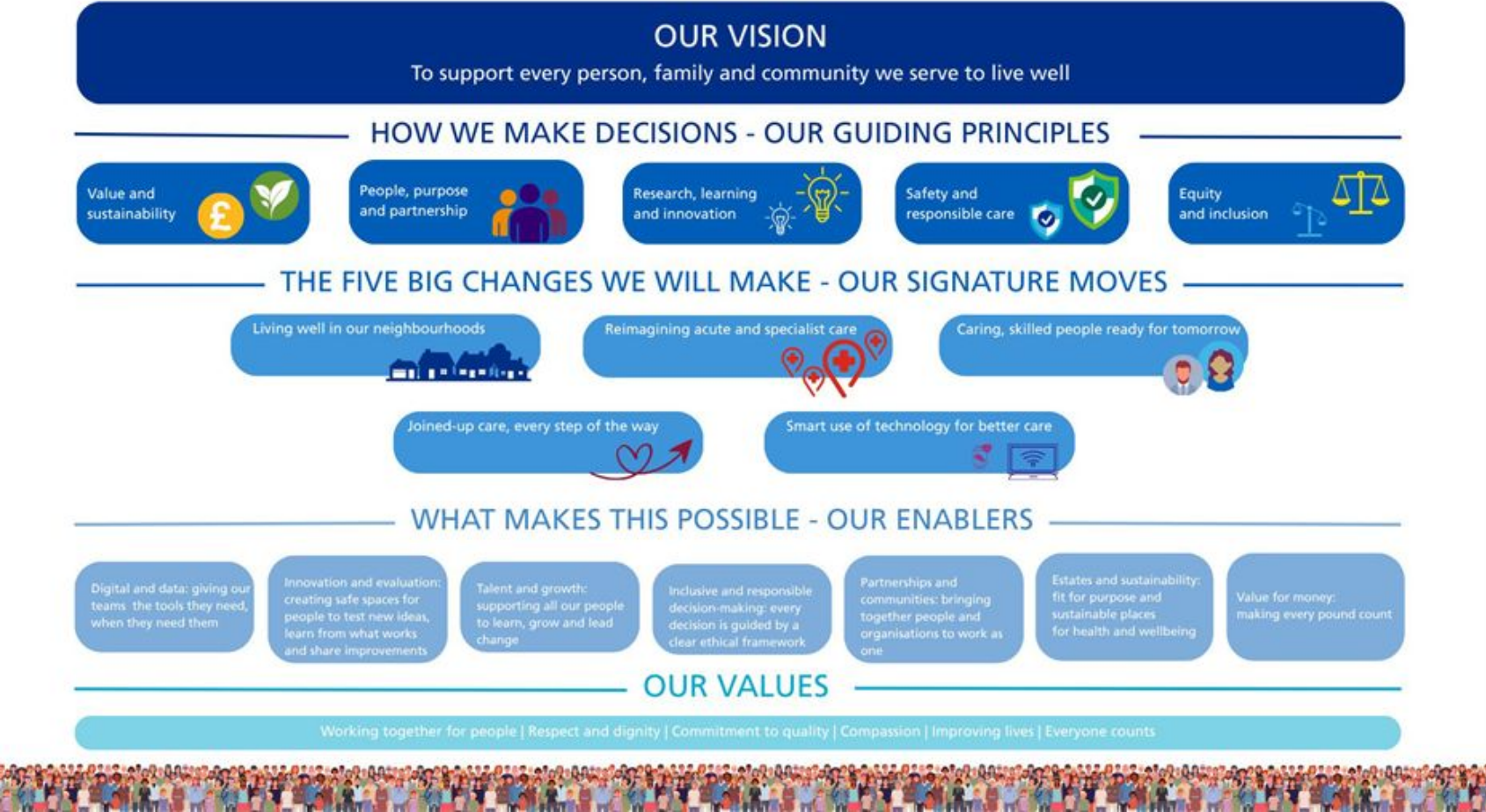
- **living well in our neighbourhoods** – working with communities to make care easy to reach and part of everyday life
- **reimagining acute and specialist care** – modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably
- **joined-up care, every step of the way** – supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout
- **smart use of technology for better care** – using digital tools and fresh thinking to make care more personal, easier to access and better connected
- **caring, skilled people ready for tomorrow** – creating a great place to work, supporting people to be their best selves, and building an agile, inclusive workforce for the future.

Each signature move connects immediate priorities with long-term transformation, ensuring that our work today creates the future we want to share.

The enablers that make this possible

To deliver these changes, we will strengthen the core capabilities that underpin the whole strategy. This includes digital and data, innovation and evaluation, talent and growth, inclusive and responsible decision-making, strong partnerships with communities, fit-for-purpose estates and a clear focus on value for money. Together, these enablers ensure our strategy is deliverable, affordable and sustainable over the long term.

Our strategy on a page



Strategy into action

Over the next 6–12 months we will :

- align this strategy with the wider Devon clinical strategy enabling acceleration of local initiatives
- bring existing programmes under this strategic framework as part of Our Plan for Better Care, using our governance and delivery structures to coordinate transformation
- develop clear implementation plans for our signature moves and enablers
- strengthening financial stability and core operational performance
- work with colleagues, partners (such as GPs and VCSE) and communities to co-create change and build shared ownership.

A shared invitation

This is a strategy for everyone who cares about the future of health and wellbeing in Torbay and South Devon. It invites each of us – our communities, colleagues, partners and volunteers - to shape care that is compassionate, intelligent and sustainable, where support feels joined up and where people can start well, live well, age well and die well.

Together, we can build care that does more to prevent avoidable ill-health and responds when things go wrong, so more people can live well for longer.

Chapter one: why we need to change

Local knowledge, local action

We are rooted in our geography and united by a shared ambition: supporting every person, family, and community we serve to live well.

Our decisions are grounded in local insight, shaped by the lived realities of Torbay and South Devon - and by the expertise of our clinical leaders and teams, who have the autonomy to act on what they know matters most. We know our communities because we are part of them and we believe the best solutions are those designed with and for local people.

A generational shift: putting children and families first

Our future begins with our children. Too many grow up facing challenges that no child should - poverty, unstable housing or the need for extra support at school. The number of children in care here is among the highest in England. We see the impact this has, not just on young lives today, but on the health and wellbeing of our whole community for years to come.

Every child deserves the best start. We're committed to working with families, schools and partners to invest in children and young people, so future generations can thrive.

We believe that, together, we can make a generational shift - giving every child and family the chance of a brighter future.

Understanding our population: local challenges and strengths

Torbay and South Devon is a place of contrasts—full of beauty, diversity, and complexity. We're proud that people choose to spend their lives here and we celebrate our long life expectancy. But with more than one in four of us now over 65, and the proportion of people aged over 85 among the highest in the country, too many of those extra years are spent in poor health. Around half of all adults live with at least one long-term condition and one in five manage three or more.

Our geography is diverse, with rural villages, market towns and coastal communities - each with unique strengths and needs. Some coastal areas face significant hardship, including poverty, loneliness and poor housing.

Yet, there's so much to celebrate. Our communities are full of kindness, generosity and a spirit of looking out for one another. Volunteers, carers, and neighbours step up every day to support those around them. This resilience is our greatest strength and it's what gives us hope for the future - even as the social fabric that sustains wellbeing is under strain.

The NHS in the south west peninsula

The south west peninsula brings together the communities of Devon, Cornwall and the Isles of Scilly. Across this area, NHS organisations, local councils and community partners are working more closely than ever to improve health and wellbeing for everyone.

Our area is served by a new Integrated Care Board (ICB) cluster, which unites NHS leaders from Devon, Cornwall and the Isles of Scilly. This cluster helps us plan and fund health and care services in a joined-up way, making sure resources are used wisely and care is shaped around what matters most to local people.

As a provider organisation, we work hand-in-hand with the ICB cluster and our partners - delivering hospital, community and neighbourhood care and helping to design services that reflect the needs and strengths of our Peninsula. By working together, we can ensure everyone in our region has the best chance to live well, now and for generations to come.

The bigger picture: what shapes our health

We know that good health is about so much more than just healthcare. It's about having a safe place to live, decent work, strong connections and opportunities to thrive. That's why we work hand-in-hand with our partners - tackling poverty, improving housing, boosting local jobs, and building a sense of belonging.

In Torbay and South Devon:

- we have an eight-year gap in life expectancy between our most and least affluent areas
- many families struggle to make ends meet, and the cost of living hits hard
- good, affordable housing is out of reach for too many
- jobs can be seasonal or low-paid, making it tough to plan for the future
- many people choose to move here to enjoy their later years, but growing older here can sometimes mean facing ill-health, frailty, or feeling alone
- our young people are facing more pressures than ever, with rising challenges around mental health, self-harm and isolation
- many in our communities quietly care for loved ones, often without recognition or support
- our natural environment is a gift, offering green spaces and fresh air that support our wellbeing
- climate change brings new challenges, but also opportunities to work together for a healthier environment.

[pull quote: one in six children in Torbay grow up in relative poverty]

As one of the area's biggest employers and a proud part of our communities, we have a responsibility to use our influence to make life better for everyone who calls Torbay and South Devon home.

What it feels like today

The challenges we face are stark and interlinked. Demand for urgent and elective care is rising, hospital capacity is stretched and too many people wait too long - for diagnosis, treatment or support. Each delay carries a human cost.

Recruiting and keeping staff is tough, especially when the cost of living, lack of public transport and affordable housing make it hard for people to stay. Some clinical and technical roles are particularly hard to fill in rural areas. When colleagues move on, it's not just a gap in the rota - it's a loss of relationships, experience and continuity for the people we serve.

Our buildings are ageing and our digital systems need to catch up with the way we want to work.

Financially, we face tight constraints, requiring disciplined financial stewardship and clear choices about where and how we invest for the future.

These pressures show we need to move from short-term fixes to long-term, sustainable solutions. Real health and wellbeing means looking beyond emergencies and focusing on prevention, continuity and what matters most to people. We cannot meet these challenges through incremental improvement alone. Working harder within the old model will not be enough. The current system is stretched between growing demand, constrained resources and the limits of its design. It's time to work differently – together - so we can build a future that truly supports everyone.

Listening and learning locally

We never make decisions in isolation. We talk to patients, families, colleagues and partners. We ask, "What matters to you?" - and we act on what we hear.

We are committed to embedding lived experience and community voices in how we design, test and evaluate new approaches so that our services reflect what matters most to local people.

People tell us they value the NHS being free when they need it and they want care that's close to home, joined-up and easy to access.

They want us to focus on prevention, not just treatment and to make sure no one is left behind as technology changes the way we deliver care.

By listening and learning from local voices, we can shape services that truly reflect the needs and hopes of our communities.

[pull-quote: "We ask, 'What matters to you?' - and we act on what we hear."]

Breaking the cycle: from crisis to prevention

Too often, people only get help when things have already reached crisis point. We see families and individuals caught in a frustrating cycle - waiting until things go wrong, facing repeated assessments and feeling like they're always starting over. We know it doesn't have to be this way. By working together, we can spot issues

earlier, offer support before anyone reaches breaking point and make sure help is there when and where it's needed most.

Pressure on our services often results from missed opportunities for early help and prevention, leading to more emergencies and hospital visits.

This cycle isn't just costly—it causes avoidable harm and leaves people feeling let down. We want to break that pattern. That means shifting our focus from reacting to crises, to working together as communities to provide earlier, more joined-up support. That's at the heart of our strategy: helping people stay well, connected and confident in their own lives.

We recognise that too many promising innovations stall before reaching the people who need them most. That's why we are considering new ways to bridge the gap between research, innovation and real-world delivery through an evaluation and investment hub. This would help us ensure that what works in theory becomes what works in practice, with lived experience and community voices embedded in every step.

Our promise: health and wellbeing for every stage of life

We believe in supporting people at every stage:



Our ambition is bold, but it is grounded in the expertise and insight of our clinicians and teams. We will achieve our goals by giving clinical leaders the autonomy to innovate, adapt and be accountable for the outcomes that matter to people locally.

Looking ahead: a community-informed future

We're proud to be part of an organisation that brings together hospital and community care - allowing us to design support around people's lives, not organisational boundaries. Our integrated approach means we can listen closely to local voices, invest in children and families and empower clinical leaders to shape care and take responsibility for outcomes delivered within the financial constraints we face. By working hand-in-hand with partners across Devon and the south west Peninsula, we can build a future where clinical leadership and accountability shape every decision.

Our challenges are real, but so are our strengths. By putting children and families at the centre, listening to what matters most and working together, we can create a local NHS that truly belongs to everyone in Torbay and South Devon - now and for generations to come.

With compassionate colleagues, established locality neighbourhood teams, and strong partnerships across GPs, the voluntary sector, universities, colleges and industry, we can help shape a brighter future and give everyone the chance to live well.

Chapter 2: Our purpose, vision and role

Our purpose

We exist to improve health and wellbeing for every person, family and community we serve.

This means treating illness well, preventing ill health and using our resources responsibly so they make the biggest difference. We work with partners because health is shaped by more than NHS services – it depends on relationships, environments and opportunities.

Our purpose is not only to deliver care, but to learn, innovate and share knowledge – so that every person, family and community benefits from the best that modern health and care can offer. We will explore new partnerships and proposals to help us generate evidence, support innovation and ensure that improvements are informed by those with lived experience.

Integration is central to our purpose. We will build on what we know works, joining up care across hospitals, neighbourhoods and communities so people experience one connected NHS, not separate services.

Our vision

To support every person, family and community we serve to live well.

We imagine a future where:

- care feels personal, joined-up and close to home
- hospitals, neighbourhoods and communities work as one connected whole
- care is proactive and prevents illness, not just reacts to it
- people are part of a health system that learns and improves every day
- resources are used responsibly and wisely so health, economic and environmental benefits go hand in hand.

We are committed to strengthening clinical leadership in our work so those closest to care have the freedom to shape services and deliver what matters most to our communities.

This vision defines the future we will build together.

Our role

We have a distinctive role in shaping the future of care. This role is not just about what we provide – it is about how we facilitate, connect and enable change across the whole health system.

Our role has three elements:

- **provider:** we will deliver excellent community, hospital and remote services with safety, quality and compassion focussed on best outcomes
- **convener:** we will bring partners together around shared purpose and outcomes, then connecting information, pathways and people so care feels seamless

- **enabler:** we will support communities, colleagues and volunteers to play their part in improving wellbeing and creating the right conditions for partners to thrive. Clinical leaders will be empowered to act on local insight and experience.

We will support integration, act quickly, take managed risks and evaluate what works, so progress is bold, inclusive and grounded.

Our mindset

We will make decisions and lead change, however difficult, with courage and clarity.

We will empower clinical leaders, health leaders and teams to innovate and lead improvement, supported by open feedback and sharing learning.

Our values

Our values guide how we treat people and how we work together. They shape our culture and influence every decision we make. We use the NHS Constitution values as our foundation.

- **working together for people:** patients come first in everything we do
- **respect and dignity:** we value every person and listen to what matters to them
- **commitment to quality:** we earn trust by seeking to get care right every time
- **compassion:** we respond with kindness and humanity
- **improving lives:** we strive to make health and wellbeing better for all
- **everyone counts:** we use resources for the benefit of all and make sure no one is left behind.

These values sit at the heart of how we change and improve. They are the means by which we earn and maintain the trust of our communities, our partners and one another.

Strategic assumptions – the key factors shaping our plan

Our strategy doesn't exist in isolation. Our ambitions are grounded in our reality.

These are the key factors shaping our plan – from national priorities to local realities:

- we will continue to provide community, hospital and remote care while working closely with NHS partners across the Peninsula
- national NHS plans call for more prevention, neighbourhood-based care and digital transformation – and we will drive and support these changes locally
- specialist hospital services will be concentrated in fewer locations to meet national standards
- financial constraint will remain a defining condition, so we must prioritise, contain costs and focus on value
- we will break even and live within the funding available in the next three years
- the Peninsula will move towards shared services and infrastructure, including digital and data
- success depends on partnership, leadership and trust – not just technology or structures.

Our commitment to our people

Colleagues told us they want more freedom to lead change and take responsibility for improving care within the financial constraints in which we work. We have listened - our strategy commits to greater clinical leadership and local autonomy, ensuring those delivering care have a real say in how services evolve.

Chapter three: our guiding principles

Our guiding principles turn our values into action. They shape every decision, design and partnership so we move closer to our vision. They are not words on a page – they are active commitments that define how we act and work together as one connected, compassionate and learning organisation.

Why they matter

Our principles provide coherence in a complex health and care system, connecting today's actions with tomorrow's ambitions. They underpin our decision-making for all future service development and prioritisation

Principle one: value and sustainability

Our commitment:

We will live within our means and invest in services that make the biggest difference to the health and wellbeing of our population. We will make brave, transparent decisions to stop funding services that do not deliver the outcomes we expect.

Why it matters:

Financial sustainability is essential for safe, high-quality care. We cannot deliver for the future if we fail to prioritise resources today.

In practice:

- we define clinical sustainability clearly: services must be safe, high-quality with good outcomes and staffed appropriately, with clinical leaders involved in shaping and reviewing service models
- where services cannot meet these standards or cannot be staffed safely, we will redesign, partner or consolidate rather than compromise care
- we will recognise where partnership is essential to sustain services and act as an anchor organisation to support shared solutions
- we will focus investment on prevention, independence and community-based care, not just treatment
- we will make transparent decisions about priorities and opportunity costs, explaining why some services will change or stop.

Example

When reviewing elective surgery waiting lists, we shift investment towards community-based rehabilitation and prevention programmes that reduce future demand, even if it means reducing low-value elective procedures.

Where specialist services cannot meet quality or staffing requirements, we partner within the south west peninsula or regionally to maintain safe care rather than dilute standards locally.

Principle two: people, purpose and partnership

Our commitment:

This principle recognises that health and care are built on relationships between communities, patients, families and colleagues. Compassion, trust and inclusion are the foundation of everything we do.

We act in partnership with others in our roles as convenor and enabler, so that every person experiences joined-up, compassionate and reliable care, wherever and however they encounter the system.

We will attract, develop and retain talented people who share our vision and values. We will create an inclusive culture where everyone feels seen, heard and valued – a place where people belong and can be their best selves at work to deliver the best care.

Why it matters:

Health and care are built on relationships. Purpose is shared, not owned. Partnership and inclusion are how we deliver excellence.

In practice:

- we invest in leadership, learning and development so our people can grow and thrive
- we create a culture of belonging where diversity is respected and everyone feels valued
- we work with partners across health, care and community sectors to connect pathways and make care seamless
- we enable our people, communities, colleagues and volunteers to play an active role in improving wellbeing, with clinical leaders empowered to shape local services.

Example

When deciding whether to invest in a new integrated care hub, we prioritise models that bring partners together (GPs, voluntary sector, social care) and create joined-up pathways rather than isolated services.

We ensure our colleagues have the right support and the right environment to deliver high-quality care.

Principle three: research, learning and innovation

Our commitment:

We learn from anyone and anywhere to bring fresh thinking and action that improves outcomes for local people. We are not afraid to fail fast – without judgement – because every test teaches us something. Curiosity drives us to act, learn and adapt so we can accelerate the adoption of innovation.

We are committed to creating a culture where learning from research, innovation and lived experience is valued and shared.

Why it matters:

A learning organisation adapts and grows. Innovation turns learning into better care and ensures progress is continuous. Research is essential for transforming care and improving outcomes for our people and communities.

In practice:

- we seek ideas from across health, care, communities and beyond – wherever they can add value
- we test, share what works and stop what doesn't, without blame
- we embrace fast, safe failure as a way to learn quickly and move forward with confidence
- we act with curiosity and humility, using evidence and lived experience to guide improvement, with clinical teams leading change on the ground.
- we will involve our people in research which will improve experience, quality and impact.

Example

When considering digital tools for remote monitoring, we pilot first, gather feedback from patients and colleagues and scale only when evidence shows improved outcomes and experience. If a pilot doesn't deliver, we learn why and adapt rather than abandon innovation.

Principle four: safety and responsible care

Our commitment:

We will not tolerate unsafe care. Safety, integrity and trust will remain the foundation of everything we do. We will manage risk actively and transparently and we will use resources responsibly to ensure care is safe today and sustainable tomorrow.

Why it matters:

Safety builds trust. Stewardship (responsible care) ensures that every decision supports long-term quality and resilience.

In practice:

- we extend safety beyond clinical care to psychological, digital and ethical areas, with clinical leaders playing a key role in setting and upholding standards
- we act decisively to remove unsafe practices and continuously monitor and manage risk
- we use resources and the environment responsibly, ensuring decisions today do not compromise tomorrow.

Example

When introducing AI-driven diagnostics, we ensure robust governance for data security and ethical use, ensuring patient safety before speed or cost savings.

Principle five: equity and inclusion

Our commitment:

All decisions will be guided by the principle of reducing health inequalities and addressing barriers. Access does not mean only access to healthcare – it includes access to employment, education and prevention. We will design for equity so that everyone can thrive and feel seen, heard and valued.

Why it matters:

Reducing health inequalities is essential if we are to support everyone that we serve

to live well. Health outcomes are shaped by more than clinical care – they depend on social and economic opportunities.

In practice:

- we remove barriers that prevent people from accessing care, support and opportunities that influence health, with clinical leaders championing equity and inclusion
- we ensure compassionate, high-quality care for every person, regardless of background
- we actively test decisions against equity and inclusion, considering wider determinants of health such as housing, education and employment.

Example:

When planning new urgent care facilities, we ensure we locate services where transport links and deprivation data show greatest need, not just where estate is available.

We work with partners to connect people to employment and education opportunities that support long-term wellbeing.

Together, these principles guide how we prioritise, invest and innovate - ensuring clinical and health and care leadership and local autonomy and accountability are woven through every decision, so improvements are grounded in real experience and deliver what matters most to our communities.

These principles are our compass – they keep every decision aligned with our vision and values.

Chapter four: making change real

Delivering our vision means changing how we think and work. We will need to make some difficult but necessary decisions to improve our performance and put our finances on a more sustainable footing, while redesigning services for the future. Clinical leaders and teams will be empowered to shape our solutions and improvement.

By connecting research, education and innovation with everyday practice, we aim to build a culture of continuous improvement, where every colleague, partner and community member can contribute to shaping our future.

We have used the Three Horizons framework to connect immediate priorities with long-term goals:

- **year one** (2026/27): taking decisive action to strengthen today (horizon one)
- **years two and three** (2027/28-2028/29): redesign and scale what works (horizon two)
- **years four and five** (2029/30-2030/31): build the future (horizon three).

Year one – caring well now - stabilising today

Before we can transform, we must ensure services are safe, reliable and sustainable, building on what we know already works and strengthening our foundations. We will support clinical leaders and teams to take the lead in stabilising and improving services within the financial resources we have available and building trust through consistent delivery.

Our priorities:

- improve urgent and emergency care and reduce elective waits
- support our people's wellbeing and develop compassionate, inclusive leadership
- put our finances on a sustainable footing and make better use of our resources
- shape, develop and support our teams to meet the needs of today and tomorrow
- stabilise and improve our digital services so they work better for staff and patients
- build trust through consistent, reliable delivery
- work with partners to make the most of collaboration.

What this will look and feel like:

- meeting the financial commitments, we set for ourselves
- teams shaped to meet changing needs, with the right skills in the right places
- faster ambulance handovers and better flow through urgent and emergency care
- more flexible working patterns and wellbeing support to help colleagues stay well at work
- increased access to education and development and career opportunities
- reliable core digital systems that allow clinicians to access patient records without disruption.
- partners working together to design and deliver holistic person-centred care

Years two and three – improving together - redesigning for tomorrow

With greater stability in place, we will accelerate change, redesigning together how we work and spreading new ideas and new ways of working. Clinical leaders and teams will support this redesign, working with partners and communities to test, learn and scale what works.

We will:

- expand integrated neighbourhood teams and wellbeing hubs
- join up hospital and home care with clear pathways
- work as one NHS with shared outcomes and risks
- invest in prevention and early intervention
- use data and rapid testing to learn and innovate
- move to digital systems that work together to support real-time decisions.

What this will look and feel like:

- virtual wards allowing people to stay at home or leave hospital earlier to recover safely at home with remote monitoring and clinical oversight
- shared dashboards showing system-wide performance so partners can act together
- testing new models for frailty care that reduce hospital admissions and improve independence.

Years four and five – realising our shared future

By the early 2030s, we will operate as part of a connected, compassionate and adaptive health and care community that:

- focuses on prevention and health creation, not just treatment
- organises around people and relationships, not institutions
- personalises care and co-designs solutions with communities
- learns and improves continuously through feedback and innovation
- is financially and environmentally sustainable
- builds trust and shared purpose across health, care and community sectors
- is shaped by clinicians and teams who act on local insight and experience.

What this will look and feel like:

- a person with multiple conditions receives care planned jointly by their GP, hospital team and community support – all connected through shared data
- health hubs in neighbourhoods offer clinical care, social support and digital access in one place
- real-time data helps clinicians and community teams adapt services quickly based on what works
- we thrive together creating a future where care, learning and wellbeing are fully joined-up.

This approach connects immediate improvements with long-term transformation. It ensures every decision moves us closer to a future that supports every person, family and community we serve to live well. By empowering clinical and health leaders and teams throughout, we make sure change is grounded in real experience and delivers what matters most.

Chapter five: our signature moves – reimagining care

Translating our vision into action

Our signature moves are the practical changes we will make. They turn our ambitions into real changes for people, colleagues and communities. Each move builds on the last, taking us from stabilising services, through improvements, to a future where care helps people live well, every day and at every stage of life.

Together they deliver the aims of the NHS 10-Year Plan and Devon's commissioning intentions, but they go further - shaped by what we've learned from people, colleagues and partners in Torbay and South Devon. Rooted in local knowledge, they reflect what matters most to our communities, the challenges they face and the strengths they bring.

When we get this right, people will experience care and support that feels personal, joined-up and easy to access. Communities become healthier and more resilient. Colleagues will feel valued and able to make a difference. And together, we will see better health, greater independence and a sense of belonging for everyone in Torbay and South Devon.

Our five signature moves

- **living well in our neighbourhoods:** working with communities to make care easy to reach and part of everyday life
- **reimagining acute and specialist care:** modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably
- **joined-up care, every step of the way:** supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout
- **smart use of technology for better care:** using digital tools and fresh thinking to make care more personal, connected and easier to access
- **caring, skilled people ready for tomorrow:** growing a compassionate, adaptable team and a positive culture, so colleagues feel valued and ready to meet changing needs.

Signature move one: living well in our neighbourhoods

Working with communities to make care easy to reach and part of everyday life

Why this matters

Most of what helps us to live well happens where we live—not in hospitals. When care only starts at the hospital door, it's harder for people who face poverty, loneliness or long-term health problems to get the help they need. By moving more care and support into our neighbourhoods, we can make help easier to reach and improve lives.

Neighbourhoods will be places where prevention and care happen together—not just where services are managed. Integrated teams (including GPs and voluntary partners) shaped by local voices and lived experience will work together. Clinical leaders in each neighbourhood will have clear accountability for outcomes that matter locally, supported by research, innovation and shared learning. Over time we aim to shift the care model and balance of investment from hospital to community to support our neighbourhoods.

Neighbourhood care brings our vision to life: everyone in Torbay and South Devon can start well, live well, age well and die well - supported by local relationships, community resources and services that work together around what matters most to each person.

Where we are now

We already have five local hubs:

- Torquay
- Paignton and Brixham
- Newton Abbot
- Totnes, Dartmouth and the Moor (Moor to Sea)
- Teignmouth and Dawlish (Coastal).

These will be strengthened to support us to work with local Primary Care Networks as convener and enabler to design services that fit the needs of their local area.

Our Integrated Neighbourhood Teams (INTs) already bring health and social care together, with approaches shaped by local need. We now have an opportunity to build on this experience, benefit from best practice and shape services for the future, including

- NHS England's Neighbourhood Health Guidelines (2025/26): putting local teams at the heart of planned and responsive care
- a decade of INTs: showing that real integration is about trust, strong relationships and local flexibility
- the Health Innovation Network: highlighting the need for stable teams, time to build trust and good digital systems.

In line with the expectations in the 10-year health plan for England, more services will move out of hospitals and into our communities - making care easier to reach, focusing on prevention and reducing costs of expensive urgent and emergency care. This will mean diagnostics, minor injuries, urgent care, outpatient clinics, rehabilitation and more, all delivered closer to where people live.

Local priorities and partnerships

Creating services that truly work for people means looking beyond our own walls. We already have partnerships that make a real difference for people. Looking ahead we'll deepen our collaboration – bringing together expertise from across the south west Peninsula and the wider region to shape neighbourhood care that works for everyone. Sharing ideas, testing new ways of working and learning from each other as we go.

What this means for people

People won't have to knock on lots of different doors to get help. Instead, there will be one local team they can turn to—making things simpler and more personal. Support will start early, with prevention and practical help available locally and shaped by the voices of their communities. Physical, mental and social needs will be met together, so care feels joined up rather than fragmented. People will be supported to remain at home and only attend hospital for active treatment with more diagnostics available locally. Moving between home, community and hospital will be smooth, with warm handovers and clear communication every step of the way.

These neighbourhood hubs won't be designed in isolation—they'll be shaped by the people who use them. Communities will have a real say in what matters most and how services should work. For example, in a coastal area facing deprivation, a hub might work closely with housing, youth services, schools, faith groups and local organisations to support wellbeing and reduce pressure on GPs and hospitals.

What this means for colleagues and teams

In the neighbourhood hubs, colleagues from primary care, community services and social care will work side by side - planning together and learning from each other as one team. Mental health workers, voluntary, community and social enterprises, volunteers and peer supporters will be fully part of the team, bringing their specialist skills and perspectives. Hospital staff will feel confident that when someone leaves their care, strong local teams are ready to provide the right support.

Each hub will have a health and care professional who is responsible for local outcomes and accountable to the communities they serve, supported by sharing learning, research partnerships and rigorous evaluation. Colleagues will have opportunities to train together and work across sectors, building shared understanding and trust. Because in the end, strong relationships, a common purpose and mutual respect matter just as much as any structure or system.

How we will work

This signature move means:

- **from separate services to joined-up support:** services work together as one team, making it easier for people to get the help they need without navigating lots of different doors
- **from one-size-fits-all to local solutions:** each hub shapes its own approach based on local needs and voices, while following shared principles
- **from reacting to problems to preventing them:** using local knowledge and data to spot issues early and act before crises happen

- **from institutions to community action:** schools, housing, faith groups, businesses and residents all play a part in creating health and wellbeing together.

We will embed improvement science, research and education into daily practice, ensuring every change is informed by evidence and lived experience.

Digital records, secure communication and smart decision tools will help teams work together and provide care that is more personal, proactive and connected.

Starting well together: neighbourhood care for young families

Today

Sophie, 28, lives in Torquay with her partner Dan and their two-year-old son, Leo. When Leo starts showing signs of delayed speech and Sophie feels anxious after returning to work, getting help isn't easy. The family faces long waits for specialist appointments and Sophie worries about taking time off work for GP visits. Support feels fragmented and by the time help arrives, stress levels are high.

In five years time

In our "Living Well in Our Neighbourhoods" model, Sophie's experience looks very different. Instead of heading to A&E or waiting for a GP crisis appointment, Sophie contacts her local neighbourhood wellbeing hub - the first point of support for families. Within days, a family wellbeing coordinator meets them and brings together the right team: a health visitor, early years practitioner, community mental health nurse, paediatric link clinician and local voluntary partners.

Leo joins a child development playgroup linked to speech therapy, while Sophie connects with a parenting peer group and gets a mental health check-in supported by digital self-help tools. Within weeks, Leo is making progress, Sophie feels supported and confident, and the family feels connected rather than isolated.

What changes?

- **for families:** help comes earlier, stress is reduced, and support feels local and personal
- **for colleagues:** teams work proactively and together, spotting issues early through trusted relationships
- **for the NHS:** fewer crises, avoided unplanned contacts, lower long-term costs and stronger community resilience.

Ageing well together: neighbourhood care for older people

Today

Margaret, 82, lives alone in Paignton. After a fall, she spends weeks in hospital waiting for a care package to be arranged. When she finally returns home, she feels isolated and struggles to manage daily tasks. Her family worries about another crisis.

In five years time

Margaret's local neighbourhood hub spots the risk before it becomes a crisis. A wellbeing coordinator visits her at home within days, supported by a team that includes a physiotherapist, occupational therapist, social care worker and local voluntary partners. Together, they create a plan that includes home adaptations, strength and balance classes at the community centre and a volunteer befriender who visits weekly. Digital monitoring tools help the team check in without constant appointments.

Margaret stays independent, feels connected and avoids another hospital stay.

Impact:

- **for Margaret:** confidence, independence and social connection.
- **for colleagues:** joined-up planning and proactive support.
- **for the NHS:** fewer admissions, shorter hospital stays, reduced long-term costs.

Living well with long-term conditions: neighbourhood care for people with diabetes

Today

Ahmed, 55, lives in Newton Abbot and has type 2 diabetes. He struggles to manage his condition and often ends up in the Emergency Department with complications. Care feels fragmented - different appointments for diet, medication and mental health support.

In five years time

Ahmed's neighbourhood hub brings everything together. A wellbeing coordinator connects him with a diabetes nurse, dietitian, mental health practitioner and local exercise group - all working as one team. He uses a digital app to track blood sugar and share updates with his care team. Peer support groups in the hub help him stay motivated.

Instead of crisis visits, Ahmed feels in control and supported close to home.

Impact:

- **for Ahmed:** better health, less stress, more confidence.
- **for colleagues:** integrated care planning and shared decision-making.
- **for the NHS:** reduced complications, fewer emergency admissions, improved quality of life.

Mental health and community connection: neighbourhood care for young adults

Today

Ella, 19, lives in Teignmouth and struggles with anxiety and depression. She waits months for specialist help and feels isolated from friends and family. By the time she gets support, her condition has worsened.

In five years time

Ella's local hub offers early help without long waits. A wellbeing coordinator introduces her to a mental health nurse, youth worker and voluntary sector partners. She joins a creative arts group at the hub and uses digital self-help tools alongside regular check-ins. Her family is involved in planning, and she feels part of a supportive community.

Ella's mental health improves, and she avoids crisis care.

Impact:

- **for Ella:** faster support, stronger social connections, improved wellbeing.
- **for colleagues:** collaborative working across health, social care and voluntary sectors.
- **for the NHS:** reduced demand for specialist services, better outcomes for young people.

Neighbourhood care: creating value and sustainability

Neighbourhood care isn't just about moving services closer to home - it's about making health and care work better for people and for the NHS. When support is local, we can prevent problems earlier, improve everyone's outcomes and experience, reduce pressure on hospitals and make the most of our resources. This means:

- **fewer emergencies, shorter stays:** strong neighbourhood teams help people stay well, avoid unnecessary admissions and readmissions and recover faster when hospital care is needed
- **shared resources, less duplication:** working together across health, social care and community partners means we use our people, facilities and funding more effectively and efficiently
- **early help saves costs:** prevention and rehabilitation reduce the need for long-term, high-cost care
- **partnerships amplify impact:** community organisations bring local knowledge and networks that help make care more personal and make every pound go further
- **care where it makes sense:** moving suitable services into neighbourhood hubs improves access and makes better use of buildings and workforce.

Neighbourhoods and hospitals will work as one seamless loop of care – virtual wards, shared records and joint decision-making will make transitions smoother and safer:

- neighbourhood hubs support people day to day and feed forward into reimaged acute services when needed
- hospitals feed back into supported recovery at home, with virtual wards, shared records and joint decision-making
- more diagnostics are available locally in people's communities, reducing the need to travel and widening access
- digital tools and smart technology will help teams work together, making care more personal and proactive.

Our focus	Milestones
Year one (2026/27)	• We will expand The Harbour, our community frailty hub, including the development of a fracture liaison service. • We will work closely with GPs and primary, voluntary and social care partners to turn neighbourhood working into reality, using our capacity and capabilities to accelerate progress. • We will expand and invest in virtual wards, the Medical Admissions Avoidance Team (MAAT) and hospital-at-home services. • We will bid for neighbourhood funding through the Local Care Partnership to support delivery at scale. • We will reduce ambulance arrivals and delays by developing alternative urgent care pathways. • We will upgrade core IT systems for neighbourhood teams, enabling effective risk stratification so support is focused on those most in need. • We will review our bed-based offer to ensure it supports reablement, promotes independence and delays unnecessary moves into long-term bed-based care.
Years two and three (2027/28-2028/29)	• We will expand neighbourhood teams and wellbeing hubs, building capacity closer to home. • We will join up hospital and home-based care through clear pathways for long-term condition management, with a strong focus on prevention. • We will implement anticipatory care planning across neighbourhoods to prevent escalation into crisis. • We will test new models of frailty care, learning quickly what works best for people and teams. • We will use data and rapid testing to support learning, improvement and innovation. • We will develop shared dashboards to support system-wide oversight of performance and outcomes.
Years four and five (2029/30-2030-31)	• We will deliver diagnostic and outpatient appointments in community settings wherever this can be done safely and effectively. We will increase the proportion of specialist appointments delivered virtually or in the community, supported where appropriate by neighbourhood and community teams.

Signature move two: reimagining acute and specialist care

Modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably

Why this matters

Over the course of our lifetime, an accident, a sudden illness or the need for specialist treatment is almost inevitable for all of us – and when that happens, people need somewhere they can trust. Torbay Hospital is that place: a safe, skilled and compassionate environment where care happens quickly and confidently.

Our hospital exists for a clear purpose: to provide excellent local diagnostics, access to time-sensitive services and specialist care that meets the needs of our population. But demand is rising faster than capacity and hospitals everywhere are under significant pressure. Improving parts of the hospital pathway helps, but it does not address the underlying problem. We need to reduce demand on acute services through our neighbourhood model and by redesigning our services.

While it's difficult, we also need to recognise that we can't do everything we are currently doing. Where it makes sense—because of quality, staffing or cost—we will work in networks or provide care differently, always guided by what's best for people and communities. Every decision will weigh the impact on patients, colleagues and the wider pathway, not just the hospital in isolation.

This isn't about doing more of the same, faster. It's about creating acute and specialist services that learn, adapt and connect - moving from best practice to next practice, embedding research and innovation alongside humanity.

Where we are now

Torbay Hospital faces the same challenges being seen nationally: significant financial constraints, rising demand, complex discharge delays and an ageing estate. These pressures are made worse by health inequalities. But we also have strong foundations:

- an integrated health and care system, giving us a unique chance to rethink the relationship between hospital and community
- Hospital@Home and Virtual Ward models, already showing how care can safely extend beyond hospital walls
- a clear clinical framework under development, strengthening surgical and diagnostic capacity, modernising theatres and expanding day-case and elective pathways
- a Frailty support model that redesigns pathways across acute, community and neighbourhood care.
- early involvement in cancer vaccine trials, signalling our growing role in advanced therapies and innovation partnerships.

We will build on these to create a hospital that is high-performing and human-centred - technologically advanced, but defined by dignity, safety and experience.

What this means for people

Urgent and specialist care will be quick, compassionate and clear. Leaving hospital will be safe and connected to the right care at home.

Where we cannot deliver a high standard of care alone, we will work in networks so our population has access to excellent care – often closer to home through outreach clinics, telemedicine and neighbourhood hubs. For those facing barriers, extra support will make sure care is equitable and accessible.

We will embed personalised medicine and shared decision-making into every acute care pathway, ensuring people are active partners in their care. This means clinicians and patients working together to make decisions that reflect both the best available evidence and what matters most to the individual. Whether planning surgery, managing long-term conditions or responding to urgent needs, we will support people to understand their options, weigh up the benefits and risks and make choices that align with their goals and values. This approach builds trust, improves outcomes and ensures that every encounter in acute care is grounded in dignity, clarity and compassion.

At the same time, we will strengthen the role of diagnostics in acute care by expanding access to rapid, high-quality testing both within and beyond the hospital. Our Community Diagnostic Centre in Torquay will continue to ease pressure on acute services by providing timely access to imaging and cardiac investigations closer to home. We will also explore the use of point-of-care testing, mobile diagnostics including an x-ray car and AI-enabled tools to support faster decision-making and reduce delays. By integrating these innovations into acute pathways, we will ensure that people receive the right care, in the right place, at the right time - improving flow, reducing admissions and enabling earlier, more accurate treatment.

What this means for our colleagues and teams

Teams will work in an environment that feels safe and supportive, with time protected for what matters most - high-quality, compassionate care.

Collaboration across hospitals, neighbourhood and primary care will be routine, supported by real-time data, digital tools and research. We will support professional growth through shared learning, simulation and opportunities to be involved in research.

Above all, our culture will value inclusion, psychological safety and learning.

How we'll work

Reimagining acute and specialist care means:

- **from reactive to proactive:** using predictive tools to anticipate demand and reduce delays
- **from stand-alone to connected:** linking digitally and clinically with neighbourhood and primary care teams for shared care as well as with partner organisations across Devon and the south west Peninsula
- **from one-off episodes to continuity:** making recovery and rehabilitation part of the pathway

- **from isolation to networks:** creating shared standards, joint governance and mutual support across services and sites so every part of the pathway feels equal and valued
- **from top-down to empowered teams:** giving teams real-time insight and shared leadership
- **from rigid spaces to flexible design:** modernising our estate for adaptable use and better experience
- **from best practice to next practice:** embedding innovation and learning at every level.

Digital transformation will support this change, with shared records, AI-enabled diagnostics, real-time dashboards and automation to free up time for care.

From long waits to seamless flow

Today

John, 67, arrives at Torbay Hospital with breathlessness. He waits hours in A&E because beds are full and staff are stretched. After tests, he's admitted for observation, but discharge is delayed because community support isn't ready. John spends extra days in hospital, feeling anxious and disconnected from home.

In five years time

When John arrives, predictive analytics have already flagged bed availability and care pathways. He's assessed quickly, tests are fast-tracked using AI-enabled diagnostics, and his care team includes hospital clinicians and neighbourhood partners from the start. As soon as he's stable, a virtual ward and home monitoring plan are activated. Community teams are ready and John goes home sooner—with confidence that support is in place.

Impact:

- **for John:** faster care, safer discharge, less stress
- **for colleagues:** real-time data and shared planning reduce delays
- **for the NHS:** shorter stays, fewer readmissions, better use of resources.

Planned surgery – from uncertainty to personalised care

Today

Maria, 54, needs a hip replacement. She faces long waits, multiple pre-op appointments and unclear timelines. On the day of surgery, delays mean her procedure is cancelled and rescheduled weeks later. Recovery feels fragmented, with limited follow-up support.

In five years time

Maria's journey starts with a single digital care plan. She has access to an App she can use to support both prehabilitation and rehabilitation and is confident to use this. Pre-op checks are streamlined, and day-case surgery is scheduled with precision using AI-driven scheduling. Her recovery includes physiotherapy at a neighbourhood hub and virtual check-ins with her surgical team. She feels

informed and supported throughout, with fewer hospital visits and a faster return to independence.

Impact:

- **for Maria:** predictable, personalised care and quicker recovery
- **for colleagues:** integrated planning and reduced cancellations
- **for the NHS:** efficient use of theatres, improved outcomes, lower costs.

Frailty – from crisis to prevention and continuity

Today

George, 83, falls at home and is admitted with a fractured hip. While in hospital, he becomes deconditioned and loses confidence. Discharge Leaving hospital is delayed because he needs extra care at home. When he returns home his muscles are weaker and he is at risk of another fall.

In five years time

George's frailty risk is flagged early through shared data. His risk of osteoporosis is identified and treated. When he falls, the hospital team and neighbourhood hub coordinate immediately. His hospital stay is short, and discharge includes a personalised recovery plan with home adaptations, strength classes and digital monitoring. Community teams check in regularly, preventing further crises.

Impact:

- **for George:** faster recovery, independence and confidence
- **for colleagues:** joined-up working across acute and community care
- **for the NHS:** reduced readmissions, lower long-term costs, better quality of life.

Children's specialist care – from fragmented support to family-centred excellence

Today

Tom, aged 7, lives in Totnes and has a complex neurological condition. His parents juggle multiple hospital appointments in Torbay and Plymouth, and sometimes Bristol for specialist care. These journeys mean time off work and school, and care feels fragmented - different specialists, separate clinics, and long waits for therapy. Communication between hospital teams, the GP and school is patchy, leaving Tom's family stressed and uncertain.

In five years time

Tom's care starts with a single, shared digital plan that brings together hospital specialists, his GP, school nurse and neighbourhood hub. Many consultations happen virtually, reducing travel and disruption. Diagnostics and routine checks are available closer to home through outreach clinics and mobile units.

The hospital acts as an anchor for advanced care and innovation, offering access to cutting-edge therapies and research trials. Rehabilitation and family support are

integrated into the plan, with mental health and peer networks available locally. Tom's parents feel informed and supported, and his school is part of the conversation - helping him thrive both medically and socially.

Impact:

- **for Tom and his family:** less travel, faster access to care and a joined-up approach that supports school and home life
- **for colleagues:** collaborative working across acute, community and education sectors
- **for the NHS:** improved outcomes, reduced delays and stronger partnerships for children's health.

What will we do in the first year of this strategy:

We will work with key teams where the pressure is greatest and ask ourselves key questions:

- is this the care our population needs?
- are we delivering care to the standard that we would wish to receive, recognising that standards are changing as new treatments emerge.
- can we deliver this sustainably? This may relate to people, finance or our estate.

If **all** the above are true, we will deliver these services, in particular, time-critical services for our population. However, this may mean that we need to consider a different way of delivering some services. This might include networking services with other providers across Devon.

We also want to build on areas of strength and ensure local care is provided where we can do so sustainably and to a high standard.

Our focus	Milestones
Year one (2026/27)	• We will review six specialties against clear service viability criteria, including quality, safety, workforce sustainability and value for patients. • We will continue to progress legacy projects already underway to stabilise and strengthen fragile services. • We will roll out service line reporting across all specialties, using best practice and GIRFT standards to support consistent improvement. • As part of this, we will review productivity indicators and implement a productivity programme across hospital specialties, focused on reducing variation and low-value activity. • We will expand elective capacity, including additional anaesthetists and orthopaedic surgeons, to meet growing demand where this is safe and sustainable. • We will implement a new model of clinical leadership across acute and specialist services,

	strengthening accountability and improvement at specialty level.
Years two and three (2027/28-2028/29)	• We will support the Integrated Care Board's reviews of birthing services, paediatric care, and the urgent and emergency care front door. • We will reduce reliance on independent sector provision by bringing activity back into NHS services where this delivers better value and patient experience. • We will continue to expand our planned care offer at the Torbay Hospital site. • We will expand our use of telemedicine to improve access, continuity and specialist support. • We will embed GIRFT standards and strengthen research partnerships to support evidence-based improvement.
Years four and five (2029/30-2030-31)	• We will develop fully integrated acute and community pathways to support safer transitions and better outcomes. • We will introduce AI-enabled diagnostics where they are safe, effective and supported by robust clinical governance. • We will deliver excellent outcomes for the services our acute hospital provides, aiming for upper-quartile performance where appropriate and measurable.

Signature move three: joined-up care, every step of the way

Supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout.

Why this matters

Imagine a person's care as a thread. When that thread frays - at **leaving hospital**, referral or handover - the whole fabric of care begins to unravel. People feel lost, anxious and uncertain. Clinicians feel pressured, with little time for conversations that matter. We know these moments of fragmentation create risk, delay and frustration.

Our ambition is simple: to make every transition seamless so people feel safe and supported and teams share accountability for a person's whole care

Joined-up care is not about doing everything everywhere. It is about focusing on what matters most: relationships, clarity and continuity. It is about reducing "failure demand" by getting things right first time. And it is about creating a place that feels coherent, compassionate and trustworthy - for people and for those who care for them.

Crucially, this move will be shaped by the voices of people and communities with lived experience. Their insights will guide what continuity really means in practice - what feels supportive, what feels confusing and where the gaps are. We will co-design solutions with those who use services, so that joined-up care reflects real lives, not just organisational intent.

Where we are now

We have strong foundations:

- our discharge improvement and flow programme has reduced long stays and improved experience
- evidence-based pathways are in place
- virtual Wards and Hospital@Home are bridging acute and community care
- Shared Care Records are extending across Devon and the south west Peninsula, enabling shared data
- integrated health and social care teams with experience in multi-agency working
- collaborations with GPs and mental health partners to improve integration.

But gaps remain - people still experience disconnection, especially at boundaries of acute, community and mental health care. Clinicians tell us there is rarely time for conversations that build trust. This is our opportunity to turn every transition into a moment of continuity and learning.

What success looks like

Success means clarity and focus:

- advice and guidance prioritised for urgent and elective care
- new multidisciplinary teams for the highest-risk populations
- a stocktake of all pathways to understand performance and productivity
- a financial framework that enables activity to move across partners

- greater adoption of digital tools - from shared records to the MY CARE app - so people can be partners in their own health
- clear roles: what we provide and what we enable others to do.

And above all, success means our people and communities recognise their voice in the design. We will measure not only operational improvements but also the experience of people (those receiving and giving care).

What this means for people

For people, joined-up care means a single, coordinated plan that everyone involved understands and follows. It means that moving from home to hospital and back again feels smooth and supported, with follow-up calls and virtual check-ins that provide reassurance. Instead of juggling multiple appointments for physical, mental and social needs, people experience care that is connected and coherent.

For those living with frailty, dementia or complex conditions, this continuity of relationships and information can be life-changing. It brings clarity about who to contact, what happens next and what support is available. Most importantly, it creates a sense of dignity, partnership and trust - so people feel cared for, not passed around.

We will work with communities and people with lived experience to shape these improvements, ensuring that what matters most to them drives our priorities.

What this means for our teams

For us, joined-up care means sharing accountability for the whole patient journey, not just the part we touch. It means having access to the same digital information and care plans across settings, so decisions are informed and consistent. It means clarity on roles, escalation routes and shared priorities, reducing duplication and confusion.

It also means stronger relationships between acute, community, primary care and voluntary partners - relationships built on trust and collaboration rather than transactional referrals. And it means embracing a learning culture, where every stage of care becomes an opportunity to improve, adapt and innovate together.

All our leaders will champion this culture, supported by research and improvement. Feedback from people and families will inform how we work, so improvement is grounded in reality, not assumptions.

By supporting our teams' health, prevention and wellbeing, we help them do their best work - delivering safer, more compassionate and more sustainable care for our population.

How we will make it happen

We will deliver five interlocking shifts:

- **from referral to relationship:** we will replace transactional hand-offs with shared planning and responsibility across pathways, bringing our specialists together with our primary care community to agree new pathways

- **from fragmented information to shared understanding:** we will have real-time, interoperable data connecting hospital, neighbourhood, primary and social care
- **from discharge to continuity:** we will embed coordinated discharge planning from admission, including home-first principles
- **from inequality to inclusion:** we will design pathways that anticipate needs and ensure equitable access and follow-up
- **from episodic improvement to system learning:** we will use every stage of care as an insight opportunity to identify friction and unmet need.

Digital and data capabilities—shared records, care navigation apps, predictive analytics and AI-supported decision tools—will underpin these shifts.

This will be supported by investing in our people - equipping our teams with the skills, confidence and support to look after their own health and wellbeing and to support one another, so they can deliver these changes safely and sustainably.

Where prevention meets treatment

Neighbourhood teams provide continuity before and after hospital care while acute and specialist services deliver excellence at the point of highest need. Joined-up care is the connective tissue that binds these together.

By integrating digital, clinical and relational pathways across settings, we create one continuum—where prevention, treatment and recovery are not separate events but part of the same seamless story. This alignment makes every patient’s experience safer, smoother and more humane. And it makes every interaction more intelligent, reducing friction and enabling care that feels coherent and compassionate.

Our focus	Milestones
Year one (2026/27)	• We will review all pathways against best-practice evidence and make changes where care is not meeting that standard. • We will identify and develop proposals for care that can safely and appropriately be delivered closer to home. • Where possible, patients will have the right assessments and diagnostics completed before referral to the acute hospital. • We will build prevention into pathways wherever possible, learning from successful models such as Joint School. • We will expand advice and guidance pathways to support earlier decision-making and reduce unnecessary referrals. • We will continue to expand our virtual ward capacity, supporting safe care at home and avoiding unnecessary hospital admission.

	• We will roll out MYCARE to support better communication, coordination and patient experience.
Years two and three (2027/28-2028/29)	• We will embed shared care records across all settings, enabling primary and secondary care teams to plan and manage care together. • We will strengthen integrated in-reach discharge planning, supporting earlier coordination and safer transitions of care. • We will co-design pathways with people who have lived experience, ensuring services reflect real needs and experiences.
Years four and five (2029/30-2030-31)	• We will use predictive analysis to support proactive planning, enabling more personalised care and tailored remote monitoring where it adds value. • We will support more joined-up workforce models, enabling rotational roles and varied career portfolios across health and care. • We will introduce interoperable care navigation tools that support personalised care plans and clearer coordination for patients and professionals.

Signature move four: smart use of technology for better care

Using digital tools and fresh thinking to make care more personal, easier to access and better connected

Why this matters

Technology and innovation should make life easier for people and teams. Used well, it frees time for human connection and gives people more control. Used poorly, it creates barriers.

Our aim is simple: combine smart tools with fresh thinking so care feels seamless, personal and safe. Every solution will be shaped by lived experience – feedback from people using our services and those delivering care. We will work with partners across the south west Peninsula to share learning and innovation, so that technology becomes a trusted part of care – not a distraction from it.

Where we are now

We've made real progress in building the foundations for smarter, more connected care – but the experience is still uneven.

We've laid strong foundations:

- our electronic patient record (EPR) programme will bring systems together
- Shared Care Records enabling safer coordination
- AI-enabled imaging pilots for early cancer detection
- remote monitoring and telehealth supporting people at home
- partnerships with universities and Health Innovation Networks for co-design and evaluation
- our Digital Futures Hub is nationally recognised as an NHS England blueprint site for XR innovation.

But digital maturity is uneven. Many colleagues still juggle multiple logins and slow systems. Real-time data isn't always available when decisions need to be made. We need to turn strong foundations into a seamless, human-centred digital experience.

What success looks like

Success means more than systems going live – it's about creating a health and care experience that feels seamless, personal and efficient. Technology and innovation will become part of everyday practice, not an add-on. People will feel the benefits in their daily lives and teams will have the tools and insight to work smarter, not harder.

We will know we've succeeded when:

- our EPR is live and delivering measurable benefits – improving flow, reducing duplication and enhancing patient experience, while maintaining performance during rollout
- AI moves from pilots to practice – supporting early diagnosis (for example phlebotomists uploading skin images for remote analytics) and predictive planning for prevention
- wearables and remote monitoring are mainstream – helping people stay safe and independent at home, for example alarm-sensors on mattresses which could alert agencies to potential falls
- legacy systems are retired and digital-first culture embedded – paper disappears and colleagues feel confident using intuitive, integrated tools

- business intelligence and data-driven decision-making are the norm – insight flows to every team, supporting continuous improvement
- our digital offer connects nationally – integrated with the NHS App and aligned with national standards.

What this means for people

For patients and families, care will feel more joined-up and personal. People's information will follow them wherever they go, so they won't have to repeat their story. People will be able to see their records, care plans and test results online, book appointments digitally and use virtual consultations when it suits them. Remote monitoring and smart devices will help people stay well at home and AI will support earlier diagnosis and tailored treatment.

Digital inclusion will be a priority – whether people are confident with technology or need extra support, they'll have the tools and help to benefit from these changes. We will work with partners such as the Good Things Foundation to reduce digital poverty in our most deprived communities so that no one is left behind. Care will feel easier to access, more responsive and more connected to people's lives.

What this means for our teams

For our teams, this will mean that technology works for them, not against them. No more juggling multiple logins or waiting for slow systems – instead, one login and integrated platforms will free up time for care. Real-time dashboards will give colleagues the information they need to manage flow, safety and workload. Our teams will be digitally skilled and enabled through training and development, supported by digital volunteers and champions.

Digital tools will reduce duplication and error, making decision-making faster and more confident. Innovation will become part of everyday practice, with teams able to test, evaluate and shape new ideas quickly. We will be able to better support research and education through simulation, immersive technologies and data-driven learning. Clinical leaders will play a key role in adoption, ensuring digital tools enhance care rather than distract from it.

We will also use digital tools to make how we work simpler and more effective in our corporate services, such as our financial and people services - freeing up time and resources to focus on frontline care.

And with better data and insight, improvement will feel easier and more rewarding. Ultimately, technology will help colleagues spend more time with patients and less time wrestling with systems.

How we will make this happen

We will:

- complete the digital foundations – deliver the EPR and ensure systems are interoperable across acute, community and social care
- make technology work for people – simplify access with single sign-on, intuitive tools and real-time information for colleagues, support people to see their records, appointments and results online

- build on our Digital Futures Hub, a recognised innovation space where clinical teams, technologists and people with lived experience work together using our three-way interface model
- turn data into insight – build a strong Business Intelligence function and an analytics engine that gives every team actionable intelligence for safety, flow and planning
- harness AI and predictive tools – expand beyond pilots, define risk appetite and partner with innovators to push boundaries
- champion digital inclusion and work with partners to address digital poverty – provide support and increase confidence and access so everyone can benefit, regardless of age, location or digital skills
- retire legacy systems and unlock existing capabilities – streamline the digital estate and make full use of tools we already have.

Benefits for today and tomorrow

This will:

- release time for care by reducing duplication, delays and administrative burden
- improve flow and efficiency through real-time insight and predictive planning
- prevent problems earlier with data-driven and AI-enabled approaches, reducing high-cost reactive care
- make resources go further by automating routine tasks and optimising workforce deployment
- spread benefit and reduce risk through shared investment and innovation partnerships across the south west Peninsula.

Technology and innovation will amplify human connection – not replace it.

How it all links together

Technology and innovation run through everything we do – the strong, continuous threads that hold everything together and give it resilience. They run through every signature move, enabling joined-up care, smarter use of resources and better experiences for people and teams.

By making digital and innovation part of everything we do, we create the conditions for better access, better experience and better outcomes – for people, for teams and for the NHS.

Our focus	Milestones
Year one (2026/27)	• We will implement our new acute and community electronic patient record in April 2026, supporting safer, more joined-up care across settings. • We will build digital skills and peer support across all roles, so colleagues feel confident using new tools in their everyday work. • We will strengthen partnerships with universities and Health Innovation Networks to deliver joint projects that improve care and learning. • We will review the evidence for AI-supported triage tools and introduce them where appropriate, such

	as in dermatology, to support timely and effective care. We will support community teams with up-to-date technology for care at home, including remote monitoring where it adds value.
Years two and three (2027/28-2028/29)	• We will strengthen integrated health, social care and community platforms to support more joined-up care around people. • We will use insight and predictive tools to better anticipate demand, plan our workforce and target prevention where it can make the greatest difference. • We will jointly design and evaluate digital pilots with our partners, learning quickly what works and what adds value. • We will continue to expand remote monitoring, virtual wards and AI-supported triage where they support safe, effective care. We will develop a learning academy that brings together clinical skills, simulation and digital capability to support learning, confidence and professional development across roles.
Years four and five (2029/30-2030-31)	• We will work towards a fully interoperable digital health environment across Devon, supporting joined-up care wherever people are seen. • We will strengthen a learning health system, using insight and AI-supported tools to help clinicians make informed decisions in day-to-day practice. • We will build a connected innovation network, linking health providers, universities and industry across Devon and Cornwall to learn, test and improve together. • We will develop personalised digital support and AI-enabled care navigation tools to help patients better understand and manage their care.

Signature move five: caring, skilled people ready for tomorrow

Creating a great place to work, supporting people to be their best selves, and building an agile, inclusive workforce for the future

Why this matters

The future of health and care depends on people – their compassion, creativity and ability to adapt. Technology and infrastructure matter, but transformation is powered by relationships, behaviours and culture.

We face a generational shift: new ways of working, new roles and new expectations from colleagues and communities. To thrive, we must become an organisation that talented people want to join and where they can stay, grow and thrive. That means creating a great place to work, supporting people to do their best work and embedding a culture of learning, inclusion and accountability.

As the largest employer in Torbay and South Devon, we have a unique responsibility and opportunity. We are not just a health and care provider – we are an anchor institution, shaping the wellbeing, economy and future of our communities. How we recruit, develop and support our people has a ripple effect far beyond our walls: it influences local prosperity, education and social inclusion.

This is not just about recruitment – it's about careers, retention, development and agency: giving people the confidence, flexibility and support to lead change, learn continuously and make decisions that improve care.

By creating a great place to work and investing in home-grown talent, we strengthen our teams, our services and our communities. When we help people to be their best selves, we don't just improve patient care – we create opportunities, reduce inequalities and build resilience in our communities.

We will embed research, education and lived experience at the heart of our approach. Our Learning Academy will offer research opportunities, multidisciplinary education and leadership development for all our colleagues. Lived experience – of colleagues, patients and communities – will shape our programmes and priorities, ensuring that every voice is heard and valued.

Where we are now

We have strong foundations:

- a history of organisational commitment to research, education and innovation.
- a multi-professional approach to developing our people
- quality improvement (QI) programmes have helped teams deliver measurable improvements
- initiatives like Care Under Pressure to promote psychological safety and wellbeing.
- excellent clinical and medical education and training and improved development opportunities for all
- strong partnerships with the local Universities, Colleges and Health Innovation Networks

But these strengths are not yet systemic. Learning is still not accessible to all, talent management is underdeveloped and leadership capacity and capability needs review. We lack a robust Business Intelligence approach to workforce planning and we need a clearer picture of the shape of services before defining future roles and career pathways.

Our people and teams are committed and skilled, but we face challenges:

- recruitment and retention pressures
- gaps in transformation, digital, research, people and education capacity and capability
- limited agility to respond to changing needs
- cultural inconsistencies in behaviours and accountability.

Our ambition is clear: to create future-ready teams who feel valued, included and empowered to lead change great care.

What success looks like

Success means more than filling vacancies – it's about building thriving, adaptive teams and a supportive, compassionate, learning culture.

We will know we've succeeded when:

- health and wellbeing and a just and learning culture are embedded - psychological safety, reflection and ownership for action become the norm
- inclusion and engagement are real - colleagues feel they belong, can speak up and see their lived experience reflected in decisions
- leadership and management are strong - clear behaviour standards and accountability, coaching and distributed leadership are present at every level
- our teams and roles are future-ready - integrating research, education and digital skills
- research and innovation are part of everyday work, with colleagues supported to participate and lead
- lived experience is visible and valued, sharpening our learning, improvement and service design
- we are recognised as a great place to work and an anchor institution – attracting and retaining the best people while driving local employment, skills and career development
- talent management is proactive – identifying gaps, new and emerging roles and sponsoring career development
- agility and flexibility are built in – new roles, shared services and adaptive teams ready for change.

Alex – a newly qualified nurse, Coastal Community Nursing Team

Today

Alex has access to a named buddy and preceptorship support, but service pressures make it hard to protect learning time. Digital systems feel clunky and research opportunities seem distant. Wellbeing resources exist, but they're not always visible. Alex wants clearer career pathways and more say in shaping care.

In five years' time

Alex's development is guided by the Learning Academy, with easy access to research, digital skills, and peer support. Alex co-leads a project to improve patient

safety, and wellbeing resources are part of daily life. Career progression is clear, and Alex feels valued and heard.

Impact:

- For Alex: more confidence, better support, and a sense of belonging
- For colleagues: shared learning and innovation
- For our organisation: higher retention, improved care

What this means for our people and teams

Colleagues will feel safe, valued and supported to do their best work. They'll have opportunities to learn, grow and lead— whether through the Learning Academy, leadership and coaching programmes and research involvement. Inclusion will be visible and meaningful and leadership will feel accessible and empowering. Our colleagues will feel safe to speak up, confident to act and supported to do their best work through continuous engagement.

Everyone will feel they can contribute fully and have the flexibility to shape their careers, take on new roles and adapt as health and care evolves.

Colleagues will see their lived experience and insights reflected in our programmes and priorities and will have opportunities to co-design education, research and improvement initiatives.

Teams will become hubs of learning and innovation. Improvement won't be a project – it will be part of daily work. Collaboration across disciplines will be routine, supported by shared learning, research involvement and digital tools.

Managers will lead with clarity and compassion, setting behaviour standards and creating psychological safety. Teams will have the data and insight to make decisions and the confidence to act on them. Ultimately, teams will feel empowered, connected and proud of the difference they make.

Priya – Admin Team Leader, Cancer Services

Today

Priya manages an admin team. Leadership training is generic and not tailored to her role. Recognition is rare, and development feels focused on clinical staff. Priya wants more practical support and a voice in Trust decisions.

In five years' time

Priya has completed a bespoke leadership programme and mentors new team leaders. She's part of a cross-team improvement group, and her lived experience shapes flexible working policies. Achievements are celebrated, and Priya feels empowered as a leader.

Impact:

- For Priya: tailored development and recognition
- For colleagues: stronger teamwork and inclusion
- For our organisation: more effective, motivated teams

What this means for our patients and communities

For patients and communities, success means care delivered by confident, compassionate teams who listen and learn. They'll experience services that feel

joined-up and responsive, because colleagues have the skills and flexibility to adapt to their needs.

They'll see improvements shaped by community voices and benefit from innovations that make care safer, more accessible and more personalised. Teams who feel valued and supported means better experiences, fewer delays and higher-quality outcomes for people and their families.

Sam – Healthcare Assistant, Intermediate Care Team, Moor to Sea

Today

Sam enjoys working as an HCA but feels overlooked for training and development. Decisions seem distant, and feedback isn't always acted on. Sam wants more opportunities to learn and contribute.

In five years' time

Sam has completed an apprenticeship and co-leads a research project on dementia care. Sam's feedback shapes service improvements and peer support is routine. The culture is open and inclusive and Sam is proud to help lead change. Sam is a staff network lead and co-chairs a staff forum that influences organisational policy.

Impact:

- For Sam: new skills, influence, and pride
- For colleagues: continuous learning and support
- For our organisation: better care, stronger staff engagement

How we will make it happen

We will:

- **prioritise health and wellbeing and a just and learning culture** – with wellbeing offers, psychological safety and improvement embedded in daily work
- **champion and strengthen inclusion and engagement** – co-designing education and development programmes with colleagues, patients, partners and communities; celebrating lived experience
- **strengthen leadership and management** – clear standards, training and development, coaching and mentoring, distributed leadership and accountability
- build a Learning Academy integrating education, research, simulation and digital capability
- embed talent management and succession planning—developing local talent through apprenticeships and partnerships
- foster agility and flexibility—new roles, shared services and adaptive workforce models
- strengthen partnerships with universities, colleges and community groups to expand research and education opportunities for all colleagues.

The difference this will make

Investing in people and culture will transform care for patients and communities:

- improved safety and quality – confident, well-supported teams reduce errors, improve reliability and respond faster to risks

- improved patient experience – compassionate, engaged colleagues create more positive interactions and continuity of care
- faster access and fewer delays – agile teams and new roles help manage flow and reduce waiting times
- more personalised care – colleagues and teams skilled in digital, research and innovation can tailor interventions to individual needs
- stronger relationships and trust – inclusive, learning cultures ensure patients feel heard and involved in shaping services.

And on a practical level for us this means:

- a more attractive place to work, people actively wanting to join us
- higher retention and lower turnover costs, reducing reliance on temporary staff.
- greater adaptability to meet changing needs and integrate new models of care
- leadership capacity and capability at every level, driving improvement and innovation.

This is how we create teams that are ready for tomorrow – and a culture where everyone can do their best work for the people and communities we serve.

Our focus	Milestones
Year one (2026/27)	• We will introduce a strengthened health and wellbeing offer, supporting our people to stay well and helping reduce sickness absence while improving retention and performance. • We will co-design and launch a Learning Academy to attract and help people grow into future roles, including preventative, community-based and digital roles. • We will introduce a renewed leadership and management programme, equipping leaders with the skills to create positive working environments and support safe, effective care. • We will co-design and agree our advancing practice strategy, supporting new and evolving roles across health and care. • We will implement a clear culture charter and accountability framework, setting consistent expectations for leaders and managers. • We will create safe spaces where people feel confident to speak up, share experiences and learn together. • We will strengthen our people and culture insight, helping us identify priorities early and provide proactive support for teams.
Years two and three (2027/28-2028/29)	• We will establish an integrated approach to professional development through our Learning

	Academy, bringing together simulation, quality improvement and research capability. • We will develop joint learning and evaluation frameworks with system partners, supporting shared improvement and learning across organisations. • We will expand research opportunities and support for people at all levels, aligned with our ambition to attract, develop and retain talent. • We will embed lived experience as a core part of all development pathways, strengthening person-centred and people-centred care.
Years four and five (2029/30-2030-31)	• We will develop a new and expanded Learning Academy, creating the space and capability to support learning, development and innovation. • We will embed research, education and innovation into everyday work, supporting our people to learn, adapt and lead change. • We will ensure lived experience shapes all programmes and improvement work, with regular recognition and celebration of its impact.

Chapter six: making change possible – the enablers of our vision

Why this matters

Our vision is ambitious: to help every person, family and community that we serve live well, now and for generations to come. Our signature moves describe what we will change. Our enablers set the environment and conditions that make those changes possible and sustainable.

They are the essential foundations that make transformation possible - ensuring every improvement is sustainable, every innovation is ethical and every person can benefit from the generational shift we are leading.

They equip our people and teams at all levels with the tools, support and culture needed to deliver change confidently and collaboratively.

Digital and data	Giving our teams the tools and information they need, when they need it, by connecting insight, decisions and action through reliable, secure, and integrated systems
Innovation and evaluation	Creating safe spaces for people to test new ideas, learn from what works, and share improvements, so we can keep getting better together
Talent and growth	Supporting all our people to learn, grow and lead change, with clear pathways for development and a culture that values every colleague
Inclusive and responsible decision making	Building a culture where every decision is guided by our ethical framework, where we listen to people, act equitably and support colleagues and each other to make the right choices, even when they're difficult
Partnerships and communities	Bringing together the NHS, councils, universities, voluntary and community partners to work as one, sharing responsibility and shaping better outcomes for everyone
Estates and sustainability	Providing sustainable, flexible and digitally connected places that help people to deliver and receive great care, wherever it's needed
Value for money	Making every pound count by using our resources wisely, investing where it matters most, and ensuring we remain sustainable for the future

Enabler one – digital and data

Giving our teams the tools and information they need, when they need it, by connecting insight, decisions and action through reliable, secure, and integrated systems

We will provide reliable, secure and integrated systems that connect information and decisions across all our services, enabling personalised and proactive care.

A connected infrastructure will make new ways of working possible, such as virtual wards, population health dashboards, shared care records and intelligent automation, while keeping data governance, privacy and security fundamental to how we work.

Clinical leadership will guide how digital tools are designed and adopted, ensuring they improve patient safety, reduce variation and support evidence-based care. Clinicians will champion digital inclusion and lead conversations about ethical use of AI and automation.

Using digital tools to simplify how we work will help release time, energy and resources, for example in corporate services such as financial and people services - so more can be focused on supporting frontline teams and patient care.

What this involves

- unified architecture: a single digital framework across health and care, interoperable with regional and national platforms
- real-time integration: bringing together clinical, operational and population datasets for faster, safer decisions
- simplified workflows: secure, user-friendly interfaces that reduce duplication and support multidisciplinary collaboration
- actionable intelligence: analytics and automation to support proactive care and free up clinical time
- trust and security: strong governance and ethical oversight to maintain public confidence
- networked systems across Devon to support shared functions

Our focus	Milestones
Year one (2026/27)	• We will streamline core systems through the implementation of EPR and MYCARE, supporting safer and more joined-up care. • We will implement a clear business intelligence and data approach to support better decision making at every level. • We will agree a shared target operating model for digital and intelligence across Devon, supporting consistent ways of working. • We will establish a clinical leadership group to guide digital transformation and ensure it supports patient care. • We will use data and insight to inform decisions and improvement, focusing on what makes the greatest difference to care. • We will implement shared financial services to reduce duplication and improve efficiency.

Years two and three (2027/28-2028/29)	• We will develop integrated platforms across our services to support smoother coordination of care. • We will continue to expand remote monitoring and virtual wards, supporting safe care at home where appropriate. • We will support clinician-led review of AI and automation to improve safety, quality and efficiency. • We will expand shared support platforms, including people services, working across Devon where this adds value.
Years four and five (2029/30-2030-31)	• We will work towards a fully interoperable digital environment across Devon, supporting joined-up care across settings. • We will embed digital inclusion as standard, ensuring people and communities are not left behind. • We will use predictive analytics to support population health, prevention and earlier intervention. • We will support clinical leaders to champion ethical governance and patient-centred design in digital and data use.

Enabler two – innovation and evaluation

Creating spaces for people to test new ideas, learn from what works, and share improvements, so we can keep getting better together

We will make innovation everyday practice – time-boxed testing, clear measures, permission to learn and courage to stop what doesn't work. Too many promising innovations stall between proof of concept and business-as-usual delivery. Our approach will bridge this gap by connecting discovery, development, evaluation and implementation as one continuous process.

Clinical and health and care leaders will co-design innovation priorities, lead evaluation of new care models and ensure that every improvement is clinically sound and delivers better outcomes for patients. Their involvement will build trust and accelerate adoption. We will use our established three-way interface model, bringing together patient experience, clinical expertise and digital innovation capability, to ensure solutions are grounded in real need.

What this involves

- innovation and evaluation hub: a single place for research, practice-led testing and deployment-ready evidence, where clinical teams work alongside researchers with academic and industry partners

- integrated improvement: so innovation, operations and evaluation move together with a clear pipeline from innovation through to IT implementation and business as usual
- one front door for ideas: with design, analytics and evaluation support
- rapid-bid innovation fund: to unlock frontline ideas with light-touch governance
- implementation infrastructure: a dedicated digital transformation capability to bridge the gap between successful pilots and sustained adoption at scale.

Principles for success

- **fleet of foot:** start small, scale fast - time-boxed testing cycles and evaluation cycles with clear stop/go criteria
- **bravery and incentives:** permission to fail, recognition for learning and rewards for bold ideas
- **spend to save:** prioritise innovations that deliver efficiency and cost avoidance
- **replace, don't layer:** innovation should simplify, not add complexity.
- **baseline and evaluation upfront:** every project defines starting point and success measures before launch
- **learning repository:** capture and share lessons from every initiative to avoid repeating mistakes.
- **propulsive evaluation:** evaluation that generates deployment-ready evidence packages, not just assessment

Our focus	Milestones
Year one (2026/27)	• We will establish an innovation and evaluation hub to support testing, learning and improvement. • We will re-establish a transformation function to support delivery of our strategy and help turn ambition into action. • We will publish a clear set of shared measures and appoint clinical theme leads to guide improvement and innovation. • We will establish a clear innovation-to-implementation pipeline, with agreed handover points between innovation, transformation and business-as-usual services.
Years two and three (2027/28-2028/29)	• We will rapidly test and evaluate new models of care, learning quickly what works and what adds value. • We will develop an integrated learning repository that is accessible across our organisation, supporting shared learning and improvement. • We will introduce clinically led stop-go gateway reviews at each stage of the innovation pipeline, ensuring safety, value and focus. • We will strengthen routine feedback loops, connecting frontline experience to innovation priorities and improvement work.

Years four and five (2029/30-2030-31)	• We will identify priority innovations for NHS Innovation Passport accreditation, focusing on those with the greatest potential benefit for patients and services. • We will co-design innovations with communities, embedding lived experience throughout to ensure care reflects real needs and experiences. • We will ensure evaluation routinely considers value, equity and environmental impact, alongside quality and safety. • We will support clinical leaders to mentor and develop frontline improvers across the system. • We will develop sustainable income from innovation, including testbed services, intellectual property and commissioned evaluation, to reinvest in improvement.

Enabler three – talent and growth

Supporting all our people to learn, grow and lead change, with clear pathways for development and a culture that values every colleague

We will provide shared development pathways, coaching and wellbeing support so people can grow with confidence and lead change together.

Clinical leadership development will be a core strand of our learning academy and we will accelerate this, with programmes that equip clinicians to lead transformation, steward resource and influence system-wide decisions. We will create visible clinical leadership roles in every major change programme.

What this involves

- **a learning and development academy:** bringing education, leadership, improvement and digital together
- **shared learning pathways:** across health, care and voluntary sectors to enable mobility and shared competence
- **leadership at all levels:** focused on compassion, stewardship and collaboration
- **wellbeing first:** with proactive mental health and peer support
- **research opportunities for all colleagues:** with support to participate in and lead research projects
- **co-designed programmes** that draw on lived experience, ensuring our development pathways reflect the realities and aspirations of our people
- **regular feedback loops** and recognition schemes to celebrate lived experience and improvement.

Our focus	Milestones
Year one (2026/27)	• We will review and implement a revised management structure that supports clear leadership, accountability and delivery. • We will deliver and embed our culture charter and action plan, including a co-designed approach to health and wellbeing. • We will maintain a rolling programme of engagement and communication, keeping our values and behaviours at the heart of everyday work. • We will develop and deliver a refreshed leadership development programme, aligned to the national framework and the needs of our services. • We will increase apprenticeship pathways for new and existing colleagues, including digital and community-based roles. • We will complete a full policy review to embed a just and learning culture across how we work. • We will remodel people and education services so they are fit for the future and able to meet the needs of our organisation and teams. • We will maintain strong workforce controls and implement e-rostering tools, including dashboards and medical e-rostering, to support safe and effective staffing. • We will support the delivery of workforce transformation programmes across administrative, operational management and corporate roles. • We will sustain compliance with the Resident Doctor ten-year plan, supporting safe training and working environments.
Years two and three (2027/28-2028/29)	• We will broaden access to employment opportunities for under-represented and vulnerable groups, including care leavers and young people not in education, employment or training.
Years four and five (2029/30-2030-31)	• We will build agility and inclusion into how we work, so flexibility, fairness and opportunity are the norm. • We will strengthen clear clinical accountability and autonomy within teams, supporting confident decision making and improvement. • We will embed wellbeing and mental health support as part of everyday practice, not as an add-on.

	• We will support continuous learning through regular feedback, reflection and improvement. • We will embed wellbeing, inclusion and lived experience across all programmes, with regular recognition and celebration of the contribution people make.

Enabler four – inclusive and responsible decision-making

Equity-led, evidence-based decisions — even when views differ

We will build a culture where every decision is guided by a clear ethical framework, listening to people, acting fairly and supporting colleagues and each other to make the right choices, even when they are difficult. This means embedding principles that prioritise patient safety, outcomes, inclusion, support for the most vulnerable and financial sustainability while maintaining transparency and trust. We will be open about why decisions are being made, the evidence behind them, and their impact and we will always stay transparent and respectful, recognising that not everyone will agree with the direction of travel.

Our ethical decision-making framework will be aligned with our equality impact assessments and grounded in lived experience, so decisions reflect real-world impact and reduce avoidable inequality. We will strengthen how research, improvement and education inform decisions, ensuring choices are evidence-based – with quality and equity considered as standard, not as an afterthought. . Clinical leadership will be central – leading structured conversations about risks and ethics, modelling openness and supporting consistent decision-making in everyday practice.

What this involves

- **ethical decision-making framework:** clear principles and criteria for what makes a decision ethical, considering societal and organisational impact, equality and sustainability
- **risk and ethics dialogue:** embedded in operational and leadership forums
- **clinical and quality integration:** safety, outcomes and equity guide choices alongside financial stewardship
- **community voices:** lived experience informs service design, research, simulation and evaluation
- **responsible AI and transparency:** bias checks and clear governance to maintain trust
- **education and improvement:** ethics and inclusion modules in leadership programmes and simulation-based learning for complex decisions.

Our focus	Milestones
Year one (2026/27)	• We will agree a clear ethical decision-making framework to guide choices at every level. • We will establish a network-based ethics oversight model, supporting shared ownership and learning rather than central control.

	• We will build trust through consistent delivery and clear follow-through on decisions. • We will review leadership programmes to ensure ethics, equity and inclusion are embedded throughout.
Years two and three (2027/28-2028/29)	• We will launch ethics simulation training for clinical leaders, supporting confident and reflective decision-making. • We will develop clear guidance on financial impact to support responsible, evidence-based decisions. • We will embed ethical frameworks and lived experience into service redesign, from the outset. • We will integrate responsible AI principles and bias checks into digital governance as standard. • We will embed equitable processes for recruitment and promotion, supporting opportunity and inclusion. • We will publish transparent decision logs, explaining why decisions are made and the evidence behind them. • We will hold structured conversations about risk, safety and quality as part of everyday leadership. • We will expand research partnerships to evaluate the impact of ethical decision-making. • We will introduce improvement collaboratives focused on equity and safety. • We will make ethical decision-making and equality impact assessment standard practice in all major decisions.
Years four and five (2029/30-2030-31)	• We will embed open dialogue and community voices in all significant changes. • We will use staff and patient feedback to evidence trust, inclusion and confidence in our decisions. • We will support clinical leaders to mentor new decision-makers and lead ethics simulations. • We will publish an annual ethics and inclusion report, sharing learning and progress openly. • We will deliver a continuous education programme to support emerging leaders.

Enabler five – partnerships and communities

Bringing together the NHS, councils, universities, voluntary and community partners to work as one, sharing responsibility and shaping better outcomes for everyone.

We will connect partners and communities to act with shared outcomes and risks, pooling intelligence and resources in our triple role as provider, convener and enabler.

Clinical leadership will strengthen partnership working through networks across organisations, ensuring collaboration is grounded in shared clinical priorities and evidence-based practice.

What this involves

- **shared ownership framework:** with south west Peninsula partners, councils, VCFSE sector, colleges and universities
- **as a system convener:** enabling VCFSEs to provide even greater support to the delivery of integrated solutions
- **collaborative planning forums:** at neighbourhood, place and system level.
- **joint investment and risk sharing:** with clear benefits and accountabilities
- **partnership capability:** through training, facilitation and shared learning
- **shared data and insight:** for population-level insight and learning.

Our focus	Milestones
Year one (2026/27)	• We will scope, review and evaluate all VCSE agreements — including those through the BCF, ICB and direct commissioning — to strengthen and simplify our partnerships with the voluntary sector. • We will agree future arrangements for the delivery of adult social care and continuing health care, working closely with partners to support continuity and quality. • We will take a leading role in acute provider collaborations, strengthening shared clinical leadership and delivery. • We will re-establish clinician-to-clinician forums for our top ten acute specialties, funding the time needed for GPs and consultants to work together on shared challenges. • We will convene and support joint GP and consultant forums, working with the Primary Care Collaborative Board to enable practical problem-solving across pathways. • We will take a leading role in the Health Innovation Network, supporting the faster adoption of evidence-based innovation. • We will strengthen partnership capability through development programmes for leaders and clinicians. • We will strengthen partnerships with schools and colleges, supporting skills development and future career pathways.

Years two and three (2027/28-2028/29)	• We will use population risk stratification to identify those most in need and put anticipatory care plans in place for the top ten per cent of our population, supported by multidisciplinary working across partners. • We will strengthen partnerships with children's services, creating pathways into employment for care leavers and young people not in education, employment or training. • We will establish priority partnership networks focused on mental health, prevention and health inequalities. • We will review and strengthen our partnership with the hospice, investing in high-quality end-of-life care. • We will deepen partnerships with universities, the voluntary sector and community organisations. • We will develop joint clinical outcomes dashboards with partners to support shared learning and improvement.
Years four and five (2029/30-2030-31)	• We will make shared services and joint investment the norm for functions that can be delivered together across Devon. • We will support clinician-led, cross-organisational improvement collaboratives, linked to our priority networks.

Enabler six – estates and sustainability

Providing fit-for-purpose and sustainable places for health and wellbeing that are flexible, adaptable and future-proofed

We will provide sustainable, flexible and digitally connected places that support people to deliver and receive great care — wherever it is needed and wherever it happens. Our estate will enable modern models of care, support flow and multi-disciplinary working and adapt as needs change over time.

Alongside maintaining and improving our existing estate, we will lay the foundations for the New Hospital Programme. While the main construction phase is expected to begin beyond the lifetime of this strategy (around 2033–34), the programme is critical to delivering the NHS 10-Year Health Plan for England and to our long-term vision for planned care, diagnostics and elective recovery. Decisions we make now - about estate, infrastructure, digital readiness and clinical models - will shape the success of that programme.

Clinical leaders will play a central role in shaping our estate. They will influence design so spaces support modern care models, patient flow and integrated working,

and they will help prioritise investment based on clinical need, safety and long-term value.

What this involves

- **integrated estates strategy and delivery model:** aligning with neighbourhood care models and acute site redevelopment supported by strengthened governance
- **make best use of current estate:** ensuring safe, efficient and integrated care
- **disinvestment and reinvestment:** rationalise or exit estate that cannot meet modern healthcare standards, reinvesting in facilities that deliver quality, value and sustainability
- **modern hubs and hospital redesign:** digitally enabled neighbourhood hubs (physical and virtual), improved diagnostics and elective pathways, supported by resilient infrastructure and additional car parking. This will also provide the platform for our future hospital redevelopment through the New Hospital Programme
- **co-location:** with partners to make best use of public estate and supporting joined-up care
- **sustainability:** incorporating energy efficiency, renewable energy, Electric Vehicle (EV) infrastructure, and circular economy principles into all projects
- **risk management:** embed proactive compliance audits and integrate estates risks into organisational governance.

How this evolves

Our focus	Milestones
Year one (2026/27)	• Recruit a sustainability lead and re-establish our sustainability group • Prioritise and address high-risk capital backlog through the estates safety fund • Implement a new Computer Aided Facilities Management (CAFM) system • Establish strong clinical leadership within EFM and capital functions • Strengthen estates governance with clear board visibility of risk • Equip the EFM function with technical resources proportionate to estate need • Update the estates master plan to reflect our strategic direction and future hospital programme • Develop a long-term strategy for staff accommodation • Implement a risk-based programme to reduce backlog maintenance and mitigate critical infrastructure risk
Years two and three (2027/28-2028/29)	• Review and refresh our Green Plan based on learning from year one • Exit community estate that is not fit for purpose

	• Establish a new health and wellbeing hub in Torquay and/or Paignton • Deliver a multi-storey car park and sustainable travel strategy at Torbay Hospital • Build a new four-ward block to replace the Tower Block • Expand partner co-location at priority sites • Deliver energy efficiency, renewables and EV infrastructure projects • Embed social value in procurement and design to benefit local communities • Strengthen clinical design reviews at every gateway • Build EFM and capital capability through targeted skills and role development
Years four and five (2029/30-2030-31)	• Deliver estate solutions that optimise our neighbourhood care vision • Secure funding and develop designs for a new planned care centre at Torbay Hospital, aligned with the New Hospital Programme • Demonstrate sustained reductions in high and significant backlog with resilient infrastructure planning • Ensure universal digital connectivity across hubs • Embed structured post-occupancy clinical evaluations to track flow, experience and safety and inform future capital design

Enabler seven – value for money

Making every pound count by focusing on what genuine improves outcomes, experience and independence for patients while remaining financially sustainable for the future

Value for money starts with delivering the right care, at the right time, in the right place. We will use our resources wisely by prioritising interventions that improve outcomes, reduce harm and support people to live well - including avoiding unnecessary tests, treatments and hospital stays that add little value for patients.

We will steward public money responsibly by strengthening financial literacy, linking investment decisions to clinical outcomes and experience, and focusing resources on care that delivers the greatest benefit. This means aligning financial decisions with evidence-based practice and values-based medicine, rather than activity for its own sake.

Clinical leaders will play a central role. They will be supported to understand the financial impact of clinical choices and involved in investment decisions, ensuring resources are directed to interventions that deliver meaningful patient benefit —

improving quality, safety and independence, while reducing unwarranted variation and low-value care.

This approach will support delivery of the Medium-Term Financial Plan, with a clear three-year trajectory to break even, improve the underlying position and recover £99m through efficiency, income capture and reinvestment. Financial sustainability will be achieved by improving how care is delivered — not by compromising quality or access.

There will be times when we need to stop or redesign services that do not deliver sufficient benefit for patients. We will seek clinical consensus wherever possible, but we recognise this will not always be achievable. In these cases, decisions will be guided by the best available clinical evidence, patient outcomes and experience, equity and long-term sustainability.

What this involves

- **clinical and financial literacy for all:** understanding of value, outcomes and cost embedded into leadership and professional development, supporting informed clinical and operational decision-making
- **value focused productivity:** a targeted programme of productivity reviews that focus on reducing waste, duplication and low-value activity - aiming for top quartile NHS performance in all of our clinical specialties and shared services while protecting quality and experience
- **service Line Reporting (SLR):** will become the norm, linking cost, productivity, outcomes and experience so teams can understand and improve the value of care they deliver
- **reducing low-value care:** actively reviewing where tests, procedures or pathways do not add sufficient benefit, redesigning care to reduce harm, inconvenience and unnecessary interventions
- **value dashboards:** integrating finance, quality, safety and experience data to make value visible and supporting evidence-based decisions
- **aligned investment and portfolio management:** aligning investment decisions to clear impact and benefit trajectories, prioritising prevention, community-based care and early intervention
- **income and reinvestment:** maximising income and investment opportunities through education, research and innovation, alongside accurate coding and best value procurement
- **clear governance for complex services:** strengthening governance for continuing healthcare, adult social care and uncommissioned services to ensure sustainability and appropriate use of resources
- **joint finance and design teams:** bringing clinical, financial and design expertise together to evaluate new models of care focusing on outcomes, experience and value
- **partnership finance forums:** co-creating reinvestment approaches that support shared outcomes and reduce duplication
- **south west Peninsula alignment:** supporting joint investment in shared services, estates and digital infrastructure where this improves value and quality of care.

How this evolves

Our focus	Milestones
Year one (2026/27)	• We will begin accreditation of our finance function as part of a wider programme to strengthen financial skills and capability. • We will implement shared finance and procurement services across Devon, supporting best value and reducing duplication. • We will ensure all care we deliver is fully understood, counted and accurately coded, so activity and value are visible. • We will deliver a Trust-wide productivity and efficiency programme, focusing on opportunities highlighted through benchmarking and evidence. • We will implement a clear and consistent accountability framework across all services. • We will pilot value dashboards in priority services, bringing together outcomes, experience and cost.
Years two and three (2027/28-2028/29)	• We will explore a range of funding options to support investment, including capital allocations, public loans, partnerships and asset disposals. • We will roll out financial skills training for all budget holders, supporting confident and informed decision-making. • We will implement clear financial strategies for education, research and development, diversifying income and strengthening resilience. • We will establish partnership finance forums with clear principles for reinvestment. • We will strengthen portfolio-based resource management, supporting clearer prioritisation and investment decisions. • We will expand service-level reporting to support productivity improvement and better outcomes.
Years four and five (2029/30-2030-31)	• We will fully implement value dashboards, shared services and advanced financial models to support predictive modelling of strategic investment. • We will embed outcome-based investment decisions, with clinical leaders co-chairing investment panels. • We will maintain a clear trajectory to break even while improving our underlying financial position.

Chapter seven: financially sustainable and affordable

Where we are now

We want to deliver great care for the people and communities we serve — now and for the long term. To do that, we need to live within our means and invest in what makes the greatest difference.

We operate in a challenging financial environment. Rising demand, workforce shortages, inflationary pressures and ageing infrastructure all add complexity. Our income is largely set through national allocations and commissioning agreements, while costs are shaped by pay awards, energy prices and the needs of our people and communities.

We start 2026/27 with an underlying deficit of almost £100m, around 15% of our annual operating spend. We have a statutory duty to breakeven. In the early years of this strategy we will need to make significant changes so that the care we provide is affordable and sustainable – while remaining safe, compassionate and effective.

Alongside this, we face major infrastructure challenges. We carry significant risk in parts of our estate and critical infrastructure and we will need to explore new ways of generating funds to invest in the buildings, equipment and digital technology required to transform services.

This is not about asking people to work harder. We know our teams are under pressure. It is about working differently – reducing waste and duplication, focusing on what adds real value for patients and making clear decisions about services and ways of working that we can no longer sustain.

Why this matters

Financial sustainability is what makes the rest of this strategy deliverable. Without a credible and affordable plan, even the best ideas cannot be delivered or sustained.

Our communities rely on us to use every pound of public money wisely - balancing immediate recovery with investment in prevention, neighbourhood care and innovation for the future. Every financial decision affects real lives, the services people can access, the experience of care and the support available to colleagues.

Alongside day-to-day financial pressures, we also need to plan responsibly for major long-term investment. The New Hospital Programme, with construction expected beyond the lifetime of this strategy, is a critical part of delivering the NHS 10-Year Health Plan for England. While delivery sits in the next decade, the financial discipline, productivity improvements and capital planning decisions we make now will determine whether that programme is affordable and deliverable.

By being open about our financial position and clear about our priorities, we build trust with our communities, partners and our colleagues.

Our approach

Our financial model is built on clear assumptions about funding, cost drivers, demand and investment needs. Decision-making will be guided by principles of

stewardship, transparency, value for money, equity and adaptability, and by strong alignment with our partners across Devon and the south west Peninsula.

Clinical input will be central. Clinicians will help shape priorities and investment decisions so that changes protect safety and outcomes and focus resources on interventions that deliver the greatest patient benefit. This includes using the best available evidence to reduce low-value activity and unwarranted variation.

Our Medium-Term Financial Plan sets out the scale of the challenge: recovering from current deficits, investing in transformation and delivering savings without compromising quality or safety. It requires discipline, clarity and transparency – staying realistic about what we can deliver while keeping sight of our long-term direction.

There will be times when we need to stop, redesign or change services that do not deliver sufficient benefit for patients, or that we cannot sustain. We will seek clinical consensus wherever possible, but we recognise this will not always be achievable. Where views differ, we will be clear about the evidence, the reasons for decisions and what they mean in practice.

Building sustainability

In the short term, our priority is to stabilise our finances through credible savings, improved productivity and restoring confidence in our ability to live within our means. This creates the headroom needed for investment.

As we build confidence and create headroom, we can invest in changes that deliver better outcomes and greater value - digital transformation, new models of care and workforce development. Our plan for better care sets a clear trajectory: from deficit to break-even, then reinvesting savings to drive improvement.

Strong governance and regular review will keep us on track and we will adapt our approach as the external environment changes.

Affordability and options

Delivering this strategy requires significant investment in digital, estates, people and new models of care. We will prioritise investments that have the greatest impact on people's lives and the sustainability of our local NHS. Affordability will be tested at every stage, with clear criteria and phased delivery where needed.

We will explore financing options - including capital allocations, system loans, partnerships and asset disposals - to maintain flexibility. We will use scenario planning to prepare for different futures and to make informed choices about where we invest, what we redesign and how we work differently with partners.

Measuring progress

We will track progress through:

- a clear timeline to achieve and maintain financial balance
- how investment shifts towards prevention and community-based care
- productivity benchmarks aligned with best practice

- progress in shifting resources into shared and neighbourhood based approaches.

Progress will be reported openly to our Board, partners and the public.

Shifting our approach

We are moving from a narrow focus on cost control to a broader stewardship role - maximising value across our health and care community and acting as an anchor institution for our communities.

Clinicians will be embedded in financial governance, ensuring decisions reflect frontline insight and patient impact. We will work with partners to develop shared investment approaches and support community-based ownership of resources where this improves outcomes and reduces inequity.

Financial sustainability is what turns ambition into reality. It gives us stability and confidence to invest where it matters most, change what no longer serves patients well and deliver our vision – helping every person, family and community to live well – now and for generations to come.

Chapter eight: turning vision into action

Our vision is about people – every person, family and community we serve and every colleague who makes care possible. This chapter sets out how we will move from words to action, creating a local NHS that feels different because it works differently: more connected, more compassionate and more focused on what matters to people.

From strategy to everyday change

This isn't about a rigid plan. It is a dynamic approach that learns, adapts and grows with the people it serves. We will balance two essentials:

- *making today better* – stabilising and strengthening the services people rely on now
- *building tomorrow together* – investing in new ways of working that reflect the generational shift towards personalised, digitally-enabled and community-rooted care.

Clinical and health and care leaders will play a central role in shaping priorities, guiding redesign and ensuring every change improves outcomes and experiences.

How we will work

Delivery will be organised so that everyone – from front-line teams to south west Peninsula partners – can see how their work connects to our vision. We will:

- join up planning, finance, people and improvement so decisions make sense for people, not just processes
- create space for reflection and learning, so we scale what works and stop what doesn't
- keep progress visible and honest, so trust grows.

Our delivery principles

These describe how we will organise and implement change in line with our core values and behaviours outlined in chapter three (our guiding principles):

- *coherence* – aligning programmes, signature moves and enablers so they deliver on our person-centred, equitable vision
- *participation* – involving colleagues, partners and communities, with clinical leadership at the centre of shaping priorities and defining success
- *transparency* – making progress and learning visible to build trust and shared ownership
- *adaptability* – refining as we learn so we stay responsive to people's needs and future opportunities.

Creating the conditions for success

To make change real, we need strong foundations. That means:

- tackling immediate pressures so care feels safe and reliable
- clarifying who owns what, so accountability is clear
- building integrated systems for planning, finance and performance
- setting up a dedicated Transformation Delivery Unit to coordinate and support change
- keeping communication open, so everyone feels involved and connected.

Governance that enables, not restricts

We will keep governance simple, clear and connected:

- a Delivery Oversight Group chaired by the Chief Executive reporting directly to the Trust Board.
- programme leads for each signature move and enabler.
- a Transformation Delivery Unit with expertise in change, analytics and engagement
- one strategic delivery plan that brings short-term improvements and long-term ambitions together
- regular learning cycles to adapt and improve
- strong links with ICB cluster governance and south west Peninsula priorities.

Learning and course correcting as we go

We will embed evaluation into everything we do:

- agree shared outcomes that matter to people – quality, experience, equity and value
- build data and insight capability for real-time learning
- use feedback loops to scale what works
- work with academic partners to strengthen evidence and share impact.

Financial stewardship

Transformation must be affordable and add value for people and communities:

- apply the financial and value framework to guide investment
- review services to identify improvement or redesign opportunities or to cease services we can no longer afford to deliver
- implement shared services and procurement with partners
- align estates, digital and workforce plans for maximum benefit.

Next six months

Our immediate focus:

- finalise the delivery framework and governance
- bring existing programmes into the new structure
- audit foundational enablers and prioritise capability building
- engage clinicians in shaping future models of care
- define evaluation and benefits-realisation
- prepare implementation and communication plans.

This is more than a technical exercise. It's a cultural shift – towards openness, collaboration and care that feels personal. By working together differently, with clinical leadership at the centre, we can create a future where every person, family and community we serve has the chance to live well.



Our Plan for Better Care

Summary of Year 1 and Transition into Year 2

April 2026

Torbay and South Devon NHS Foundation Trust



Summary of Year one 2025/26



Building Our Brighter Future: Where did we start?



Torbay and South Devon
NHS Foundation Trust

- Devon's integrated care system operates in a highly challenging environment, with one of the largest financial pressures in the country and spending that exceeds its allocation.
- Despite the Trust being in the National Operating Framework (NOF) Segment 4 for two years, improvement had been slower than required.
- The Trust had the largest deficit in Devon and a savings target of £41.5million in year.
- Rising urgent and emergency care demand continued to put pressure on frontline services, and despite some improvement in diagnostics and planned care, the Trust was not meeting national standards and had to rapidly reduce waiting times and ambulance handover delays.
- Staff morale was extremely low, and while leadership and service stability was improving, there was a pressing need to strengthen compassionate, safe workplaces and accelerate organisational transformation to deliver better care fit for the future.





What did we do?



- Worked collaboratively with colleagues from the NHS England Recovery Support Programme (RSP) to align our strategy, focus on national operational planning priorities and develop our 2025/26 Integrated Improvement Plan (IIP).
- Branded our IIP to '*Our Plan for Better Care*' to provide clear messaging to the organisation and involved staff in our improvement activities.
- Improvement programmes were aligned to appropriate executive portfolios, strengthening leadership ownership and accountability, providing assurance to national and regional colleagues.
- Resourced our workstreams in a targeted and proportionate way, taking account of priorities and key interdependencies.
- Utilised RSP support, including coaching on best practice and associated funding to effectively deliver clear value for money and embed sustainable processes ahead of planned exit from NOF4.
- Established a robust programme board known as '*Our Plan for Better Care Oversight Group*' to drive pace and oversee delivery of improvements which further assures the board of directors.
- Recruited to key positions including Head of PMO and strengthen our PMO capability. This team are now proactive in overseeing delivery through standardised programme management methodology, identifying risks, issues, and potential escalations, working early to mitigate concerns and maintain delivery confidence.
- Senior leaders were coached to strengthen accountability, improve the quality of reporting, and clearly distinguish between reassurance and assurance.



What did we achieve in year 1? - *Leadership Domain*

Through the leadership domain, the Trust has strengthened its governance arrangements through a redesigned committee structure, enhanced reporting, assurance and decision making. The Board Assurance Framework (BAF) was updated to ensure the Board has current, credible, and relevant assurance to deliver its strategic objectives and manage its principal risks effectively. This has been complemented by participation in an externally led Well-Led review, with recommendations aligned to relevant workstreams and actioned to improve assurance, alignment, and effectiveness. Key substantive executive appointments have been made with clearly aligned portfolios. A comprehensive Board and Executive development programme has commenced and continues, alongside ongoing implementation of the Leadership Behavioural Framework to support sustained cultural improvement.

Governance & Assurance

- A redesigned governance model is now implemented, including a streamlined committee structure, refreshed Terms of Reference, and improved reporting through standardised balanced scorecards.
- The updated Board Assurance Framework is strengthening ward-to-Board assurance.

Well-Led Review

- The independent Well-Led review is complete, accepted by the Board, and shared with NHSE.
- All recommendations have been aligned into the Our Plan for Better Care programme, enabling closure of the workstream with significant assurance.

Board & Executive Development

- Key substantive appointments made.
- Executive portfolios have been finalised.
- A structured Board development programme commenced and is ongoing.
- Strong executive communications have moved into BAU.
- Work to embed the Leadership Behavioural Framework continues, with full implementation planned for 2026/27.

What did we achieve in year 1? - *Strategy Domain*

The strategy domain has delivered good early impact, with the new 5-year Trust strategy drafted ready for Board approval and already providing clearer organisational direction. Key workstreams are driving measurable benefits: EPIC implementation is already improving data quality and clinical readiness ahead of the April go-live; Adult Social Care has strengthened service stability and financial insight of the service; CHC continues to support sustainable care through timely decisions and CIP over-delivery; and the Child and Family Health Devon transition has reduced operational risk through significant preparatory milestones. Together, these achievements are building a more coordinated, resilient and sustainable foundation for Year 2.

3-5 year Strategy

- The draft strategy is on track for Board approval in March 2026, providing a clear, evidence-based long-term plan and strengthening strategic alignment across the organisation.
- Year 1 deliverables and signature moves are being aligned into the 26/27 IIP ensuring a clear line of sight between strategic intent and operational delivery.

EPIC

- EPIC programme remains on track, with strong progress in configuration, data migration and readiness work, with majority of staff now registered for training ahead of the April 2026 go-live.
- While risks remain, mitigations are in place and the programme continues to position the Trust to deliver a modern, unified electronic patient record that will improve safety, streamline workflows and enhance staff and patient experience.

Adult Social Care

- Early Case Management System testing and data migration is complete.
- Operating Model redesign has restarted, and clearer financial insight through Service Line Reporting.
- These developments, alongside stable Front Door demand, continued Home First impact, and improvements in practice and Direct Payments are helping stabilise operations, manage demand and strengthen person-centred outcomes despite ongoing system pressures.

CHC

- Performance is strong with zero long waits.
- 85.2% of decisions made within 28 days.
- CIP delivery ahead of plan.
- Although the governance review has been delayed due to ICB reorganisation, workforce modelling and commissioning discussions continue to progress, maintaining operational stability and supporting ongoing improvement despite governance timing risks.

CFHD

- The single provider option is approved.
- IM&T transfer is complete.
- Consultation and TUPE process is complete
- These milestones strengthen progress toward a sustainable single provider model.

What did we achieve in year 1? - *Performance Domain*

The performance domain delivered clear operational improvements across elective care, flow, frailty and maternity safety, supported by strengthened governance and accountability that improved organisational stability. Elective predictability improved through enhanced theatre planning and automated validation; ambulance handover delays reduced and patient streaming strengthened within UEC; the frailty model successfully diverted a significant cohort away from ED, easing pressure on acute pathways; and maternity achieved CNST 10/10, materially strengthening safety assurance. Overall, these achievements build a firmer operational platform, improved flow and access, and position the organisation more strongly for year-end delivery and 26/27 planning.

Elective Care

- Approval of the Netcall Patient Hub has strengthened digital patient engagement and improved the efficiency of waiting-list validation to support RTT recovery.
- Theatre transformation advanced with approval of the Anaesthetics/T&O business case and implementation of a nine-week anaesthetic timetable, enabling improved forward planning and more effective utilisation of theatre capacity, reducing fallow theatres
- Peri-operative optimisation roles were approved, supporting reductions in on-the-day cancellations and fallow lists

Diagnostics

- Signed contract change notice with the CDC provider has stabilised NOUS delivery and enabled a 'slot based' system for MRI supporting consistent delivery of minimum income guarantee.
- Lead Sonographer role progressing through recruitment and cultural improvement actions underway following OD review
- CDC utilisation is strengthening through case-mix review and enhanced performance monitoring.
- Recruitment and model redesign in endoscopy are will reduce insourcing and stabilise diagnostic pathways.

Outpatient Transformation

- Critical outpatient backlogs in clinic letters, outcomes and CPS were stabilising ahead of Epic go-live through targeted resource deployment and outsourcing.
- GIRFT-aligned clinic protocols for T&O and ENT currently compliant,
- Clinic template standardisation across a number of specialties delivered over a thousand additional appointments within current resources.
- COO-level agreement secured on a single management structure.
- Continued coding improvement work with Finance and the Epic reimbursement group.

Cancer Services

- Draft Skin AI Tele dermatology business case completed
- Breast One-Stop model advanced with a 26/27 plan submitted to trial new ways of working.
- Oncology redesign progressing through aligned protocols and workflows for outpatients and day-case delivery across Devon
- Radiotherapy modernisation underway, with the new treatment-planning system on track for March and LINAC business case development progressing.

Elective Centre of Excellence

- GIRFT Theatre accreditation progressed with the January visit completed and results due in March.
- Theatre expansion advanced, with refurbishment of two theatres progressing well, a decant theatre due in April 2026, and NHSE capital secured for OMFS expansion.
- Ophthalmology transformation remains on track for Q3 2026/27, addressing significant quality issues, alongside continued strategic planning for SRU, daycase and community capacity

What did we achieve in year 1? - *Performance Domain*

The performance domain delivered clear operational improvements across elective care, flow, frailty and maternity safety, supported by strengthened governance and accountability that improved organisational stability. Elective predictability improved through enhanced theatre planning and automated validation; ambulance handover delays reduced and patient streaming strengthened within UEC; the frailty model successfully diverted a significant cohort away from ED, easing pressure on acute pathways; and maternity achieved CNST 10/10, materially strengthening safety assurance. Overall, these achievements build a firmer operational platform, improved flow and access, and position the organisation more strongly for year-end delivery and 26/27 planning.

UEC

- Medical workforce stabilised through approval of the workforce business case, enabling stronger rota resilience and better alignment to demand.
- Streaming improvements delivered across surgical, medical and paediatric pathways, reducing ENT breaches, protecting ultrasound access, enabling direct SWAST transfers to SRU, and strengthening criteria-led discharge and green pathways.
- Despite demand pressures and ED building works, ambulance handover times have shown improvement.

Frailty Redesign

- Stage 1 of the Frailty Virtual Ward is fully mobilised, with Stage 2 FSDEC mobilisation on track for launch in February 2026.
- The Harbour service is delivering strong impact, diverting 158 patients from ED in the first 9 weeks and keeping almost half at home.
- Key enablers are progressing well, including estates upgrades, SOP finalisation, call-before-convey expansion and the community x-ray car, though Band 5 recruitment remains a risk.

Maternity & Neonatal Safety Improvement

- The Programme (MNIP) has transitioned from MSSP into a six-month NHSE targeted support framework (MatNeoIST) and comprises focused support on Obstetric Leadership & Capacity, Midwifery Culture & Leadership, Governance & Board Effectiveness, and Culture and Leadership.
- Achieved CNST 10/10 compliance, established Perinatal Improvement Boards, developed Maternity and Neonatal Improvement Plan, and Perinatal Compliance Lead commenced in post.
- Workforce challenges remain, including leadership gaps and EPIC-related capacity pressures.
- The improved triage model is delayed due to ventilation works, now expected to complete in March.

Managing our Estate

- The Estates workstream has matured, with major deliverables now transitioned into BAU
- Divisional assessment completed, enabling informed structural decisions for EFM and Capital.
- The six-facet survey is nearing completion, and the sustainability plan has been approved for onward submission to the ICB.
- Replacement of the CAFM system remains dependent on 26/27 funding

What did we achieve in year 1? - *Finance Domain*

Across the five Finance workstreams, the Trust has made measurable progress in strengthening financial governance, stabilising delivery performance, improving organisational capability, and developing system-level finance functions, while managing notable risks particularly where dependent on external programmes such as SBS and One Devon.

Sustainable Financial Improvement- Process

- Financial improvement foundations have been significantly strengthened, with embedded CIP governance, SOPs and an integrated PMO tracker driving clearer accountability and better data assurance.
- SLR Q2 outputs and a cross-cutting opportunity matrix now provide visibility of loss-making services and efficiency opportunities, with remaining gaps addressed through a dedicated productivity workstream in year 2 to enhance performance management and support sustained recurrent savings.

Sustainable Financial Improvement- Delivery

- Delivery performance is stabilising, with £33.7m delivered at M10 (81% of plan) and the full-year forecast remaining on track.
- The main challenge is the recurrent gap, though recent reviews have allowed several non-recurrent schemes to be confirmed as recurrent through the ULP, strengthening the underlying position.
- A reduction in red-rated schemes indicates improving grip and continued progress.

Finance Capability & Capacity

- Finance capability is strengthening, with the senior restructure consultation completed,
- key posts in recruitment.
- Level 1 finance accreditation achieved and budget-holder training ready for rollout.
- PDR completion is on track for 100% by end March 2026.
- These actions improve decision quality, forecasting discipline and partnership with operational leaders.
- Some elements (budget holder manual/SLR for non-budget holders) are deferred to Year 2, but do not prevent immediate benefits from training and strengthened business partnering.

One Devon Shared Services: Finance

- The programme has established the core governance, partnership mobilisation and data-readiness foundations required for delivery.
- Provisional agreement of the outline Finance Target Operating Model.
- Although the SBS go-live date has been delayed, progress on system readiness, TUPE preparation and risk management provides a solid platform for Year Two delivery.

One Devon Shared Services: Procurement

- The One Devon shared procurement service went live on 1 December 2025, but assurance remains limited due to lower-than-planned savings, workforce gaps and system dependencies.
- Delivery is behind plan, and while contract governance has strengthened, ongoing staffing shortages and SBS delays continue to pose risks to future savings and compliance.

What did we achieve in year 1? - *People Domain*

The People Domain has delivered substantial improvements across workforce controls, capability development and cultural transformation, establishing a more sustainable, well-governed and insightfully-driven workforce model that supports financial recovery and organisational stability. Collectively, the workstreams have strengthened leadership, enhanced staff experience, embedded cultural and organisational development foundations, and progressed key systems and processes that position the Trust for long-term improvement and the upcoming organisational redesign.

Workforce Plan & Transformation

- Strengthening workforce controls.
- Reducing temporary staffing reliance, and improving e-rostering capability with tighter alignment to finance.
- Meeting national temporary staffing requirements.
- Advancing e-rostering dashboards and medical rostering have created a more sustainable and well-controlled workforce model that supports the Trust's financial recovery.

People & Education Capability & Capacity

- Essential foundations have been laid for directorate redesign, skills and capability development, policy improvement, workflow and workforce performance insight & KPI's
- While progress is dependent on the February 2026 restructure outcomes, substantial work has been completed to analyse capability needs, update policies & workflows, stabilise leadership, refine governance, reduce ER and sickness cases & develop service KPI's.

Culture, OD & Learning

- Strengthened culture, organisational development and leadership across the Trust.
- Review of cultural indicators, enhancing staff voice mechanisms, improving the Reasonable Adjustments process, initiating the Restorative Just and Learning Culture programme, and expanding leadership, management and change support frameworks.
- Collectively embedding a more open, supportive and learning-focused culture.



What impact has this had to our core KPIs?



Torbay and South Devon
NHS Foundation Trust

	April 2025	Target March 2026	March 2026
Substantive executive leadership posts filled by 30th March 2025	75%	100%	100%
RTT 18 week wait	61.8%	66.8%	65.4% (M12 unvalidated)
RTT 52 week wait	2.6%	0.9% of waiting list	1.8% (M12 unvalidated)
Cancer FDS	75.1%	80%	80% (M12 unvalidated)
Cancer 62 day wait	68%	75%	75.1% (M12 unvalidated)
Diagnostic wait over 6 weeks	32.4%	5%	37% (M12 unvalidated)
UEC 4 hour wait	72.8%	78%	66.2% (M12 unvalidated)
UEC 12 hour wait	5.7%	6.1%	10.1% (M12 unvalidated)
Total CIP target (£) vs. delivered	£41.5m	£41.5m	M12 Delivered: £41.5m
Achieve Month 12 Workforce Plan of Total Workforce (WTE)	6815	Original target: 6363 Revised target: 6556	M12: 6710
Reduction in Agency spend by 30%	£10.1m	£7.1m (30% reduction)	M12 Final Year End: 6.2m
Reduction in Bank spend by 10%	£21.1m	£19m (10% reduction)	M12 Final Year End: £20.2m
Staff Feedback: National Staff Survey	39%	45%	35.55%
Staff Feedback: Pulse Survey Response Rate	1.96%	45%	2.58%

Work across the IIP has driven measurable improvements in core KPIs, making a significant contribution to the Trust's successful exit from NOF4.

While not all targets have yet been fully achieved, the strengthened grip and control processes now in place provide a solid foundation and are expected to continue delivering positive impact throughout 2026/27.

Our Plan for Better Care – Workstream Closures

Senior Responsible Owner:	 CEO	 CPSO	 COO	 CFO	 CPO
Programme:	1. Leadership	2. Strategy	3. Performance	4. Finance	5. People
Workstream:	1.1 Governance & assurance 1.2 Well-Led 1.3 Board & Executive Development	2.1 3-5 Year Strategy Establishment 2.2 EPIC 2.3 PASP 2.4 Adult Social Care/Continuing Health Care 2.5 Child & Family Health Devon	3.1 Planned Care Improvement 3.2 UEC Flow 3.3 Community Services Redesign - Frailty 3.4 Maternity Safety Programme 3.5 Managing our Estate	4.1 Cost Improvement & Control Programme 4.2 Financial Capability & Capacity 4.3 Managed Services & Subsidiary Company Arrangements 4.4 One Devon Shared Services – Finance & procurement	5.1 Delivering Workforce Plan 5.2 Workforce Capability & Capacity 5.3 Organisational Development & Learning

- By the end of March 2026, most workstreams will formally close, due to one of the following; successful completion of all deliverables, outstanding deliverables moving into business-as-usual processes, or the workstream is no longer progressing. Associated risks will be either transferred to the relevant departmental risk register or closed, as appropriate. A further set of workstreams will transition into Year Two OPFBC programme. These are denoted as below;

 Successful completion of all deliverables
 Outstanding deliverables transitioning to BAU

 No longer progressing
 Transitioning into year 2



What did we learn this year?



Torbay and South Devon
NHS Foundation Trust

- Bringing our improvement activities into a **single, integrated plan** aligned to **our strategic goals** and **organisational priorities** has significantly **strengthened** the quality, efficiency and sustainability of our services.
- Combining our efforts, budgets, and staff time **maximises impact and avoids wasted resources** on overlapping initiatives and projects. New workstreams must now be prioritised again and limited to avoid overstressing capacity. Realistic delivery dates need to be set from the outset to support achievable outcomes.
- Leadership has been able to **prioritise initiatives based on impact and urgency**. As governance arrangements mature, operational activity previously overseen through OPFBC is increasingly being embedded within business-as-usual structures, enabling the year two programme to focus further on key strategic transformation aligned to the new strategy.
- **Encouraging cross-functional working** and **shared accountability** has helped to break down silos between services and teams. Earlier identification and dynamic management of interdependencies is now needed to reduce the risk of delay.
- Operating through a single, integrated plan has **strengthened oversight of progress, risks, and outcomes**. Continued development and embedding robust risk management processes is essential to sustain this.
- The use of a **standardised programme methodology** across an initiative of this scale has **improved the quality and reliability of outputs** and is beginning to deliver benefits. Year two requires a sharper focus on demonstrable evidence of delivery.
- Sharing OPFBC with all staff has **increased visibility** of the Board's objectives and **supported staff engagement** in the improvement journey. Year two will continue to strengthen communication to ensure the purpose and progress of the IIP are clearly understood and progressed across all staff groups.

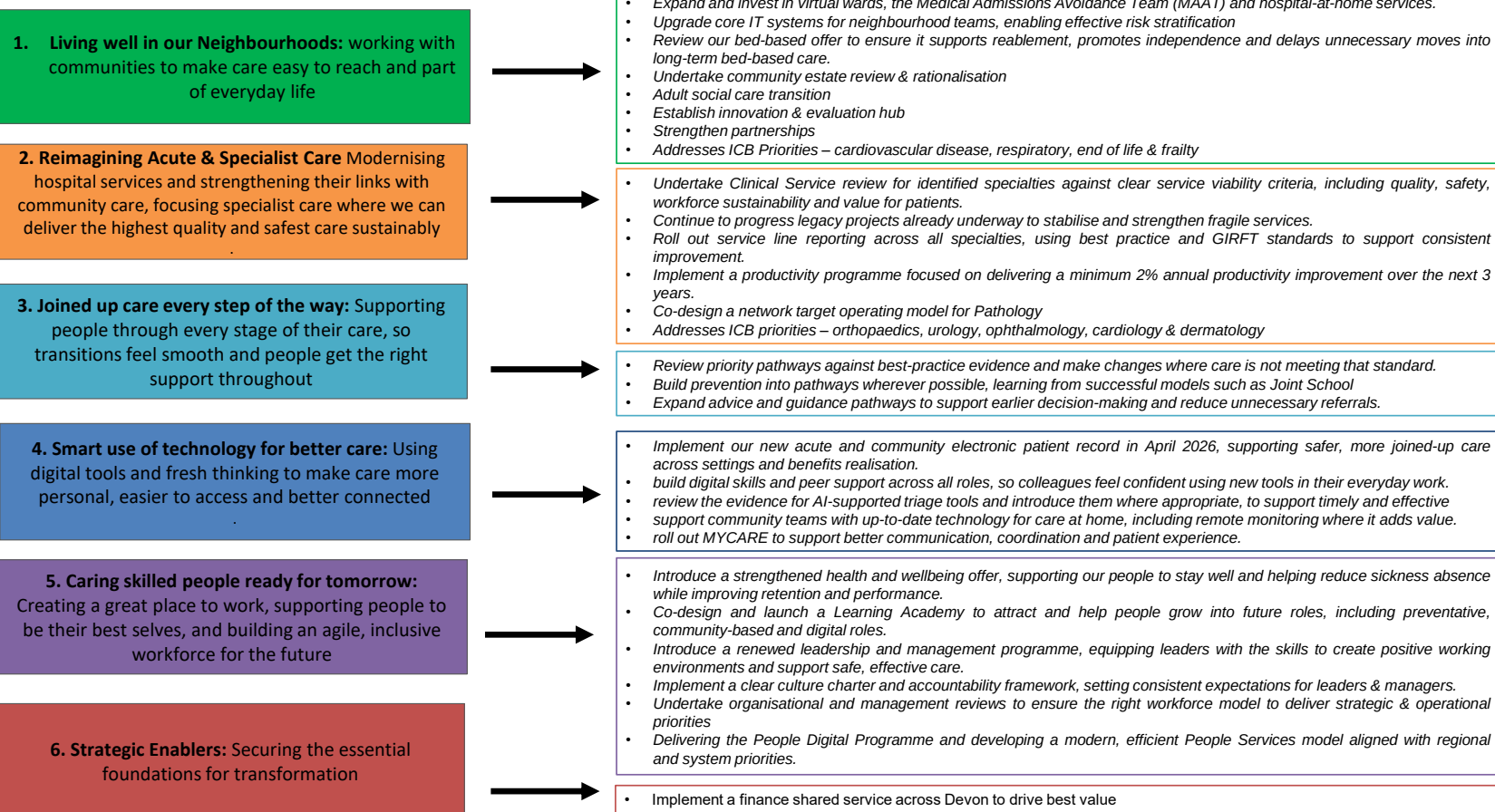


Transition to Year 2 2026/27

What will we focus on in year 2?

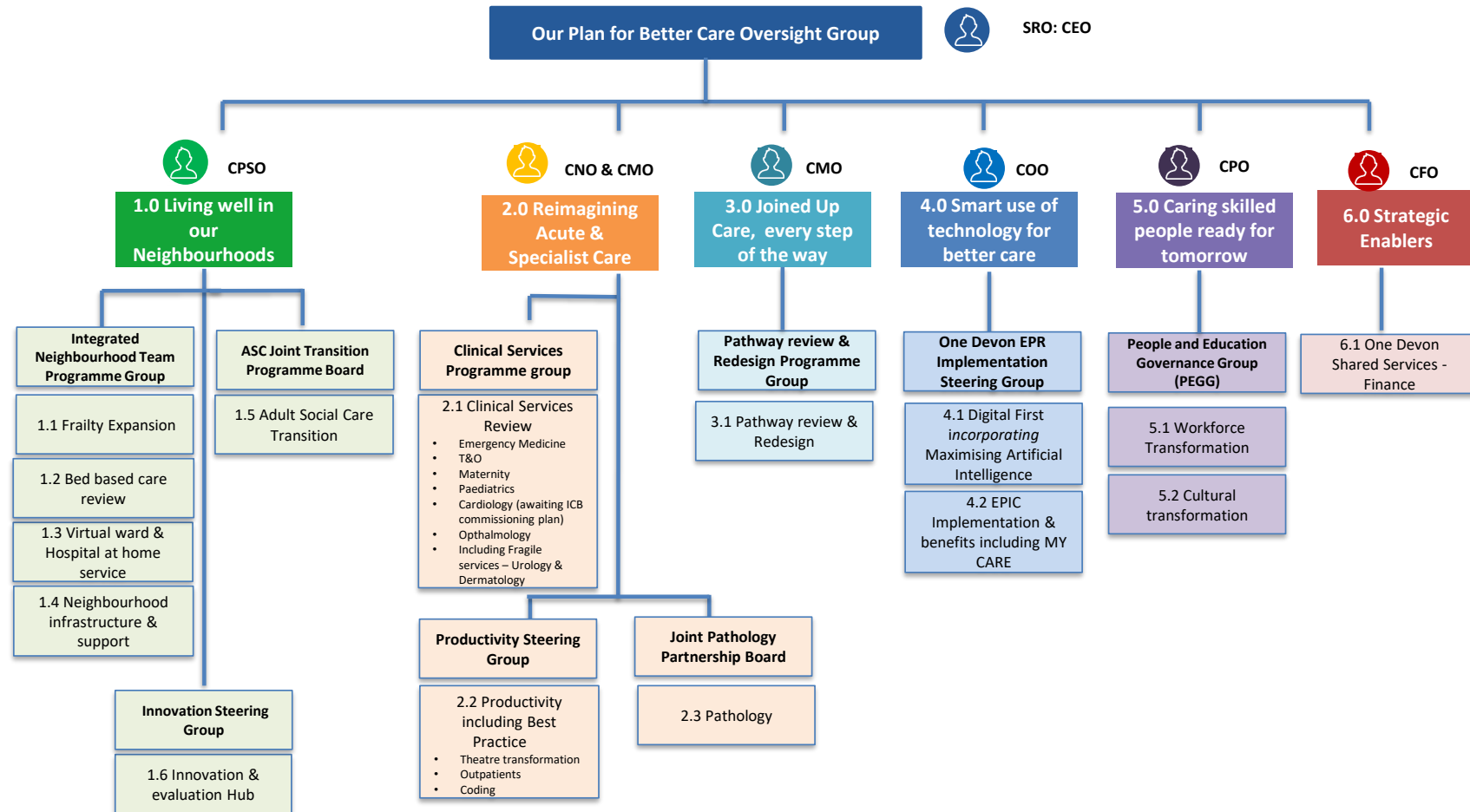
Transformation Domains

In year 2 we will.....



Annex 1: Our Plan for Better Care 26/27

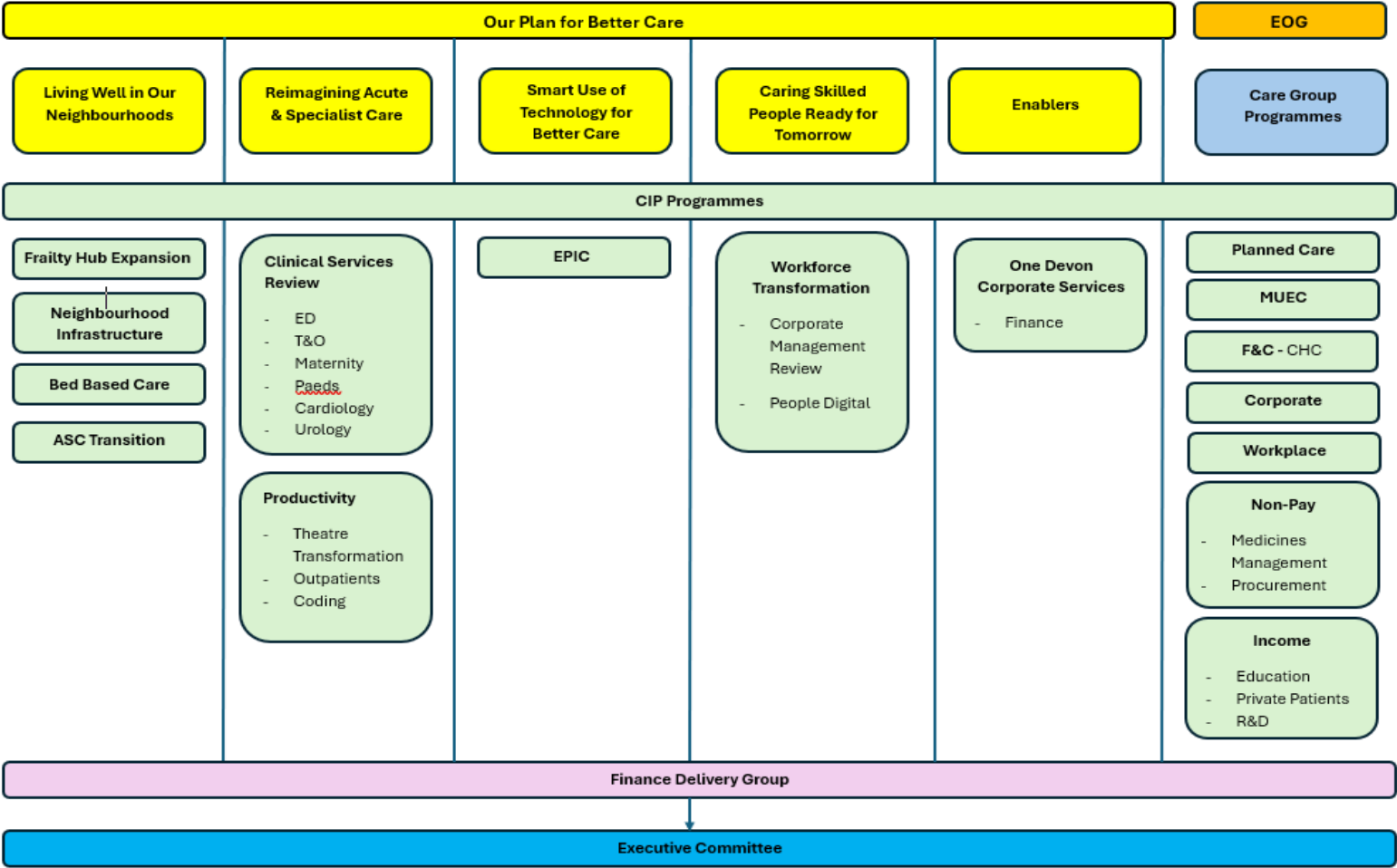
Governance





CIP Programme Governance


Torbay and South Devon
NHS Foundation Trust





Programme Risk



Torbay and South Devon
NHS Foundation Trust

For Year 2 PMO will report on programme risks to support effective oversight and assurance

Programme Management Office (PMO) Risk Register			Risk ID	Risk Category	Assessment of risk level if no action is taken			Treatment Plan	Treatment / Mitigation Actions	Current Risk Level			Treatment/ Mitigation Plan Status	Target risk level after mitigation		
Trigger	Risk	Impact			Con.	Like	Risk			Con.	Like	Risk		Con.	Like	Risk
(Why something may happen)	(What could happen)	(Likely consequence if left untreated)														
Competing Priorities Competing operational, clinical and transformation priorities i.e. Epic implementation, reorganisation, winter pressures	Reduce staff capacity and focus for OPFBC development	Leading to delays, reduced quality of input and risk to assurance timelines	1	Strategic Change & Transformation	4	4	16	Reduce	Secure formal Executive agreement that the OPFBC is a priority	4	3	12		3	4	12
									Confirm OPFBC status within the Trust's strategic objectives and transformation portfolio							
									Assign clearly accountable SROs with authority to resolve prioritisation conflicts							
									Ensure clear reporting lines into Executive and governance forums							
									Ring-fence dedicated OPFBC programme capacity							
Staff Resources Lack of dedicated programme delivery support (Finance, BI/Data analytics; HR/ER support; PM delivery, I&I support)	Leads to poor coordination and governance of OPFBC activity	Resulting in delays, reduced quality and increased risk of missed assurance deadlines.	2	Workforce and Culture	4	3	12	Reduce	Consider the use temporary or specialist external support where internal capacity is constrained	4	2	8		4	2	8
									Track OPFBC delivery against clear milestones and critical path to identify slippage early							
									Allocate dedicated PM resource to OPFBC delivery							
									Agree clear roles, responsibilities and decision-making authority							
									Use standardised plans, trackers and reporting to maintain control							
Staff Resources Voluntary redundancy reduces the availability of experienced staff and specialist expertise	Leading to reduced programme capacity	Delays to OPFBC delivery and increased risk of missed assurance deadlines	3	Workforce and Culture	4	3	12	Accept	Escalate capacity constraints early via formal governance routes	4	3	12		4	2	8
									Identify and protect critical OPFBC roles and skills							
									Consultation							
									Re-prioritise OPFBC activity within remaining capacity							
Interdependencies Programme is dependent on progress, funding, or decisions from other programmes or partners	If interdependent programmes, resources or decisions are delayed, reduced, or not delivered as planned, the OPFBC/CIP cannot be implemented in full or at pace	Failure to realise intended benefits. Delayed transformation. Risk to system credibility and stakeholder confidence	4	Financial Management	3	3	9	Reduce	Escalate resource risks early through programme governance	3	3	9		3	3	9
									Formal dependency mapping							
									Strong programme governance							
									Early and ongoing stakeholder engagement							

1.0 Living well in our Neighbourhoods

Senior Responsible Owner – Simon Tapley, CPSO

Working with communities to make care easy to reach and part of everyday life

1.1 Frailty expansion and Community bed-base care review

Senior Responsible Owner:		Chief Strategy & Planning Officer (CPSO)	
Workstream Lead & Delivery Team:		Workstream Lead – Shelly Machin Management Lead – Rachel Vokes Clinical Lead – Katherine Bhatt/Jonny Hacon PMO Support – Toby Joseph Other key individuals – Lesley Wade, Sarah Bradley, Nathalie Keens	
Workstream Objective:			
1. Improving efficiency and sustainability of healthcare: Expansion of frailty SDEC over 7 days supporting long term requirement to increase out of hospital care and capacity to offset current acute care demand growth projections. 2. Improving care co-ordination: Preventing avoidable hospital admissions through partnership working and collaboration increasing community-based care, including care co-ordination bringing together Harbour/SDEC/UCR/VWs/MAAT teams focussing on heart failure/frailty/respiratory 3. Preventing long admissions: Where frailty is a pre-existing syndrome and the patient does not require acute care hospitalisation, patients will receive inpatient care in a dedicated short stay healthcare of older people community hospital focusing on early discharge with the aim of stabilising, treating and discharging on the same day or for more acutely unwell patients, within 72 hours. 4. Preventing early admission to long term care: Reducing premature admission into long term care by increasing the provision of care in patient's homes. 5. Digital interventions hub: Telehealth service detects, assesses and manages age related decline in physiological health monitoring vital signs, tracking daily activity levels and utilising AI population health to predict/flag patients at risk of moderate or severe frailty before acute crisis occurs. 6. Community diagnostic provision: X-Ray car provides diagnostic capability in the patient's home reducing conveyance and ED attendance. 7. Proactive prevention of falls: Holistic patient health management combining bone health assessment with frailty scoring and care planning. 8. Compassionate care for all: Support delivery of precision palliative care identifying patients (in reach) who would benefit from being diverted to community services (instead of ED), supporting rapid discharge, virtual ward support and enabling patient choice for a 'good death'.			
Objective	Key High-level Deliverables	Lead	Target Date
1,3,4,8	Weekday Frailty SDEC service provision Daily Frailty SDEC service expansion	Lesley Wade Lesley Wade	Apr'26 Sept '26 / Nov '26
6	Community Xray Service implementation	Rachel Vokes	May '26
7	Falls Prevention Improvement Work - Falls assessment and medication review - Falls & Frailty MDT	Rachel Vokes Kirsty Elmers/Harbour	Mar '27
2,3,4,8	Care co-ordination Harbour Service (at Newton Abbot Hospital) - Expand clinical call handling capacity 10 hours per day - Expand Harbour@Home (virtual ward) 10 hours per day - Implement Head Injury Pathway - All patients with CFS ≥5 have a comprehensive geriatric assessment (CGA) - Harbour Service integrated working across Urgent Community Response (UCR)	Rachel Vokes	Sept'26 / Nov '26
1,2,3,4,8	Community hospital reconfiguration - Community bed base review - Community ward change of use - New SDEC Unit / Short stay assessment unit	Shelly Machin	July '26
5	Digital remote monitoring - Home monitoring / Telehealth / Digital interventions - AI Platform opportunity	Helen Davies-Cox Rachel Vokes	Nov '26 April '27
Success Criteria (target state)		Core Key Performance Indicators (what measure tells us we're achieving the success criteria)	
Reduced demand on acute care Reduction in repeat falls		10% Reduction in ED attendances for patients >65 years ? 10% Reduction in ED attendances with # HIP/NOF	
Improved flow and length of stay		Reduction in acute hospital admission for patients >65 years	
Reduced re-admission and associated harm from deconditioning		30% reduction in re-admission rates for patients >65 years	

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Required (Y/N)		How managed (consider whether at programme or workstream level)
EQIA	YES	Initial EQIA completed for business case submission Sept 25
DPIA	NO	

Benefits and Impact:	
Benefits: Improved patient experience Reduced acute hospital attendance Reduced ED attendance Reduced length of stay (LOS) Increased integration of services Reduced cost of health and social provision	IMPACT: Improved staff experience Rapid assessment Integrated Neighbourhood care (left shift) Shorter stay (reducing LLOS) Preventing re-admission. Reduced harm through deconditioning and long delays

Financial Impact and Target if known:			
Total target savings	FY26/27	FY27/28	FY28/29
	(SDEC) TBC (XRAY Car) TBC	(SDEC) TBC	

Assumptions (what we believe to be true, but is not yet confirmed)	Resource Requirements:
- Call before convey is consistently applied as an alternative - Workforce models can be sustained without significant growth - Reliable application of CGA - Growth in frailty demand is offset by pathway re-design - Planned savings can be released and is recurrent - Data is available to attribute impact	- Digital innovation - Business intelligence - Improvement and Innovation - Care Groups (Community / Medical UEC)

Key Risks:	Score & RAG
Risk: Perceived lack of robust clinical evidence for wearable technology in older people living with frailty (ASC) Mitigation: Patient involvement, training & education, technology positioned enhanced care supports hybrid care	Amber
Risk: 7 day provision of support services e.g.: diagnostics/social care/urgent care at weekends Mitigation: wider strategic investment in 7 day service provision	Red
Risk: Community short stay fails to ease pressure on acute hospital capacity by removing step down capacity Mitigation: Increased capacity in people's homes supported by therapy, virtual ward expansion and home-first	Amber

Interdependencies / Links to other programmes / projects:	Out of Scope
- Long term conditions including virtual ward expansion - Integrated neighbourhood teams - Community orthopaedic reablement - Healthcare of older people + community bed base review	- People ≤65 years - Planned care - High intensity / Hyper acute / Specialised care - Complex mental health

Governance structure (where will this project report, where is decision making)
•Project Board oversight •LCP •System INT steering group

1.2 Acute Bed-base care review

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Senior Responsible Owner:

Chief Strategy & Planning Officer (CPSO)

Workstream Lead & Delivery Team:

Lee Johns (Acute beds)
Clinical Lead: Mark Roberts, Stephen Heath
PMO Support - Toby Joseph

Workstream Objective

1. Define the optimal bed-based capacity required across the Acute settings given the transformation in the model of care, ensuring bed-based care maximises independence and aligns to 'Home First' principles

Required (Y/N)

EQIA

DPIA

How managed
(consider whether at programme or workstream level)

Required for service changes arising out of workstream

Benefits and Expected Outcomes

Right-sized, sustainable bed-based capacity

Reduced reliance on bed-based care and fewer transitions into long term care

Improved utilisation of staff & estate

Objective

High-Level Deliverables

Lead

Target Date

1

Comprehensive Demand and Capacity Analysis: Assessment of current state and projected demand, utilisation, case mix, and flow patterns across Acute and Community beds

CGD MUEC

End April 2026

1

Options Appraisal for Bed Configuration and Location: structured appraisal outlining viable options for consolidating, re-purposing, or re-balancing beds across Acute, including quality, financial, operational and workforce impacts.

CGD MUEC

Mid May 2026

1

Implementation Roadmap for Bed-Based Optimisation: phased delivery plan that sets out the actions, timelines, enablers, and interdependencies required to transition to the agreed future bed model, based on ExCo decision

CGD MUEC

Mid June 2026

1

Commence Implementation of phased delivery plan

CGD MUEC

End June 2026

1

Subject to ExCo decision, progress reconfiguration of Acute beds

CGD MUEC

End September 2026

Success Criteria

Evidence-based capacity modelling completed

Optimal bed-based capacity agreed & financially & operationally sustainable

Maintain UEC core performance standards

Core Key Performance Indicators

Bed occupancy

Length of stay improvement

4hrs, 12hrs, Ambulance handovers

Financial Impact and Target

Total target savings (£'000)

£914k

Assumptions

Final stage of Frailty Business Case implemented by end August 2026 and expected benefits realised i.e. 1825 admissions avoided

Governance structure

Integrated Neighbourhood Team programme Group

Resource Requirements:

PM Delivery support

HR / ER Support in respect of consultations

Finance in respect of validation and tracking of financial benefits

Dependency/Interdependencies

Frailty expansion

Virtual ward maximisation

Epic & impact on flow

Care Coordination

Call before convey

1.3 Virtual Ward & Hospital at Home Service

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24/05/2026

Senior Responsible Owner:		Chief Strategy & Planning Officer (CPSO)		CPD Oversight 24/05/2026		Torbay and South Devon NHS Foundation Trust							
Workstream Lead & Delivery Team:		Workstream Lead – Lee Johns Clinical Lead – Stephen Heath PMO Support – Toby Joseph Other key individuals – VW pathway specific leads, Michelle Baker				Required (Y/N)		How managed (consider whether at programme or workstream level)					
		EQIA		YES									
		DPIA		YES									
Workstream Objective:				Benefits and Impact:									
Current context is respiratory and HOP virtual wards established, with plans to expand HOP through Harbour. There are additional virtual ward opportunities to progress, including heart failure, which currently had only short-term funding for 2025/26.				- Improved access to Virtual Ward capacity through a single front door - More consistent clinical decision-making via standardised pathways - reduced length of stay and avoidance of unnecessary admissions - More flexible and resilient workforce through generic VW roles - Increased Virtual Ward capacity without proportional increase in staffing - Reduced duplication of coordination, admin, and digital setup across specialties - Improved flow from ED, SDEC, and inpatient wards									
Rationale for Review: Create a single, sustainable Virtual Ward (VW) service delivering economies of scale while preserving specialty clinical ownership													
Programme Objectives - One Virtual Ward service with specialty-led pathways - One operational management structure and budget - One digital platform and single referral front door - Centralised coordination; decentralised clinical decision-making - Phased, safety-first implementation													
Key High-level Deliverables				Lead		Target Date							
Phase 1 – Central Virtual Ward Hub –scope and integrate VW coordination and flow, referral management and triage, admin data and reporting. Single VW Budget				Rachael Vokes		June 26							
Phase 2 – Workforce Alignment – establish generic VW nurse / AHP roles, cross skill staff across pathways, move from specialty rota to VW rota				Rachael Vokes		July 26							
Implement tiered staffing model: tier 1 Generic VW Team, Tier 2 Specialty support, Tier 3 Medical oversight				Clinical Lead TBC		Aug 26							
Phase 3 – Pathway Standardisation SOP – standardise entry and exit criteria, align escalation and deterioration thresholds, formalise interfaces with community services and The Harbour, introduce shared MDT where appropriate				Rachael Vokes		Oct 26							
Phase 4 - Performance framework, refined skills and advanced roles, expanded capacity through integration without proportional WTE growth				Lee Johns		Oct 26							
Expansion Respiratory – linked to above: Funding currently for 30 beds, Team delivering 40 beds delivery (additional 1.5PA's activity) – review if the capacity is sustainable / review if it's a seasonal requirement				Michelle Baker		Aug 26							
Linked to the above, consider Respiratory new best practice pathways – direct to VW from SWAST (UHP new pathway)				Michelle Baker		Aug 26							
Expansion of Heart Failure linked to business case in respect of Acute bed base review.				Charlotte Webber		Aug 26							
Expansion: Review working practice of MAAT Team to understand further integration and support to wider virtual ward include Acute Med pathways				Michelle Baker		Aug 26							
Success Criteria (target state)		Core Key Performance Indicators (what measure tells us we're achieving the success criteria)		Financial Impact and Target if known:				Resource Requirements:					
Increased Virtual Ward capacity to 80 beds		Increased VW capacity – 80 beds		Total target savings		FY26/27		FY27/28		FY28/29		- Business intelligence - Improvement and Innovation - Finance / Procurement - IT support	
Reduce cost per VW patient		Reduced cost per VW patient				TBC in discussion with FBP		TBC in discussion with FBP		TBC in discussion with FBP			
Reduction admissions and therefore length of stay		Improved clinical outcome e.g. Los											
Key Risks:		Score & RAG		Assumptions (what we believe to be true, but is not yet confirmed)									
Risk: Loss of specialty control – pathway driven with central virtual ward Mitigation: retain the specialty pathway leads, phased workforce changes		Initial 4 x 2 =8 Mitigated 4 x 1 =4		The expansion of heart failure is reestablished. The co-ordination function is strongly linked with Harbour. There will not be any additional funding, so efficiencies will have to be delivered within existing budget.									
Risk: clinical decision making across pathways Mitigation: Standardised entry/exit criteria and MDT review standards		Initial 4 x 2 =8 Mitigated 4 x 1 =4											
Risk: Anticipated economies of scale not realised. Mitigation: Early baseline and benefits tracking; central budget control		Initial 3 x 3 =9 Mitigated 3 x 2 = 6											
Risk: Funding of expansion of service. . Mitigation : Early involvement of finance, best practice pathways; and utilisation of EPIC an operational efficiencies		Initial 5 x 3=15 Mitigated 4 x 3 =12											
				Out of Scope									
				Care Co-ordination with this function									
				Interdependencies / Links to other programmes / projects:									
				- Epic Implementation - Care Coordination - Harbour - SDEC configuration									
				Governance structure (where will this project report , where is decision making)									
				Integrated Neighbourhood Programme Group									

1.4 Neighbourhood Teams Infrastructure & Support

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24/05/2026

Senior Responsible Owner:		Chief Strategy & Planning Officer (CPSO)		24/05/2026		Torbay and South Devon NHS Foundation Trust	
Workstream Lead & Delivery Team:		Workstream Lead: Shelly Machin Clinical Lead: Rory Honney,/ Paul Highton Sarah Bradley, Natalie Keens, Chris Winfield PMO Support: Toby Joseph		Required (Y/N)		How managed (consider whether at programme or workstream level)	
				EQIA		Yes	
				DPIA			
Workstream Objective (what we aim to achieve – clear, measurable goals)				Benefits and Expected Outcomes (value created when the objectives are achieved)			
This workstream aligns to the Neighbourhood Health Plans policy paper published on 17 March 2026 in so far that there are two-stages: 2026/27 – A test-and-learn year to co-develop Neighbourhood Health Plans (systems and delivery processes) with key stakeholders and partners, and to test these in practice. 2027/28 – Implementation of the approved TSDFT Neighbourhood Health model from April 2027, with completion by 31 December 2027. 1. Deliver proactive care and risk stratification for high-risk cohorts such as frail, long-term conditions , and frequent attenders 2.Reduce crisis events, admissions, and inpatient LOS through strengthened community MDTs 3.Implement neighbourhood frailty and urgent community care operating models 4.Improve care personalisation, coordination, and experience including EOLC 5.Build sustainable neighbourhood workforce models and partnership structures 6. Strengthen Voluntary Community and Social Enterprise (VCSE) and system partnerships to support independence and prevention 7. Deliver a comprehensive review and rationalisation of the community estate to ensure it is safe, fit for purpose, financially sustainable, and aligned to future care models, while creating opportunities for cost savings				Improved coordination of services at a neighbourhood level, leading to more joined up delivery			
				Increase efficiency through shard infrastructure, systems and support functions which will lead to :			
				- Consistent year-on-year reduction in ED attendances and non-elective admissions - Reduction in 12 hour waits and conveyance rates to ED - Reduction in care home placement conversion at point of discharge - Increased volume of proactive care contacts and early interventions - Improved personalised care outcomes and patient-reported measures - Increased number of people dying in their preferred place of death - Reduction in associated harm through avoidable delay and timely discharge			
Objective	High-Level Deliverables (what we will produce to achieve the objective – key outputs) N.B avoid listing tasks, deliverables should be strategic not operational			Lead (person responsible for completing the deliverable)		Target Date	
1	Deployment of neighbourhood-level risk stratification using One Devon/Brave AI datasets			Rory Honney / Nick Peres		31 March 2027	
2	Deliver a consistent, proactive case management model for high-risk cohorts, incorporating escalation planning, Treatment Escalation Planning (TEP), and enhanced end-of-life (EOL) care.			Paul Highton, Natalie Keene and Sarah Bradley		31 March 2027	
3	The right team members performing the care only they can provide. Plan for all team members to hold the risk levels they are trained for. Maximising use of Virtual Wards and frailty service linking with voluntary organisation to support care requirements			Paul Highton, Natalie Keene and Sarah Bradley		31 March 2027	
4	Digital integration plan enabling Epic optimisation and shared care record access			Nick Peres		31 March 2027	
5	Workforce development and neighbourhood leadership capability framework			Paul Highton		31 March 2027	
6	Alignment of service actively to patient defined outcomes (not purely monitored using activity metrics)			Sarah Bradley and Natalie Keene		31 March 2027	
7	Completion of a trust-wide community estate review and rationalisation plan, including asset condition assessments, utilisation analysis, options appraisal, and an agreed implementation roadmap that delivers a safe, efficient, financially sustainable estate aligned to future service models			Sarah Bradley, Natalie Keene, Shelly Machin and Dawn Butler		31 March 2027	
Success Criteria (target state)		Core Key Performance Indicators (what measure tells us we're achieving the success criteria)		Financial Impact and Target		Resource Requirements:	
Attendances - Expect a percentage reduction		A 20% reduction in ED attendance in high-risk cohort		Total target savings (£'000)		- Improvement and innovation management support - Dedicated data and intelligence support	
Admissions – Expect a percentage reduction in admissions		A 20% reduction in avoidable admissions		FY26/27		Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)	
Care home use – Reduction in long term care and Increase in virtual ward use		Lower Higher		Not expecting any CIP as implementation from 01/04/27		- Acute pathway transformation - Frailty development - Expansion of virtual wards - Digital integration - Multi professional working with Primary Care and Devon Mental Health Partnership	
Ability to measure healthcare outcomes including disease prevalence and service demand		Utilising JSNAs to align existing health data Early case identification for LTC/Frailty/Community				Out of Scope (what is explicitly excluded from the project)	
Key Risks (potential problems or events that could impact the project)		Score & RAG		Assumptions (what we believe to be true, but is not yet confirmed)			
Lack of medical engagement both Primary Care and Acute Care (GP/Consultant)		Initial 3 x3 =9 Mitigated 3 x 2=6		- Neighbourhood footprints will be agreed - Primary care engagement sustained			
Insufficient workforce capacity and skills mix		Initial 3x3=9 Mitigated 3x2=6		Governance structure (where will this project report , where is decision making)			
Voluntary Sector capacity constraints due to socio-economic factors		Initial 4x4=16 Mitigated 4 x 3=12		- Project Board oversight - LCP - System INT steering group		Not Applicable	

1.5 Adult Social Care Transition

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Senior Responsible Owner:	Chief Strategy & Planning Officer (CPSO)	Required (Y/N)		How managed (consider whether at programme or workstream level)			
Workstream Lead & Delivery Team:	Alan Welch – Workstream Lead	EQIA	Yes	Jointly developed and approved through Transition Board			
	Trust ASC Clinical / Professional Lead – Clinical Lead	DPIA	Yes	In line with UK GDPR; joint information-sharing arrangements			
Workstream Objective (what we aim to achieve – clear, measurable goals)		Benefits and Expected Outcomes (value created when the objectives are achieved)					
1. To enable the safe, compliant, and effective transfer of Adult Social Care responsibilities, functions, staff, and financial resources and contracts from TSDFT to Torbay Council, ensuring continuity of care, protecting staff and service users and maintaining integration with wider council services.		- No gap in service for people who draw on Adult Social Care. - Safe continuity of care throughout transition and go-live - Staff stability and fair treatment, minimising anxiety and disruption - Opportunity to re-set to strengths-based ASC practice, promoting and improving independence for service users - Enables a deliberate reset, not loss, of integration - Improved financial control and transparency with no unilateral commitments					
Objective	High-Level Deliverables (what we will produce to achieve the objective – key outputs) N.B avoid listing tasks, deliverables should be strategic not operational	Lead (person responsible for completing the deliverable)		Target Date			
1	Mobilisation & Assurance: Formally establish authorised transition programme with agreed scope, governance, legal intent and and risk management to provide assurance for the safe transfer of Adult Social Care from the NHS to the Council.	Joint SROs		30 th May 2026			
1	Service, financial & contract baseline: Complete and validate baseline to define all Adult Social Care services, workforce, budgets, contracts, assets, and statutory responsibilities that will transfer to the Council.	Finance & ASC Leads		31 st August 2026			
1	Legal, workforce & organisational readiness: Undertake all legal, employment, professional, and organisational arrangements to ensure the Council can lawfully and safely assume Adult Social Care responsibilities from transfer date.	HR / Legal Leads		31 st December 2026			
1	Service Model & operating Design: Design & agree clear Adult Social Care operating model, setting out decision-making, safeguarding, commissioning, performance management, and interfaces with NHS partners within the Council.	Council ASC Lead		31 st January 2027			
1	Implementation & transfer: Formal transfer statutory responsibility, staff, budgets, contracts, and live services to the Council with continuity of care maintained and operational risks effectively controlled.	Transition Board		1 st April 2027			
Success Criteria (target state)		Core Key Performance Indicators (what measure tells us we're achieving the success criteria)		Financial Impact and Target		Resource Requirements:	
Safe continuity of care		No interruption to care packages, safeguarding, reviews, or payments		Total target savings (£'000)		- Programme and transition management (joint) - Legal support (TUPE, MoA, contracts) - HR Specialist resources - Employee Relations - Finance and Procurement support - Information governance and data protection expertise	
Stable and supported workforce		Zero pay interruptions; TUPE compliance; staff retention through transition		FY26/27			
Safe and controlled transfer		Go-live achieved with joint Go / No-Go decision		FY27/28			
				FY 28/29			
Key Risks (potential problems or events that could impact the project)		Score & RAG		Assumptions (what we believe to be true, but is not yet confirmed)		Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)	
Disruption for service users at the point of transfer				- TUPE applies to relevant staff groups - Data, workforce, and financial information provided by the Trust is complete and accurate - No unilateral financial or contractual commitments during transition - Both organisations prioritise service safety over organisational advantage		- Joint commitment to partnership working and transparency - Workforce consultation and TUPE timescales - Jointly signed off and fully validated service, financial, workforce, and contract baseline. - Readiness of receiving Council ASC operating environment (systems, access, payroll)	
Contested financial/service/contractual baseline resulting in underfunding, unfunded liabilities or misalignment of transferred responsibilities & resources				Out of Scope (what is explicitly excluded from the project)			
Workforce stability affecting service delivery				- Service redesign or transformation prior to stabilisation - Introduction of new ASC models, systems, or policies before transfer - Assumption of non-statutory ASC responsibilities by the Council			
Governance structure (where will this project report, where is decision-making)							
Joint Transition / Programme Board with named Council and Trust SROs							

1.6 Innovation & Evaluation Hub

Senior Responsible Owner:	Chief Strategy & Planning Officer (CPSO)
Workstream Lead & Delivery Team:	Workstream Lead: Nick Peres (Director, Digital Innovation & Transformation) Delivery Team: Digital Futures Hub team; Clinical Lead (Jacqui); Implementation Lead (TBC); Evaluation Lead (TBC); HIN SW (Amy Manning, Commercial & Partners Director). Internal alignment: Quality Improvement team; Research & Development; Digital Skills Programme; IT Services

Workstream Objective (what we aim to achieve – clear, measurable goals)
1. Establish the Hub as the Trust's single front door for all digital innovation activity — both internally generated ideas from staff and externally sourced innovations from industry, academic, and NHS partners — providing a consistent, governed entry point through the ISG four-gateway pathway.
2. Systematically progress the stalled pipeline to deployment or BAU, reducing the proportion stalled from 61% to below 25% by Q4 2026/27.
3. Establish a formal HIN SW partnership agreement to accelerate evidence-based adoption across the Peninsula, with named capacity allocation, co-funded evaluation, and NHS Devon ICB regional funding for innovations at Gateway 3–4 maturity.
4. Launch a rapid-bid innovation fund with light-touch governance to unlock frontline ideas, first funded cohort complete by Q3 2026/27.
5. Recruit or second a dedicated Implementation Lead to bridge the innovation-to-IT gap; pipeline SLA documented and operational by Q4 2026/27.
6. Ensure proportionate, embedded evaluation across all Hub activity, generating evidence that actively informs procurement, technology uptake, performance management, and service improvement – moving beyond compliance reporting to evaluation that drives organisational learning.

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Required (Y/N)	How managed (consider whether at programme or workstream level)
EQIA	Y Workstream level – EQIA to be completed at project inception for any innovation reaching Gateway 3 deployment approval
DPIA	Y DPIA to cover full activity of hub. Individual DPIAs per project where appropriate

Benefits and Expected Outcomes (value created when the objectives are achieved)
Closing the implementation gap: 61% of our active innovation portfolio (17 of 28 projects) are currently stalled between prototype and deployment, representing an estimated £700k in unrealised annual value (including potential IP exploitation). The Hub creates a systematic pathway to convert this pipeline into BAU delivery. Deployment-ready evidence: A single co-located space for practice-led testing, research and evaluation that generates evidence packages ready for implementation – not just proof of concept. Strategic alignment: Directly delivers Enabler 2 (Innovation & Evaluation) of the Trust's 2026–2031 strategy, supporting outpatient transformation, frailty pathways, digital skills and remote monitoring priorities. Financial sustainability: Enables cost-avoidance innovations to reach scale whilst generating commercial income through HIN partnership, IP exploitation, direct award and InSites activities. Regional leadership: Positions TSDFT as the South West Peninsula's leading deployment-ready testbed and evidence generator, supporting fast uptake of evidence-based innovations across the HIN SW network.

Objective	High-Level Deliverables (what we will produce to achieve the objective – key outputs) N.B. avoid listing tasks, deliverables should be strategic not operational	Lead (person responsible for completing the deliverable)	Target Date
1	Hub operating model documented; Evaluation Hub formally designated as the single front door for internal (staff-generated) and external (industry, academic, NHS partner) innovation activity; ISG Gateway process updated to reflect dual-pathway entry and include deployment evaluation standards.	Nick Peres	Q1 2026/27
2	Innovation pipeline review completed; all stalled projects triaged and assigned to active deployment, pause, or stop; benefits realisation dashboard live.	Nick Peres / Implementation Lead (TBC)	Q2 2026/27
3	HIN SW partnership agreement signed with Amy Manning; joint evaluation and implementation capacity confirmed; first jointly delivered project initiated.	Nick Peres / Amy Manning (HIN SW)	Q2 2026/27
4	Rapid-bid fund governance framework approved by Committee; first funding round open; minimum 3 projects funded and in active delivery.	Nick Peres	Q3 2026/27
5	Recruit or second a dedicated Implementation Lead; Innovation-to-IT pipeline SLA agreed with IT Services; first 5 innovations progressed to BAU deployment.	Implementation Lead / Nick Peres	Q4 2026/27
6	Proportionate evaluation framework published, tiered by Gateway maturity level; evaluation outputs systematically informing procurement decisions, technology uptake, performance reporting, and service improvement cycles. Methodology aligned with QI, R&D, and academic partners.	Evaluation Lead / Nick Peres	Q3 2026/27

Success Criteria (target state)	Core Key Performance Indicators (what measure tells us we're achieving the success criteria)
Proportion of active innovation pipeline stalled at prototype reduced from 61% to below 25% by Q4 2026/27.	% of 28-project pipeline progressed to deployment or BAU within 12 months; monthly project stage report via ISG.
Formal HIN SW partnership agreement in place with named capacity allocation; rapid-bid fund operational with first funded project cohort complete by Q3 2026/27.	Signed partnership agreement; number of jointly funded/delivered projects; HIN referral rate to Hub.
Implementation infrastructure operational: dedicated Implementation Lead in post; innovation-to-IT pipeline pathway documented with defined SLAs and governance 'lite' process.	Innovation-to-IT pipeline SLA adherence rate; time from ISG Gateway 3 approval to BAU deployment tracked per project.

Key Risks (potential problems or events that could impact the project)	Score & RAG
IT capacity and governance complexity may delay progression of innovations from Hub to deployment; concurrent Epic go-live may compress available IT resource.	4 x 4 AMBER
Dependency on HIN SW partnership and external funding confirmation; delay in securing Implementation Lead post could limit Hub operational capacity in Year 1.	3 x 3 AMBER

Out of Scope (what is explicitly excluded from the project)
Day-to-day management of IT infrastructure, systems and BAU support (IT Services responsibility). Primary care digital development and commissioning (ICB/PCN domain). Procurement of large commercial off-the-shelf clinical systems. Training and education delivery (separate Digital Skills Programme workstream).

Financial Impact and Target			
Total target savings (£'000)	FY26/27	FY27/28	FY 28/29
		£150k	£350k
Assumptions (what we believe to be true, but is not yet confirmed)			
HIN SW commercial discussions with Amy Manning will result in a formal partnership agreement with allocated capacity by Q1 2026/27. IT Services will engage constructively in defining an agreed innovation-to-IT handover SLA. Clinically led evaluation will follow “replace don’t layer” principles; innovations that reach deployment will replace, not add to, existing workflows. Board commitment to innovation as a strategic enabler (Enabler 2) will be maintained throughout the strategy period.			
Governance structure (where will this project report , where is decision-making)			
The Innovation and Evaluation Hub reports to the replaced BBF Committee (chaired by Robert Williams) as a named enabler workstream within the Trust’s 2026–2031 strategy. Operational oversight sits with the Innovation Steering Group (ISG), which holds monthly Gateway decision-making authority across the innovation pipeline. Nick Peres is accountable to exco. HIN SW partnership activity governed by a joint partnership agreement.			
Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work- or are reliant on this project)			
IT Services BAU delivery capacity and EPIC EPR go-live planning (competing IT priorities). HIN SW partnership formalisation (in progress with Amy Manning). ISG governance framework and BBF Committee reporting cycle. NHS England programme funding continuation for existing innovation commitments. ICB support for scaling innovations such as CareLink remote monitoring.			

Resource Requirements:
- Implementation Lead: dedicated post bridging innovation-to-IT gap; to be recruited or seconded. Funding sought via HIN SW partnership allocation and/or NHS England programme funding. - Evaluation Lead: dedicated capacity for designing and delivering deployment-ready evaluation frameworks; to be recruited or seconded. This role is distinct from implementation and ensures evaluation rigour from Gateway 2 onwards, building an evidence base suitable for wider NHS adoption. - Wider team alignment: formal working relationships established with Quality Improvement, Research & Development, and Digital Skills Programme teams to avoid duplication, share methodology, and embed Hub outputs into existing organisational learning structures. Named liaisons agreed within each team by Q1 2026/27. - Existing Digital Futures Hub team (no additional headcount required in Year 1); Hub activity time formally ringfenced within existing team structure. - NHS Devon regional funding: targeted engagement with NHS Devon to secure regional investment supporting the evaluation and implementation pipeline for innovations reaching Gateway 3–4 maturity and ready for scale and deployment. TSDFT's position as the Peninsula's deployment-ready evidence generator provides a strong basis for ICB co-funding of the acceleration phase, particularly for innovations with whole-system applicability. - Rapid-bid innovation fund: estimated £20–30k initial allocation; funding via existing NHS England programme headroom or board approval. Light-touch governance pathway designed via ISG. - Digital Futures Hub infrastructure (existing): testbed space, XR evaluation equipment, academic partnerships (Universities of Exeter and Falmouth, HIN SW).

2.0 Reimagining Acute & Specialist Care

Senior Responsible Owner – Nicola McMinn, CNO & Kate Lissett, CMO

Modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably

2.1 Clinical Services Review Workstream

Date Plan on Page Approved by
OPFBC Oversight
24/05/2026

NHS
Torbay and South Devon
NHS Foundation Trust

Senior Responsible Owner:	Chief Medical Officer (CMO) & Chief Nurse Officer (CNO)	Required (Y/N)	How managed (consider whether at programme or workstream level)
Workstream Lead & Delivery Team:	Clinical: Rory Honney & Stuart Andrews (Planned care) Yahya Mubashar (Paeds & Mat), (Emergency med TBC) Nursing: Sharon Boyne (planned care) , Jo Bassett & Liz Thomas (Paeds & Mat), (Emergency med TBC) Alan Welch & Chris Winfield	EQIA Yes DPIA No	Service level
Workstream Objective <i>(what we aim to achieve – clear, measurable goals)</i>		Benefits and Expected Outcomes <i>(value created when the objectives are achieved)</i>	
Strategic fit: To ensure service models reflect the Trust's strategic aims and remain safe, operationally and financially sustainable, and to develop system-wide solutions where these conditions cannot be met. Support financial viability of the Trust through financial improvement: To identify where services contribute towards the Trust's underlying financial deficit and develop and deliver proposals for financial improvement. Meet quality standards: Services should meet national standards for performance, outcomes, safety and experience. Operational stability: To maintain clinically and operationally stable services, incorporating sustainable and sufficient quality workforce, facilities and support services.		Success measures of the workstream are noted below. Each clinical services will have their own focused benefits. Strategic fit: Clinical services that are aligned with national, regional, system and TSDFT strategy. Financial viability: Service able to deliver financial improvement, cost benchmark improvement against peers, address income issues where appropriate, and address underlying data quality issues affecting cost comparisons. Meets quality standards: Clinical services that meet appropriate national standards. Operational stability: Services meeting agreed operational thresholds.	

Objective	High-Level Deliverables <i>(what we will produce to achieve the objective – key outputs) N.B. avoid listing tasks, deliverables should be strategic not operational</i>	Lead <i>(person responsible for completing the deliverable)</i>	Target Date
1	a) Evaluation criteria developed to align planning and decision-making with national, regional, system and Trust strategies.		• May 2026
2	a) SLR reviews and productivity analyses completed to identify clinical services contributing to the Trust's underlying deficit. b) Baseline report produced, co-developed with clinical and finance teams, outlining current position and cost drivers. c) Clinically owned tactical proposals drafted to support 2026/27 CIP delivery prior to full options appraisal. d) Initial options appraisal completed setting out potential financial improvement opportunities beyond 2026/27.	• Alan Welch • Lydia Goffron-Warr • Clinical Lead • Alan Welch/Chris Winfield	• May 2026 • May 2026 • June 2026 • June 2026
3	a) List of clinical services identified where quality and safety concerns require review. b) Baseline report produced, co-developed with clinical teams, analysing current clinical performance and drivers. c) Clinical considerations incorporated into the initial options appraisal (links to 2d)	• SROs • Lydia Goffron-Warr • Clinical lead	• May 2026 • May 2026 • June 2026
4	a) Operational viability assessments included within the initial options appraisal. b) Full options appraisal delivered for shortlisted options, including delivery plan, dependencies and required engagement. c) Stakeholder engagement activities undertaken and options evaluated through a stakeholder panel. d) Appropriate level of business case(s) developed to support the preferred option(s).	• Alan Welch/Chris Winfield • Alan Welch/Chris Winfield • Clinical Lead • Alan Welch/Chris Winfield	• June 2026 • October 2026 • December 2026 • February 2027

Success Criteria <i>(target state)</i>	Core Key Performance Indicators <i>(what measure tells us we're achieving the success criteria)</i>
Financial viability (noted within benefits above)	• SLR Surplus, Model Hospital Productivity opportunity & Model Hospital WAU variance from peer average
Meet national quality standards	• Safety and safeguarding incidents, Patient complaints & Safer staffing consistently met

Key Risks <i>(potential problems or events that could impact the project)</i>	Score & RAG
Conflict between short-term cost reduction requirements and long-term transformation goals, particularly when engaging operational and clinical teams.	
Lack of clearly defined roles, responsibilities, and decision-making authority, leading to potential governance ambiguity	

Out of Scope <i>(what is explicitly excluded from the project)</i>
- In scope: T&O, Emergency Medicine, Urology, Obs and Gynae, and Paediatrics. - Out of scope: remaining services

Financial Impact and Target			
Total target savings (£'000)	FY26/27	FY27/28	FY 28/29
	No CIP opportunity for 26/27.		

Assumptions <i>(what we believe to be true, but is not yet confirmed)</i>
- Clinical teams engage constructively. - Clinical and operational ownership of outcomes. - Workstream team has capacity and necessary support to deliver (e.g. finance, workforce and performance information). - No major operational disruption that interferes with project - Joined-up decision making regarding interdependencies

Governance structure <i>(where will this report , where is decision making)</i>
This workstream reports to the Thriving Acute & Specialist Care Programme, as part of the Our Plan for Better Care.

Resource Requirements:
- BI and data analysis - Finance - Workforce

Dependency/Interdependencies <i>(what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)</i>
Interdependencies: - Living well in our Neighbourhoods Programme - Productivity including Best Practice workstream - Fragile Services workstream - Joined up care, every step of the way Programme - Caring skilled people ready for tomorrow Programme - Devon ICB Commissioning intentions - PASP / PwC system transformation

2.2 Improving Productivity

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Senior Responsible Owner:		Chief Operating Officer (COO)		24/05/2026		Torbay and South Devon NHS Foundation Trust	
Workstream Lead & Delivery Team:		Alan Welch – Workstream Lead COO, Care Group Directors, Director of Operational Finance, Finance Team, PMO, BI Team Clinical leads – To be nominated by Care Groups.		Required (Y/N)		How managed (consider whether at programme or workstream level)	
				EQIA			
				DPIA			
Workstream Objective (what we aim to achieve – clear, measurable goals)				Benefits and Expected Outcomes (value created when the objectives are achieved)			
1. Deliver a minimum 2% annual productivity improvement over the next three years (from 2026/27 to 2028/29), aligned with the NHS 10 Year Health Plan and Medium Term Planning Framework. 2. Deliver productivity improvement that supports delivery of the operational plan by addressing capacity gaps or supporting additional activity. 3. Deliver productivity improvements that support delivery of CIP and financial recovery i.e. real cash out financial improvement. 4. Support productivity improvement in specific areas including Theatres, Outpatients, Medical Staffing, Safer Staffing and coding				• Financial Sustainability: Achieve minimum 2% annual productivity gains • Operational Efficiency: Optimise pathways, reduce delays, and improve throughput. • Workforce Optimisation: Improved utilisation. • Quality of Care: Maintain safety and patient experience while improving efficiency. • Digital Transformation: Utilise automation and utilise AI capabilities. • Long-Term Sustainability: Embed improvements supported by productivity data and focus			
Objective	High-Level Deliverables (what we will produce to achieve the objective – key outputs) N.B. avoid listing tasks, deliverables should be strategic not operational			Lead (person responsible for completing the deliverable)		Target Date	
1, 2, 3, 4	Establish strong programme governance through defining objectives, scope, principles, and success measures, supported by a clear governance structure, delivery roadmap, and risk management framework. Clear cross cutting themes agreed e.g. theatre utilisation, outpatient efficiency.			Alan Welch		April 2026	
1, 2, 3, 4	Data Analysis - Develop data and analytical capability to support local understanding and development of national productivity metrics including Implied productivity metrics, productivity opportunity packs and other data (NCC, MHS)			Alan Welch		June 2026	
1, 2, 3, 4	Validation & engagement - Validate and prioritise improvement opportunities with clinical and operational teams. Provide tools and data insights, including benchmarking and ensuring consistency of approach across specialities.			Alan Welch		July 2026	
1, 2, 3, 4	Improve – work with clinical and operational teams to develop robust clinically led productivity improvement plans and ensure delivery of real improvements and monitor/tack successful delivery of benefits.			Deputy COO		Mar 2027	
1, 2, 3, 4	Reporting – develop improvement plan reporting and establish a productivity dashboard as part of formal reporting arrangements supported by the PMO. Enable monitoring of benefits			Alan Welch		July 2026	
4	Agree improvement priorities for each cross-cutting theme based on productivity opportunity, high -cost area and early learning from clinical service reviews			Deputy COO		June 2026	
4	Develop and deliver productivity improvement plan for Theatres, Outpatients, Medical Staffing, Safer Staffing and Coding			Deputy COO		March 2027	
Success Criteria (target state)		Core Key Performance Indicators (what measure tells us we're achieving the success criteria)		Financial Impact and Target		Additional Resource Requirements:	
Deliver minimum 2% productivity improvement		Implied productivity metric		Total target savings (£'000)		• Finance Support • BI support • Clinical leadership	
Improved position in national productivity opportunity data		Reduced opportunity indicating improvement in benchmarked costs		FY26/27		FY27/28	
SLR - fewer loss making specialities and/or reduced size of overall loss		SLR data		FY 28/29			
Key Risks (potential problems or events that could impact the project)		Score & RAG		Assumptions (what we believe to be true, but is not yet confirmed)		Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)	
Inadequate programme resources and technical sills				Trust operational plan 2026/27 will require productivity improvement beyond 2% Trust must develop more analysis, understanding, tools and techniques to support productivity improvement		Finance support – costing team BI support Operational/clinical team capacity COO and Director of Operational Finance participation Operational clinical team engagement	
Operational risks e.g. industrial action, clinical engagement				Governance structure (where will this project report , where is decision-making)			
Financial risks e.g. unexpected cost increases				• Report to Reimaging Acute & Specialist services programme Group • Additional ad hoc reporting to Executive Committee			
Out of Scope (what is explicitly excluded from the project)							
• Service Line Reporting is related but a separate piece of work • Clinical Service Reviews are related but separate Workstream							

2.3 Pathology

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24/05/2026

Senior Responsible Owner:	Chief Medical Officer (CMO) & Chief Nurse Officer (CNO)	Required (Y/N)	How managed (consider whether at programme or workstream level)
Workstream Lead & Delivery Team:	Ria McCoy – Workstream Lead AAbha Sharma – Clinical Lead	EQIA	
		DPIA	
Workstream Objective (<i>what we aim to achieve – clear, measurable goals</i>)		Benefits and Expected Outcomes (<i>value created when the objectives are achieved</i>)	
To design, approve, and implement an optimised, networked histopathology service model that enhances quality, resilience, and efficiency across the Peninsula		- Strengthens the resilience and sustainability of histopathology services across the network. - Improves quality, consistency and turnaround times through a coordinated operating model. - Enhances workforce flexibility and access to specialist expertise. - Delivers operational and financial efficiencies through better use of capacity, estates and digital infrastructure.	

Objective	High-Level Deliverables (<i>what we will produce to achieve the objective – key outputs</i>) N.B. avoid listing tasks, deliverables should be strategic not operational	Lead (person responsible for completing the deliverable)	Target Date
1	Relocation of Histopathology service	Ria McCoy/Aabha Sharma	August 2027
2	Working with RDUH on a Co-design of Cellular Pathology alongside the network Target Operating Model including Blood Sciences & Microbiology	Ria McCoy/Aabha Sharma	September 2026
3	Develop the 'Gadeon House' full business case and obtain Trust Board sign off	Ria McCoy/Aabha Sharma	August 2026
4	Implementation of full business case (if approved)	Ria McCoy/Aabha Sharma	December 2026

Success Criteria (<i>target state</i>)	Core Key Performance Indicators (<i>what measure tells us we're achieving the success criteria</i>)
Safe & effective relocation of service	Diagnostic Turnaround Times
Agreed Network Target Operating Model (TOM)	Workforce stability
Full Business case approval	Operational efficiency – utilisation aligned to expected performance levels
Business case implementation (if approved)	

Key Risks (<i>potential problems or events that could impact the project</i>)	Score & RAG
Workforce retention	
Service disruption during relocation – Turnaround times impacting performance	
Infrastructure & digital readiness could hinder safe transition or full implementation	

Financial Impact and Target			
Total target savings (£'000)	FY26/27	FY27/28	FY 28/29
	£0	£0	TBC

Assumptions (<i>what we believe to be true, but is not yet confirmed</i>)
- Partner organisations remained committed to the agreed TOM and implementation timelines - Funding identified within the full business case can be delivered - Sufficient staff remain in post to deliver services - Estates, equipment, digital systems will be delivered on time to support safe relocation - Supports faster diagnostics and improved patient pathways

Out of Scope (<i>what is explicitly excluded from the project</i>)
N/A

Resource Requirements:
- Project Management Support - Finance Team Support - Human Resources Support

Dependency/Interdependencies (<i>what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project</i>)
- Partner organisation commitment - Estates & digital readiness - Assurance of no negative impact on patient pathways

Governance structure (<i>where will this project report, where is decisionmaking</i>)
- Initial options appraisal to ExCo which will determine next steps - OPFBC

3.0 Joined Up Care, Every Step of the Way

Senior Responsible Owner – Kate Lissett, CMO

Supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout.

3.1 Pathway Review and Redesign

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OPFBC Oversight
24/05/2026

NHS
Torbay and South Devon
NHS Foundation Trust

Senior Responsible Owner:	Chief Medical Officer (CMO)
Workstream Lead & Delivery Team:	Workstream lead - Kenny Naughton (Planned Care); Lee Johns (MUEC) Clinical Lead – Deputy Medical Director/Associate Medical Director; Care Group Director of Nursing

Workstream Objective (<i>what we aim to achieve – clear, measurable goals</i>)
- To ensure identified clinical pathways are systematically reviewed and aligned to best practice evidence, with changes implemented where current provision falls short. - At the same time identifying and embedding appropriate preventative elements to improve patient outcomes, reduce avoidable demand and strengthen long-term sustainability. Prioritised pathways (High volume): MUEC – Gen Med: Chest Pain & Pulmonary Embolism; Cardiology: Atrial Fibrillation & N-terminal pro-B-type natriuretic peptide; Diabetes: Hyperglycaemia & Hypoglycaemia Pathways. Planned Care - Urology: Male bladder outflow surgery, Bladder cancer- One stop haematuria & Acute stones; Oral & Maxillofacial Surgery: Removal of wisdom teeth, impacted and buried teeth in adults; Ophthalmology: Glaucoma pathway; General Surgery: Laparoscopic cholecystectomy pathway

Required (Y/N)	How managed (consider whether at programme or workstream level)
EQIA	YES
DPIA	NO

Benefits and Expected Outcomes (<i>value created when the objectives are achieved</i>)
- Improved quality & consistency of care by aligning with best practice - Prevention will be strengthened through enhanced Waiting Well, self-management support and reablement, helping patients maintain health and avoid deterioration. - Better use of Advice & Guidance will reduce unnecessary referrals and appointments, easing demand on acute and specialist services. - Streamlined processes and clearer pathways will improve patient experience, enhance flow, and support more efficient use of workforce and resources.

Objective	High-Level Deliverables (<i>what we will produce to achieve the objective – key outputs</i>) <i>N.B avoid listing tasks, deliverables should be strategic not operational</i>	Lead (<i>person responsible for completing the deliverable</i>)	Target Date
1, 2	Establish project governance and resource including stakeholder map & engagement plan	CGD	End April 2026
1, 2	Identify priority pathways to confirm scope of workstream.	CGD/Clinical Leads	End April 2026
1	Best practice compliance assessment for prioritised pathways against GIRFT Pathways – to form a consolidated view of where existing pathways meet, partially meet or fall short of national best practice.	CGD/Clinical Leads	End May 2026
2	Preventative opportunities assessment – to review where prevention can be embedded into pathways, including waiting well interventions, self management support, proactive monitoring, early intervention, reablement, and optimisation of Advice & Guidance to reduce avoidable referrals	CGD/Clinical Leads	End June 2026
1,2	Redesigned future state pathway	CGD/Clinical Leads	Sept 2026
1,2	Prioritised implementation roadmap including training needs, communication plan, policy/SOP update, digital/system changes	CGD/Clinical Leads	Oct 2026

Success Criteria (<i>target state</i>)	Core Key Performance Indicators (<i>what measure tells us we're achieving the success criteria</i>)
Pathways fully aligned to best practice	% of pathways meeting best practice standards
Prevention embedded	Regret rate
Measurable improvements in outcomes & demand	Quality indicators

Key Risks (<i>potential problems or events that could impact the project</i>)	Score & RAG
Clinical engagement and adoption	
Capacity due to operational pressures & competing demands	

Out of Scope (<i>what is explicitly excluded from the project</i>)
This workstream is explicitly focused on the pathways identified. All other pathways are out of current scope.

Financial Impact and Target			
Total target savings (£'000)	FY26/27	FY27/28	FY 28/29
	N/A		

Assumptions (<i>what we believe to be true, but is not yet confirmed</i>)
- Required data (activity, performance, workforce, outcomes) will be available, reliable and accessible. - Community and reablement capacity will be sufficient to meet increased referrals or preventative work - Necessary funding, governance arrangements and decision-making structures will remain stable. - Operational pressures and external factors (e.g., policy changes, demand spikes) will remain within manageable limits

Resource Requirements:
- Improvement support – GIRFT analysis - PM delivery support

Dependency/Interdependencies (<i>what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project</i>)
- Wider system enablers – preventative services are available, - Quality data provision

Governance structure (<i>where will this project report, where is decision making</i>)
Pathway Review & Redesign Programme group

4.0 Smart use of technology for better care

Senior Responsible Owner – Sam Wadham-Sharpe, Interim COO

Supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout

4.1 Digital First Incorporating Maximising Artificial Intelligence

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24/05/2026

Senior Responsible Owner:	Chief Operating Officer (COO)	Required (Y/N)	How managed (consider whether at programme or workstream level)
Workstream Lead & Delivery Team:	Workstream Lead: Nick Peres (Programme Director, Digital Innovation & Transformation). Delivery Team: Digital Futures Hub developer team (Jett, David, Cayden, Jonathan); Clinical Lead (Jacqui); IT Services. Internal alignment:	EQIA	Yes Workstream level; individual EQIAs at Gateway 3 per AI deployment
Workstream Objective (<i>what we aim to achieve – clear, measurable goals</i>)		DPIA	Yes Individual DPIA and DTAC per AI tool; IG lite for lower-risk deployments; full DPIA for tools processing identifiable clinical data
- Establish AI-enabled appointment intelligence that matches appointment scheduling to patient transport access, postcode and mobility needs, reducing DNA rates and improving equitable access across the Trust footprint. - Evaluate and deploy AI scribe capability – assessing both the Solventum ambient AI solution and the Digital Futures in-house developed option – reducing clinician documentation burden and improving record accuracy in outpatient and community settings. - Deploy Microsoft Co-Pilot to all staff to reduce meeting, transcription and administrative burden, with structured training and adoption support through the Digital Skills Programme. - Embed AI for operational performance and service delivery intelligence, and offer patients genuine choice of consultation modality (virtual, telephone or in-person), improving experience and optimising clinical capacity. - Deliver a structured NHS App education and digital literacy programme through the floor walker and volunteer network, improving patient self-service, reducing avoidable contacts and supporting digital inclusion.		Benefits and Expected Outcomes (<i>value created when the objectives are achieved</i>)	
		- Smarter appointment scheduling matched to patient transport access and location needs, reducing avoidable did-not-attends across a dispersed rural and coastal population. - AI scribe and Co-Pilot deployment frees clinical and administrative time from documentation, transcription and meeting administration, returning capacity to patient-facing care. - Real-time AI-driven performance intelligence supports better resource decisions, and genuine consultation modality choice (virtual, telephone, in-person) improves patient experience and clinic utilisation. - Floor walker and volunteer programme improves patient familiarity with digital self-service tools, reducing avoidable contacts and supporting digital inclusion.	
Objective	High-Level Deliverables (<i>what we will produce to achieve the objective – key outputs</i>) <i>N.B avoid listing tasks, deliverables should be strategic not operational</i>	Lead (<i>person responsible for completing the deliverable</i>)	Target Date
1	AI appointment intelligence tool scoped with IT Services and outpatient teams; Epic integration pathway agreed; postcode and transport data linked to appointment scheduling workflow; pilot in two specialties.	Nick Peres / IT Services	Q2 2026/27
2	AI scribe evaluation completed (Solventum ambient AI vs in-house Digital Futures solution); deployment decision made and ratified by ISG; pilot live in two clinical areas with baseline documentation metrics captured.	Nick Peres / Developer team	Q3 2026/27
3	Co-Pilot deployed and active for 80% or more of staff; training programme delivered via Digital Skills Programme; administrative burden baseline and follow-up survey completed.	Nick Peres / IT Services / Digital Education team	Q3 2026/27
4	Consultation modality choice (virtual, telephone, in-person) embedded in at least two outpatient specialties; AI operational performance dashboard live.	Nick Peres / Operational leads	Q4 2026/27
5	NHS App floor walker programme formally launched; training materials and volunteer handbook developed; minimum 20 trained floor walkers active across TSDFT sites.	Nick Peres / Digital Skills team	Q2 2026/27
4	Scope further opportunities for AI & Emerging Technologies to further drive productivity	Nick Peres	Q2 2026/27

Success Criteria (target state)		Core Key Performance Indicators	Financial Impact and Target			Resource Requirements:	
Epic EPR go-live compression limits IT Services capacity for AI tool integrations, delaying DNA intelligence and AI scribe deployment. Mitigated by phasing EPIC-dependent tools to Q2-Q3 2026/27 and prioritising non-EPIC tools (Co-Pilot, floor walker programme) in Q1.		Staff adoption of AI tools (AI scribe, Co-Pilot) below anticipated levels due to insufficient change management capacity or digital confidence. Mitigated by embedding AI training within existing Digital Skills Programme and designating clinical and administrative champions per tool.	Total target savings (£'000)	FY26/27	FY27/28	FY 28/29	- Existing Digital Futures Hub developer team (Jett, David, Cayden, Jonathan): in-house AI scribe development and DNA appointment intelligence tool. - IT Services: Co-Pilot tenant configuration, EPIC integration for AI scribe and DNA tool; SLA to be agreed alongside EPR programme. - Microsoft NHS Co-Pilot licensing: deployment via NHS England national framework; licensing costs subject to organisational approval. - Clinical Lead: clinical safety oversight, DTAC and DPIA completion, and clinical champion coordination across all AI deployments. - Digital Skills Programme team: Co-Pilot and NHS App training delivery; floor walker volunteer coordination.
DNA rate reduced by 10–15% in pilot specialties using appointment intelligence tool by Q3 2026/27.		DNA rate per specialty per month via EPIC EPR; reported to outpatient transformation steering group.		£80k	Co-Pilot active for 80% or more of staff by Q4 2026/27; NHS App engagement improved in patient-facing areas.	Co-Pilot monthly active user rate; NHS App registration and usage rate in TSDFT cohort; floor walker contacts logged.	
AI scribe active in minimum two clinical areas by Q3 2026/27 with measurable reduction in documentation time.		Average documentation time per consultation (baseline and follow-up); clinical staff satisfaction score.	Assumptions (what we believe to be true, but is not yet confirmed)				
Key Risks (potential problems or events that could impact the project)		Score & RAG	- Microsoft NHS Co-Pilot licensing is available under the national NHS framework and can be activated within Year 1. - IT Services will engage constructively to provide Epic integration support for the DNA intelligence tool and AI scribe, phased around EPR go-live. - NHS England AI policy and governance guidance remains consistent and supportive of the planned AI deployments. - Clinical staff and administrative teams will engage with change management and training, supported by named departmental champions. - The in-house AI scribe solution is evaluated alongside off-the-shelf options before any deployment decision is made.				
Epic EPR go-live compression limits IT Services capacity for AI tool integrations, delaying the DNA appointment intelligence tool and AI scribe Epic integration. Mitigated by phasing EPIC-dependent deployments to Q2–Q3 2026/27 and prioritising non-Epic tools (Co-Pilot, floor walker programme) in Q1.		3×3 AMBER	Governance structure (where will this project report , where is decision making) One Devon EPR Implementation Steering Group (prior to establishment of BAU governance)				
IG Pathway / Cyber Security capacity is limited and pathway for quicker deployment needed.		3×3 AMBER					
Out of Scope (what is explicitly excluded from the project)			Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)				
Clinical diagnostic AI requiring MHRA regulatory approval (separate pathway supported through NHSE, not led by this workstream). AI tools not approved through the ISG Gateway process. Large commercial AI procurement without approved business case. AI research requiring full NHS ethics approval. General IT infrastructure upgrades (IT Services BAU).							
			IT Services BAU capacity and EPIC EPR go-live planning. Microsoft NHS licensing approval and tenant configuration. ISG governance framework: DTAC, DPIA and clinical safety review per AI tool. NHS England AI policy guidance. Digital Skills Programme capacity for Co-Pilot and NHS App training. Outpatient Transformation Steering Group for DNA tool and consultation modality pilots.				

4.2 Epic Implementation & Benefits, including MY CARE

Date Plan on Page Approved by OPFBC Oversight
24/05/2026

Senior Responsible Owner:		Chief Operating Officer (COO)		Required (Y/N)		How managed (consider whether at programme or workstream level)		
Workstream Lead & Delivery Team:		Kevin Pirie – Workstream Lead / Guy Boosey – Delivery Lead Mark Tucker – Associate Director Project Finance Mike Green / Joanne Watson – Clinical Leads Toby Joseph – PMO Support		EQIA		No		
				DPIA		No		
Workstream Objective (what we aim to achieve – clear, measurable goals)				Benefits and Expected Outcomes (value created when the objectives are achieved)				
- Create a single integrated patient record accessible across the One Devon footprint supporting clinical and operational transformation, and standardising processes and pathways on best practice models - Improve the quality and safety of patient care through accurate, complete patient information, enabling better clinical decisions and safer care. - Create digital foundations to deliver clinical and operational transformation across Devon. This will enhance efficiency and productivity, streamline workflows, support data collection for audit, research, reporting and performance monitoring. - Benefits realisation, including a high level of adoption of the MY CARE app				- Trust-wide and system-wide transformation of clinical and operational services - Cash releasing benefits (transactional and transformational) - Non-cash releasing benefits (efficiency gains) - Adoption of MY CARE - access to health information, reduced paper and environmental impact, easy management of appointments, access to test results, improved communication and care coordination				
Objective	High-Level Deliverables (what we will produce to achieve the objective – key outputs) N.B avoid listing tasks, deliverables should be strategic not operational					Lead (person responsible for completing the deliverable)	Target Date	
1	Stabilisation of Epic within TSD – activity meeting or exceeding pre-Epic levels					Kevin / Guy	03/07/2026	
2	Recovery of patient activity numbers lost due to reductions over go-live period					Care Group Directors	31/03/2027	
3	Fully populated benefit realisation plans that reflect the ambitions of the FBC and capture emergent benefits					Guy / PMO	03/07/2026	
4	Cash releasing and non-cash releasing benefits on track or exceeding planned delivery					Guy / Care Group Directors	31/03/2027	
5	MY CARE adoption to exceed 50,000 users onboarded within the first year					Guy / Care Group Directors	31/03/2027	
Success Criteria (target state)		Core Key Performance Indicators (what measure tells us we're achieving the success criteria)		Financial Impact and Target				
Quality & Safety indicators		Reduction in documentation-related clinical incidents Reduction in medication errors		Total target savings (£'000)		FY26/27	FY27/28	FY 28/29
Operational Performance		Epic dashboards – various metrics		£5,842 (excl System wide per below)		£3,870		£3,123
Patient & staff experience		Staff survey Friends and Family Test		Assumptions (what we believe to be true, but is not yet confirmed)				
Cash-releasing benefits achieved		Financial reporting		- Organisation readiness with Care Group support - Epic stabilisation and optimisation remains on track - Staff engagement and training - System-wide transformation initiatives and delivery plans are in place				
Non-cash releasing benefits achieved		Tracking through the Benefits Register		Out of Scope (what is explicitly excluded from the project)				
Key Risks (potential problems or events that could impact the project)		Score & RAG		System-wide benefits are excluded, as they are not something that TSD Epic Team can control.				
Benefits are not realised as per the business case		Initial 12 Mitigated 6		Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)				
System-wide transformation initiatives do not deliver benefits		Initial 16 Mitigated 6		- UHP engagement and implementation - RDUH technical support and development roadmap - Epic - TOM				
MY Care adoption does not meet targets		Initial 12 Mitigated 4		Governance structure (where will this project report, where is decision making)				
				- One Devon EPR Implementation Steering Group (second Wednesday of the month) - RDUH are leading on the development of a One Devon BAU structure				

5.0 Caring skilled people ready for tomorrow

Senior Responsible Owner – Jess Piper, CPO

Creating a great place to work, supporting people to be their best selves, and building an agile, inclusive workforce for the future

5.1 Workforce Transformation

Senior Responsible Owner:		Chief People Officer (CPO)		Required (Y/N)		How managed (consider whether at programme or workstream level)	
Workstream Lead & Delivery Team:		Kelly Ebdon-Marks – Workstream lead Nicola McMinn – Clinical Lead		EQIA		YES	
				DPIA		YES	
Workstream Objective (what we aim to achieve – clear, measurable goals)				Benefits and Expected Outcomes (value created when the objectives are achieved)			
1. Implement organisational redesign to ensure the right workforce model Lead Trust-wide organisational and management reviews, covering executive, corporate and operational structures, together with a comprehensive establishment review, to ensure the Trust has the right people, skills, capacity and leadership structures in place to deliver its strategic objectives, operational priorities and financial plans. 2. Improve workforce productivity and modernise people services Improve workforce productivity and staff experience by delivering the People Digital Programme and implementing a modern, efficient, and user-centred People Services operating model, aligned with regional and system priorities.				Improved financial sustainability through delivery of workforce efficiencies, reduction in temporary staffing costs, and direct support to the Trust's Operational Plan and CIP. A more productive and efficient workforce by ensuring the right people, skills, capacity and leadership structures are in place, alongside improved and more consistent rostering practices across the Trust. Modernised and more responsive People Services through delivery of the People Digital Programme and the implementation of a future-focused, digitally enabled People Services model that better supports managers and staff.			
Objective	High-Level Deliverables (what we will produce to achieve the objective – key outputs) N.B. avoid listing tasks, deliverables should be strategic not operational					Lead (person responsible for completing the deliverable)	Target Date
2	To co-design the One Devon Shared Service Pension & Payroll service that delivers a consistent, efficient, and user-centred service model, ensuring improved processes, seamless integration across partners, and a strong foundation for future operational excellence.					Associate Director of People Experience	March 27
1	Undertake a trust wide management review of executive, corporate, and operational structures to design and implement a clear, sustainable organisational model, strengthen leadership and governance, and establish the methodology required to deliver effective, phased, and financially sustainable organisational change.					Associate Director of People Experience	November 27
2	Deliver the People Digital Programme milestones and develop a future People Services operating model aligned to regional and system priorities, improving digital capability, workforce productivity and the efficiency and responsiveness of People Services for managers and staff.					Associate Director of Business Services	March 27
Success Criteria (target state)		Core Key Performance Indicators (what measure tells us we're achieving the success criteria)		Financial Impact and Target		Resource Requirements:	
Organisation-wide establishment review completed		CIP workforce reductions delivered		Total target savings (£'000)		New People Structure to support delivery ensuring we have the right capacity and capability.	
People Digital programme delivered		CIP target attached - ?11WTE TBC		FY26/27		Additional ER capacity to support consultation to achieve deliverables. This is commissioning CSU.	
One Devon Shared Service Pension & Payroll Services		TUPE completion, seamless transition		FY27/28		PMO support.	
				FY 28/29		Comms and Engagement Support.	
				Assumptions (what we believe to be true, but is not yet confirmed)			
				New People Structure is completed in sufficient time to support and we have the right people in post with sufficient specialist capacity			
				Agreed funding remains in place for People Digital Programme			
				Operational engagement and line manager compliance			
				Out of Scope (what is explicitly excluded from the project)			
				None identified.			
				Governance structure (where will this project report , where is decision making)			
				People and Education Governance Group (PEGG) and QPC			
Key Risks (potential problems or events that could impact the project)		Score & RAG				Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)	
Org change programmes not delivered to plan						Staff side engagement.	
Workforce engagement and staff morale						Delivery of People digital is reliant on regional priorities and engagement	
Insufficient uptake of the VR Scheme						Workforce data.	
Delays in delivering the People Digital Programme						One Devon system	
						Digital Team Support	

5.2 Cultural Transformation

Date Plan on Page Approved by OPFBC Oversight
24/05/2026

Senior Responsible Owner:		Chief People Officer (CPO)		24/05/2026		Iorbay and South Devon NHS Foundation Trust	
Workstream Lead & Delivery Team:		Laura Fuller – Workstream lead Nicola McMinn – Clinical Lead		Required (Y/N)		How managed (consider whether at programme or workstream level)	
				EQIA	YES		
				DPIA	NO		
Workstream Objective (what we aim to achieve – clear, measurable goals)				Benefits and Expected Outcomes (value created when the objectives are achieved)			
1. Improve Trust overall culture and our People's experience through the delivery of the Culture Plan including the implementation; - of a just and learning culture approach - of a health and wellbeing programme which focuses upon prevention and support				• Better Workforce Health & Engagement – Reduced sickness, improved retention, and stronger morale.			
2. Promote inclusivity and empower staff to actively contribute to and lead organisational change.				• Positive Culture & Fairness – Embedding just and learning principles for trust and transparency.			
3. Strengthen workforce capability by attracting, developing, and retaining talent through innovative and flexible career pathways.				• Future-Ready Skills & Talent – Building capability in leadership, digital, and community roles.			
4. Establish and uphold clear organisational standards, with leaders consistently demonstrating values-driven behaviours.				• Stronger Leadership Impact – Leaders equipped to drive safe, compassionate care and team wellbeing.			
				• Compliance & Risk Reduction – Updated policies and governance frameworks ensuring safety and assurance.			
				• Cost & Productivity Gains – Lower absence costs, improved efficiency, and better resource utilisation			
				• Patient safety – Improvement in patient experience and outcome			

Objective	High-Level Deliverables (what we will produce to achieve the objective – key outputs) N.B. avoid listing tasks, deliverables should be strategic not operational	Lead (person responsible for completing the deliverable)	Target Date
1	Implement and embed a comprehensive wellbeing programme that co-designs a wellbeing strategy, introduces a new health and wellbeing offer, and ensures consistent management of sickness across Devon to reduce absence, improve retention, and enhance workforce performance	AD/DD People Development	30 th September 2026
1	Implement a Just and learning culture approach through; a review and revision of key Employee Relation policies (Disciplinary, Grievance, Bullying & Harassment, Attendance Management) to embed a just and learning approach, at the same time as standardising policies and their implementation across Devon wherever possible; roll out of Just & learning training and education.	Head of People Experience	31 st March 2027
3,4	Design & launch a Learning Academy that builds organisational capability by attracting and developing talent for future roles—including preventative, community, and digital positions—while providing focused programmes in leadership, improvement, and digital skills to drive transformation and sustainability	Head of People Development	31 st Dec 2026
2,3,4	Design, implement, and embed a renewed Leadership and Management Development Programme aligned to the national framework, equipping leaders with the skills and behaviours needed to foster a positive working environment and deliver safe, effective, and compassionate care	Head of People Development	Awaiting publication of National L&M competency framework (Delayed from March 26)
All	Remodel of people and education services and structure to ensure the people and education directorate delivers excellence, is fit for future and meets the demands of the organisation.	CPO	30 th September 2026

Success Criteria (target state)	Core Key Performance Indicators (what measure tells us we're achieving the success criteria)	Financial Impact and Target				Resource Requirements:
Health & Wellbeing programme delivering demonstratable improvement	£1m reduction (captured in Temp Staffing) Across 2 years only if investment is secured	Total target savings (£'000)	FY26/27	FY27/28	FY 28/29	• Wellbeing investment to provide targeted support to reduce sickness absence rates
Policy compliance	100% compliance- current stat 46%		1,000 (temp staffing)			Assumptions (what we believe to be true, but is not yet confirmed)
Staff engagement	45% response rate for Staff Survey (2027)	Key Risks (potential problems or events that could impact the project)				• Timely appointment of deliverable leads as part of People & Education Restructure
Recommend as a Place to Work	66% Staff Survey; 66% People Pulse	Ability to support the organisation transform its learning culture. Cause: Current policies and process are not aligned to the organisational ambitions of a just and restorative learning culture. Consequence: Increased dissatisfaction from staff contributing to a negative blame culture. People feeling unsafe to speak up and/or feeling a sense of it is not meaningful to do so. And an organisation which does not learn from previous incidents leading to repetition and risk of moral, psychological and physical injury.				Score & RAG
Culture plan delivered	90% Retention 81% Stability					• Staff to be released to participate in J&L training
Out of Scope (what is explicitly excluded from the project)						Dependency/Interdependencies (what tasks, deliverables, or teams are we reliant upon to complete our work-or are reliant on this project)
• Merged occupational health provision across Devon system		Rejection of wellbeing investment proposal £250k				• Leadership and Management national framework to be launched
						• Wellbeing investment & successful recruitment of Preventative Health Check Clinical Practitioner
						Governance structure (where will this project report , where is decision making)
						• People and Education Governance Gorup (PEGG) and QPC

6.0 Strategic Enablers

Senior Responsible Owner – James Corrigan, CFO

Securing the essential foundations for transformation

6.1 One Devon Shared Services - Finance

Date Plan on Page Approved by
OPFBC Oversight
24/05/2026

Senior Responsible Owner:	Chief Finance Officer (CFO)	Required (Y/N)	How managed (consider whether at programme or workstream level)
Workstream Lead & Delivery Team:	Andrea Wright and Kerry Jenkinson	EQIA	Y Completed by One Devon System
		DPIA	Y Completed by One Devon System
Workstream Objective (<i>what we aim to achieve – clear, measurable goals</i>)		Benefits and Expected Outcomes (<i>value created when the objectives are achieved</i>)	
To develop and implement a localised plan for shared finance services in Torbay and South Devon NHS Foundation Trust (TSDFT) aligned to the wider One Devon Shared Services model, with a focus on: - Develop a shared Finance service model including AP, AR, GL, Cash Management, VAT, Payroll, and Costing. - Deliver efficiencies, improve resilience, and support integrated working across the ICS. - Engage stakeholders and staff to co-design effective and sustainable services.		- Streamlined and consistent corporate processes across Devon. - Economies of scale due to reduced duplication. - Reduced costs due to a single system.	

Objective	High-Level Deliverables (<i>what we will produce to achieve the objective – key outputs</i>) N.B. avoid listing tasks, deliverables should be strategic not operational	Lead (<i>person responsible for completing the deliverable</i>)	Target Date
1	Finance operating model finalised – clarity on retained, transferred, and redefined roles	Kerry Jenkinson	01/01/2027
2	Launch and operationalise the new Finance Target Operating Model (FTOM) foundations:	Kerry Jenkinson	01/01/2027
3	Local implementation plan aligned with ICS-level programme and signed off by Trust executive.	Kerry Jenkinson	01/10/2026
4	System configuration & testing support provided to NHS SBS from Torbay representatives	Kerry Jenkinson	30/06/2026
5	TUPE Consultation and process completed for impacted Torbay finance staff	Kerry Jenkinson	01/01/2027
6	Training and change readiness activities rolled out to all relevant staff	Kerry Jenkinson	30/06/2026
7	Post-Implementation support plan prepared for local deployment from April 2026	Kerry Jenkinson	31/12/2026

Success Criteria (<i>target state</i>)	Core Key Performance Indicators (<i>what measure tell achieving the success criteria</i>)
Safe & effective Tupe of service	Workforce stability
Agreed Network Target Operating Model (TOM)	Monitoring to ensure benefits realisation is achieved.

Key Risks (<i>potential problems or events that could impact the project</i>)	Score & RAG
Staff anxiety or turnover and insufficient time for local change activities	12
Insufficient capacity to deliver change alongside BAU	6
Slow decision-making causes delay to implement Finance Target Operating Model (FTOM).	6
Inconsistent policy implementation across Trusts	6
Board not approving FTOM and One Devon Collaborative Corporate Services (“CCS”)	6
There is a high likelihood that some or all of the treasury staff who have been notified that their roles are likely to become redundant will look for a new role.	16
Finance system failure due to the lack of IT support from Unit 4.	12

Financial Impact and Target			
Total target savings (£'000)	FY26/27	FY27/28	FY 28/29
	0	0	0

Assumptions (<i>what we believe to be true, but is not yet confirmed</i>)
- Partner organisations remained committed to the agreed TOM and implementation timelines - Funding identified within the full business case can be delivered - Sufficient staff remain in post to deliver services - Estates, equipment, digital systems will be delivered on time to support Tupe

Resource Requirements:
- Finance staff to work on specific task and finish groups when required - HR person assigned to work with staff on Tupe consultation - IT staff to work with SBS to ensure compliance with trust systems - Information Governance

Out of Scope (<i>what is explicitly excluded from the project</i>)
- Legal Services - Estates & Facilities Management

Governance structure (<i>where will this project report, where is decision-making</i>)
- SBS Programme Board - Finance & Performance Committee - OPFBC Board

Dependency/Interdependencies (<i>what tasks, deliverables, or teams are we reliant on this project</i>)
- Other Devon NHS trusts - Devon ICB - Implementation of SBS - People directorate - Staffside - OPFBC Leadership, Finance and People programmes



Torbay & South Devon NHS Foundation Trust

Final Internal Audit Report: Our Plan for Better Care - Part 1: Governance

Report Reference: TSD36/26
February 2026

Distribution List (for action):

- Jenny Shepherd, Head of PMO
- Simon Tapley, Chief Strategy & Planning Officer
- Emily Long, Director of Corporate Governance & Trust Secretary
- James Corrigan, Chief Finance Officer

Additional Copies (final report, for information):

- Joe Teape, Chief Executive Officer
- Grant Thornton, External Audit

Assurance Opinion: Control Design	
Significant	
Satisfactory	
Limited	
No	



Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the 2025/26 Audit and Assurance Plan, as agreed by the Audit and Risk Committee, we were requested to undertake a review of Our Plan for Better Care - Part 1: Governance.

The Trust has been in a significantly challenged position over recent years which resulted in it being placed under intensive support and oversight (NOF4) by its regulator, NHS England. It was recognised that an improvement plan was needed to consolidate existing plans into one overarching plan which would address the key challenges the Trust has been facing around finance, performance and quality.

An Integrated Improvement Plan (IIP) was initially developed in Quarter 4 2024/25 and approved by the Trust Board of Directors in March 2025. The IIP was designed to draw together all the individual pieces of work that were already being undertaken into a single document. It was created to give a clear line of sight of the development and execution of a single, comprehensive plan for Trust recovery and exit from NOF4 and used to assure and brief regulators and external partners.

The IIP was refreshed into the 'Our Plan for Better Care' (OPFBC) and was presented to the Trust Board in May 2025. The OPFBC is intended to have well defined, time bounded actions that are measurable and achievable allowing the Trust to improve its financial position, performance and quality. The OPFBC is to be delivered across three phases:

- Phase 1: Stabilising – April 2025 to March 2026.
- Phase 2: Performing – April 2026 to March 2027.
- Phase 3: Transforming – April 2027 onwards.

The OPFBC is structured across five Domains (programmes of improvement): Leadership, Strategy, Performance, Finance and People. Each Domain has defined Workstreams designed to meet the objective for the Domain. The progress of each of the Workstreams is currently being reported to the Trust Board on a monthly basis.



Objectives and Scope of the Audit

The overall objective was to confirm that the Trust has appropriate governance arrangements in place around the OPFBC.

We reviewed the governance arrangements put in place to support the creation and management of the OPFBC, and determined the adequacy of the design and operation of these arrangements in consideration of the following:

- The OPFBC has been created to include actions arising from existing plans both internal to the Trust, and as part of the wider system (for example, local NHSE CIP Review, One Devon Shared Services programme, Peninsula Acute Sustainability Programme, EY Well Led Review).
- An Oversight Group with appropriate Executive-level membership has been created to oversee the OPFBC and is supported by agreed Terms of Reference.
- Domains (programmes of improvement) and Workstreams (projects) within each Domain have been agreed, and Executive Senior Responsible Owners (SRO) and Workstream Leads have been appointed.
- Individual Workstreams each have identified Project Management Office (PMO) support, agreed Delivery Plans and “Plan on a Page (PoP)” and identified key deliverables and KPIs, ratified by the OPFBC Oversight Group.
- A defined Workstream risk management process is in place, which includes the agreement of risk appetites.
- A structured reporting regime, including highlight reports to the OPFBC Oversight Group and summary reporting to Board (including performance linked to agreed KPIs) is in place and consistently observed.
- A process to define Workstream assurance RAG ratings is in place and is consistently applied by Executive SROs.
- A process to assure the ongoing progress of Workstreams is in place and consistently observed.
- A process to agree the completion and closure of individual Workstreams is in place.

OVERALL CONCLUSION

The OPFBC provides a comprehensive, well defined, detailed plan to manage a diverse and complex range of key programmes of work and the associated projects, captured as Workstreams. The OPFBC’s foundation is structured around a suite of tools and documentation provided by the NHSE Recovery Support Programme (RSP) and includes clear, agreed key deliverables and key performance indicators (KPIs) for the Workstreams. Accountability is clear throughout, and robust mechanisms for reporting, scrutiny and oversight, escalation and risk management are in place. Key processes and controls are well defined and consistently operated.

Overall, there is strong corporate level oversight of programmes of work being undertaken to improve the Trust’s financial position, performance and quality with a clear monthly cycle of business reporting to the Oversight Group and the Board.



We identified a system design weakness around the availability of assuring evidence to support declared performance, which is not currently being consistently provided. This was discussed with PMO leadership and is a recognised area for improvement. We have raised a moderate risk recommendation on this topic, and three further low risk recommendations relating to minor administrative matters.

Our overall conclusion is supported by the conclusion for each area reviewed, as set out below:

Area reviewed	Rating	Conclusion
1. Plan Creation		The OPFBC was created to include existing plans, actions and programmes of work internal to the Trust, external reports provided to the Trust, and as part of the wider system. We were able to map the content of the OPFBC to key local and system priorities, including the Trust's 2025/26 BAF Objectives, NOF 4 Exit Criteria and the EY Developmental Well-led Review.
2. Oversight Group		The OPFBC Oversight Group provides Executive Director level overview of progress of the overall plan. Terms of Reference exist, with appropriate membership including Workstream and PMO representation. Meetings were held as planned, except for three meetings, one in December and two in January 2026 which were stood down due to competing operational priorities. Standing Agendas are used for each meeting, with updates from the PMO and Highlight Reports from each Workstream within the relevant Domains being reviewed. Overall, the governance arrangements set up provide opportunity for check and challenge by Executive Directors and ensure there is suitable corporate level oversight of programmes of work being undertaken to improve operational performance across the Trust. Some minor updates to the Terms of Reference upon next review would ensure that it reflects current working practice.
3. Domain and Workstream Leadership		There is appropriate Executive Director oversight for each of the five Domains. Nominated individuals have been appointed as Workstream Leads (also referred to as Programme Director/Programme Manager) for each of the separate programmes of work within each Domain with other named individuals in supporting roles. Consistency in role titles for individuals across programme documentation would enable greater clarity from a documentation perspective only.
4. Project Management		Appropriate project management arrangements are in place for each Workstream within each Domain. Required project documentation has been completed, with individual Workstream plans (PoPs) approved by the Oversight Group (one Workstream plan remains under discussion to agree key deliverables). A monthly cycle of business is in place with scheduled reporting to the Oversight Group for each Workstream, and monthly meetings between Workstream Leads and the respective PMO representatives.



Area reviewed	Rating	Conclusion
5. Risk Management		There is a structured process in place, defined within a PMO guidance document for the management of the programme risks which is working well, with risks being regularly reviewed and updated by Workstream Leads and presented to the Oversight Group as part of the monthly reporting process. Risk scoring is aligned to the Trust's risk scoring matrix. The full IIP Risk Register was stood up in October 2025 following a review of existing risks to ensure that only current risks with appropriate scoring were included. It is taken to the Oversight Group each month as part of the individual Highlight Reports, rather than as a whole document. The Head of PMO produces a monthly report which is presented to the Oversight Group. This report informs a monthly summary position to Trust Board, covering movement on risks together with the highest risks to delivery (20+risks) within the programme at that moment in time. We confirmed that there is a clear alignment between the individual Domains and their associated workstreams and the BAF Objectives and Supporting Objectives, with Supporting Objective 5.1 on the BAF specifically in relation to the creation and work of the OPFBC.
6. Reporting		There is a robust and comprehensive reporting process operating which sees detailed Workstream Highlight Reports being prepared, reviewed and presented at Oversight Group and in a condensed form to the Trust Board. These reports have had SRO scrutiny to ensure suitable accountability for delivery of the plan. In addition to the Workstream Highlight Reports, the PMO provides to the Trust Board a comprehensive report summarising the current position on a number of topics including performance/delivery, risk and CIP. The Board has opportunity to understand and challenge the latest position and associated actions in relation to the OPFBC programme. There is a well-structured escalation process in place for Workstream Leads/SROs to escalate matters to the Oversight Group. Escalations are captured in Workstream Highlight Reports, and actions agreed/decisions taken are documented (either in the Oversight Group Action Log or Decision Log, or in the Change Log within the relevant Domain's Programme Workbook). We noted that escalations included requests to extend deadlines/completion dates for agreed key deliverables. Assurance reporting to Board includes commentary on Workstream achievements to date in a section titled "Delivered", but does not include a list of all agreed key deliverables or their deadlines/completion dates. As such, there is no visibility at Board level of any changes to originally agreed schedules of delivery. Although this information is available at Oversight Group, inclusion at Board level may improve the context of the reported position.



Area reviewed	Rating	Conclusion
7. Workstream Assurance RAG Ratings		The OPFBC has agreed a set of criteria to define Workstream assurance RAG ratings which link directly to performance against the key deliverables and KPIs. We confirmed that Workstream assurance RAG ratings are consistently applied, in line with the agreed OPFBC assurance definitions.
8. Assuring Progress		Information around the progress of Workstreams and performance against key deliverables and KPIs is provided by Workstream Leads and discussed with the respective PMO representative at their monthly meetings. We noted that evidence to support reported performance is not routinely provided by, or retained for, all Workstreams. The lack of relevant supporting evidence to assure declared progress and performance risks inconsistencies or inaccuracies that may not be identified, and the potential for any such errors to be included in Board reporting. This is a known system weakness, and PMO leadership has identified this a development area to improve the management of the OPFBC as the plan and system matures.
9. Closure of Workstreams		There is an appropriate Workstream closure process in place, with approval to close to be granted by the Oversight Group, and reported to Board. This process is not explicitly captured either as a standalone process or within the Terms of Reference for the Oversight Group and should be formally documented and shared with Workstream Leads and PMO staff for clarity.

Overall Assurance Opinion

It is our view that the overall assurance opinion on the design of controls is **Significant** as recorded in the table on the face of this report and in accordance with the opinion definitions under the *ASW Assurance - About Us* section of this report.

We would like to acknowledge the help and assistance given by the Head of PMO and the Chief of Staff to the Chief Executive during 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	26 November 2025
Date of Issue of Draft Report	29 January 2026
Date of Return of Draft Report	9 February 2026
Date of Approval of Final Report	10 February 2026
Lead Auditors	Angela Tucker (Audit & Assurance Manager- Specialist Services); Russell Scarbro (Senior Audit and Assurance Specialist)
Client Lead Manager(s)	Jenny Shepherd, Head of PMO
Client Lead Directors	Emily Long, Director of Corporate Governance and Trust Secretary, Simon Tapley, Chief Strategy and Planning Officer
Governance/Regulatory Links	NHSE Regulatory Requirements



Action Plan

Unique ID*	Recommendation	Risk rating	Agree/disagree	Management action (SMART)	Evidence required to close action	Action lead/manager responsible	Action date
1755	The Terms of Reference for the OPFBC Oversight Group should be amended to reflect current working practice relating to: 1. minute taking requirements. 2. accountability and reporting. When being updated, the current Master Terms of Reference Template should be used, available on the Corporate pages of ICON, and once approved uploaded in line with current contents of the existing document, if this remains a requirement.	Low (4)	Agree	To update Terms of Reference and publish on ICON.	Published updated Terms of Reference.	Emily Long, Director of Corporate Governance and Trust Secretary	31/03/26
1795	The Trust should consider the inclusion of information regarding the agreed extension of target completion dates within OPFBC Workstream assurance reporting to the Trust Board.	Low (4)	Agree	1. Monthly Head of PMO report to include the number of deliverables that are subject to date changes. 2. Board report to summarise number of deliverables subject to date changes.	1. Updated monthly Head of PMO report. 2. Updated Board report.	Jenny Shepherd, Head of PMO	31/03/26



1791	Evidence should be provided to the PMO team by Workstream Leads to support declared progress and performance against agreed OPFBC key deliverables and KPIs.	Moderate (9)	Agree	1. Incorporate 'Evidence' section within the Workstream lead guidance - writing quality highlight report document. 2. Incorporate 'Evidence' section within IIP Handbook including dispute escalation process. 3. Develop training session & resources for PMO team on quality evidence.	1. Updated workstream lead guidance that is published. 2. Published IIP handbook. 3. PMO training session completed.	Jenny Shepherd, Head of PMO	31/03/26
1792	The process for requesting and approving the closure of Workstreams should be documented, and shared with relevant postholders including Workstream Leads and PMO staff.	Low (4)	Agree	To incorporate closure process into IIP Handbook and circulate to all workstream leads and published on ICON.	Published IIP handbook.	Jenny Shepherd, Head of PMO	31/03/26

* Recommendation Unique ID is generated by our K10 Vision Audit Management System so these may not appear in consecutive order.



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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.



Overall Assurance Opinion Definition

The overall assurance opinion on the front page of this report is based on the following definitions:

Significant	Controls are well designed and are applied consistently. 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	Controls are generally sound and operating effectively. 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	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	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.

Rating of Individual Findings

The following ratings have been used to summarise our evaluation of each area reviewed and helps form our overall assurance opinion:

	Processes are appropriately designed and appear to be operating well. Any areas for improvement that were identified are not significant and are unlikely to reoccur.
	Controls and arrangements are generally appropriately designed working well but we have identified areas where these arrangements should be further strengthened. We do not have significant concerns regarding this area and any issues that were identified are unlikely to reoccur if properly managed.
	Urgent action is needed to address weaknesses in the processes which are in place to manage the task or function. We have significant concerns regarding this area and consider that issues may arise or reoccur.



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Torbay and South Devon NHS Foundation Trust

Final Internal Audit Report: Our Plan for Better Care: Part 2 – Performance Assurance

Report Reference: TSD39/26
April 2026

Distribution List (for action):

- Jenny Shepherd, Head of PMO
- Simon Tapley, Chief Strategy and Planning Officer

Additional Copies (final report, for information):

- Cath Parnell, Chief of Staff to the Chief Executive
- Joe Teape, Chief Executive
- Grant Thornton, External Auditors

Assurance Opinion	
Significant	☒
Satisfactory	☐
Limited	☐
No	☐



Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the 2025/26 Audit and Assurance Plan, we have undertaken a Part 2 review of the Trust's key improvement programme, Our Plan for Better Care (OPFBC). This review focused on the Trust's arrangements for assuring reported performance and the closure of Workstreams.

OPFBC was created as an Integrated Improvement Plan (IIP), designed to consolidate existing plans into one overarching plan, which would address the key challenges the Trust has been facing around finance, performance and quality, and support the Trust's exit from NOF4. NHS Oversight Framework (NOF) is the system used by NHS England to monitor the performance, quality, and financial sustainability of NHS trusts and integrated care boards.

The OPFBC is structured across five Domains (programmes of improvement): Leadership, Strategy, Performance, Finance and People. Each Domain has defined Workstreams designed to meet the objective for the Domain. The OPFBC was presented to the Trust Board in May 2025, and was designed to be delivered across three phases:

- Phase 1: Stabilising – April 2025 to March 2026.
- Phase 2: Performing – April 2026 to March 2027.
- Phase 3: Transforming – April 2027 onwards.

We published our Part 1 review of the OPFBC in February 2026, which focused on the Trust's governance arrangements for the management and delivery of the plan. This review provided a Significant Assurance Opinion on the design of the plan's governance arrangements, but identified a system design weakness around the routine provision of evidence to support declared performance, which the Trust recognised as an area for improvement.

Objectives and Scope of the Audit

The overall objective of this review was to examine the evidence available to support the following, and assess its suitability for assurance purposes:

- Reported performance against deliverables and Key Performance Indicators (KPI) within individual Workstreams.
- The closure of individual Workstreams within the Domains of the OPFBC.



OVERALL CONCLUSION

We confirmed that the performance reported to the OPFBC Oversight Group in February 2026 was accurate and we obtained relevant assuring evidence to demonstrate this for each of the ten deliverables and KPIs that we reviewed.

One Workstream had been closed at the time of our review. This Workstream was only closed after correctly observing the relevant closure request and approval processes. We also confirmed that the reported completion, or transfer, of each of the relevant deliverables was accurate and we obtained relevant assuring evidence to demonstrate this for all of the deliverables in this closed Workstream.

Our overall conclusion is supported by the conclusion for each area reviewed, as set out below:

Area reviewed	Rating	Conclusion
Reported performance against deliverables and KPIs		We reviewed a random sample of ten deliverables and KPIs within individual Workstreams, across all five Domains of the OPFBC (Leadership, Performance, Strategy, Finance and People), and confirmed that evidence was held by the Trust to demonstrate that the performance reported to the OPFBC Oversight Group in February 2026 was accurate.
Closure of Workstreams		Workstream 1.2 (Well-Led) was formally approved for closure by the OPFBC Oversight Group in October 2025, upon the receipt and review of a duly completed Workstream Closure Report. The Group’s approval to close Workstream 1.2 was captured in the relevant Action Log’s Decision Record. We reviewed each deliverable within Workstream 1.2 and confirmed that evidence was held by the Trust to demonstrate that the position reported to the OPFBC Oversight Group in October 2025 (ten actions complete, and one action transferred to a different Workstream) was accurate.

Overall Assurance Opinion

It is our view that the overall assurance opinion on the design and operation of controls is **Significant** as recorded in the table on the face of this report and in accordance with the opinion definitions under the *ASW Assurance - About Us* section of this report.



We would like to acknowledge the help and assistance given by the Head of PMO and Chief of Staff to the Chief Executive during the course of this review.

Rating of Recommendations

No recommendations have been raised in this report.

Report Data

Date of Work Undertaken	March to April 2026
Date of Issue of Draft Report	9 April 2026
Date of Return of Draft Report	10 April 2026
Date of Approval of Final Report	16 April 2026
Lead Auditor	Russell Scarbro, Senior Audit and Assurance Specialist
Client Lead Manager(s)	Jenny Shepherd, Head of PMO
Client Lead Director	Simon Tapley, Chief Strategy and Planning Officer
Governance/Regulatory Links	NHSE Regulatory Requirements



Detailed Findings

1. Reported performance against deliverables and KPIs



What We Checked

We reviewed the performance against a sample of deliverables and KPIs for individual Workstreams, as reported to the OPFBC Oversight Group in February 2026, and assessed this against evidence available across the Trust to confirm that the reported performance was accurate.

What We Found

Reported performance could be substantiated with assuring evidence for each of the ten deliverables and KPIs reviewed. Our findings are summarised in the table below.

Ref	Domain	Workstream Ref & Name	Deliverable or KPI	Description	Reported Status (Feb 2026)	Evidence to Support Reported Performance	Audit Assessment of Evidence
1	1 – Leadership	1.1 Governance and Assurance	KPI	Updated BAF and aligned to risk register with cyclic process defined and implemented	Complete and process in place	- Minutes of July 2025 ARC meeting, detailing discussions around revisions to BAF. - BAF report to Board, September 2025. - BAF report to Board, November 2025, showing revisions to BAF, and links to risk registers.	
2	1 – Leadership	1.1 Governance and Assurance	Deliverable	Support developing balanced scorecard for care groups on all aspects of performance, finance & governance to support decision-making with clear and consistent data on a monthly basis	Complete	- Balanced scorecards now in place for Family & Community, Medicine and Urgent and Emergency Care, and Planned Care. - Balanced scorecards reported monthly to Executive Operations Group (EOG).	
3	2 – Strategy	2.2 EPIC	KPI	Implementation – As defined in the Epic progress and Orion Build & Change Management reports	Current Status is Watch	- Epic report to IM&T Group in February 2026, confirming programme status of "Watch". - Epic Monthly Progress Report to EOG in February 2026, confirming programme status of "Watch".	



4	2 – Strategy	2.2 EPIC	Deliverable	A fully informed and prepared workforce	Off-track recoverable	- Epic report to IM&T Group in February 2026, highlighting issues around change and operational readiness capacity, and staff training. - Epic Monthly Progress Report to EOG in February 2026, highlighting need for focus on end user training. Report also requests Executive oversight of super user readiness.	
5	3 – Performance	3.4 Maternity and Neonatal Safety Improvement Programme	KPI	Safety standards for Maternity Incentive Scheme (CNST)	10/10	- MIS - Year 7 Report to Private Board in February 2026, detailing proposed self-assessment declaration of full compliance with all 10 Safety Actions. - Minutes of Private Board, February 2026, confirming Board agreement to sign off declaration of full compliance with all 10 Safety Actions.	
6	3 – Performance	3.4 Maternity and Neonatal Safety Improvement Programme	Deliverable	Development of the MNIP - including engagement with patients, staff and system partners.	Complete	Live Maternity and Neonatal Improvement Programme is now in place. Programme is structured into five Workstreams and includes a total of 59 actions.	
7	4 – Finance	4.1(b) Sustainable Financial Improvement Programme (Delivery)	KPI	Total CIP target (£) vs delivered (£)	£33.7m transacted full year	- CIP Assurance Report to EOG in February 2026 confirms CIP achieved to date for 2025/26 is £33.69m. - CIP Assurance Report to EOG in January 2026 confirmed CIP achieved to date for 2025/26 was £32.1m.	
8	4 – Finance	4.1(a) Sustainable Financial improvement Programme (Process)	Deliverable	Updated governance structure for CIP oversight, with terms of reference and clear escalation routes agreed and embedded.	Complete	- CIP oversight arrangements set out in PMO and CIP Assurance Processes report to EOG in March 2025. - Minutes of EOG for March 2025 confirm the group's agreement of the proposed PMO and CIP assurance processes. - CIP Development Plan to EOG in July 2025 set out improvements to the Trust's CIP arrangements. - Minutes of EOG for July 2025 confirm the group's agreement of the CIP Development Plan. - Terms of Reference for EOG include oversight of CIP.	
9	5 – People	5.1 Workforce Plan & Transformation	KPI	Achieve Month 12 Workforce Plan of Total Workforce (WTE)	M10 Plan: 6411 M10 WTE worked: 6644	- Integrated Workforce Performance Report to Quality and People Committee in February 2026 reports total workforce at M10 was 6,649 against plan of 6,411. - M10 Finance Report to Board in March 2026 reports total workforce was 6,644 against plan of 6,411.	



10	5 – People	5.1 Workforce Plan & Transformation	Deliverable	Conduct a strategic review of employee relations cases, this includes undertaking an analysis of operational, financial and ER issues with current AfC staff on-call	Completed	• ER Updates to People Committee in October and December 2025 set out details of review of open ER cases. Data reported includes monthly caseload, and an analysis by both type and Care Group. • Confidential ER cases review to Executive Committee in November 2025. • On-Call Proposal (AfC) to Executive Committee in November 2025. • Confirmation of revisions to On-Call payments published in ICONews on 16/3/26.	



2. Closure of Workstreams



What We Checked

We reviewed the closure of Workstream 1.2 Well-Led (in the Leadership Domain), as agreed by the OPFBC Oversight Group in October 2025, to confirm that the relevant process had been followed. We also reviewed the reported completion of the individual actions within Workstream 1.2 and assessed the actions against evidence available across the Trust to confirm that the closures of the individual actions and the entire Workstream were appropriate.

What We Found

The closure of Workstream 1.2 Well-Led followed the correct process, with a formal closure report submitted to the OPFBC Oversight Group, and the Group's approval to close captured in the relevant Decision Record.

Reported performance could be substantiated with assuring evidence for each of the 11 deliverables reviewed. Our findings are summarised in the table below.

Deliverable Ref	Deliverable Description	Reported Status	Evidence to Support Reported Performance	Audit Assessment of Evidence
1	Commission a development well-led review with NHSE ensuring a terms of reference is ratified by all stakeholders	Complete	- EY Statement of Work, which includes: - Background and Objectives. - Scope of Services. - Approach and Plan and Timetable.	
2	Agree funding to undertake well-led review	Complete	Funding secured from NHSE Recovery Support Programme.	
3	Communicate with relevant stakeholders explaining purpose and scope and initiate the review	Complete	- Final EY report confirms Methodology, including: "The review involved: A series of structured interviews and meetings with senior leaders, Non-Executive Directors, clinical and operational staff, sample of Governors, and system partners."	
4	Undertake the review and receive regular progress updates to SRO and executives from commissioned team	Complete	n/a - Activity concluded and EY final report received.	



5	Undertake interviews with Board members and key people in the Senior Leadership Team and external stakeholders	Complete	- Final EY report confirms Methodology, including: "The review involved: A series of structured interviews and meetings with senior leaders, Non-Executive Directors, clinical and operational staff, sample of Governors, and system partners." - Confirmed EY attended Private Board in June 25.	
6	Commissioned team to share draft findings with SRO and executives to review for factual accuracy	Complete	Final EY report presented at Public Board on 24/9/25.	
7	Present a final well-led report including recommendations for consideration of the Board of Directors	Complete	Paper to Public Board on 24/9/25 confirms that Board Development session in August 2025 reviewed and discussed feedback from the Well-Led Review.	
8	Formulate action plan following receipt of reviews recommendations	Complete	Trust response to Well-Led review completed and presented at Public Board on 24/9/25.	
9	Communicate outcome of well-led review with organisation through comms	Closed	Confirmed action included in 1.3 Board and Executive Development.	
10	Share final report and action plan with NHSE and Region	Complete	Paper to Public Board on 24/9/25 co-authored by NHSE Improvement Director.	
11	Agree governance for progression of recommendations and monitoring of timebound actions including accountability arrangements for each action	Complete	Confirmed via internal audit of OPFBC Part 1.	



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Devon



University Hospitals
Plymouth
NHS Trust



Royal Devon
University Healthcare
NHS Foundation Trust



Torbay and South Devon
NHS Foundation Trust

Torbay and South Devon NHS FT MATERNITY BOARD REPORT

JANUARY – FEBRUARY 2026

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 people committee (QPC) 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 quality 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	Numerous feedback cards via the MNVP collection scheme provide majority positive feedback around staff attitude and caring.	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
2) Themes of complaints	Feeling that concerns not taken seriously. Issues with care and transfer to another unit in early post-natal period	Investigation ongoing.	Respond to concerns and identify if changes to practice necessary.	May-2026
3) Devon Maternity & Neonatal Voice (MNVP) projects/ additional comments	Best practice identified the requirement to embed our DMNVP Strategic Lead in the Perinatal Leadership Team (PLT) and to ensure closer working with all senior leads.	DMNVP to be working in partnership with all leads for service development	From April DMNVP Strategic lead will be present one day a month to work alongside the PLT. The DMNVP Trust lead and neonatal Leads will also be present one day a month to	Ongoing

			meet with staff and service users.	
4) CQC Maternity survey 2025	Report presented to the board in Jan 2026. Action Plan for improvement in place	Partners staying overnight on the postnatal ward is main area of focus.	TDS now an outlier in Devon for partners staying postnatally. RDUH went live in Feb 2026. Detailed action plan to be developed as part on the MNIP	Ongoing

2.2 Additional Service User Feedback- MD/LS

Debriefs / Birth Afterthoughts

Service continues to run with an aim to improve oversight and cover with the introduction of a Lead Professional Midwifery Advocate substantively.

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- February 2026	Walkaround highlighted a continued focus on cultural improvement, clinical training needs, and understanding rising clinical pressures. A key theme was the increase in preterm births, prompting a deep-dive review with national input to identify contributory factors and strengthen care processes. There was also a discussion around gathering service user feedback around epidural anaesthesia.	Reinforcing that recent cultural work is having some tangible effects. It also highlights that education team strengths boost team morale and validates investment in maternity education.	Actions include exploring EPIC's capacity to capture anaesthetic experience data and refining approaches to ensure efficient PROMPT training delivery for anaesthetic staff.	Ongoing

	Positive impact of education team also highlighted			
2)Listening events for all perinatal staff	Individual listening events were completed by independent practitioner across both maternity and neonatal teams. 16 staff participated and the feedback has been collated and shared with the leadership team	The feedback will guide the areas of focus and support and is particularly important in strengthening psychological safety	Themes from all the listening events that have been held in the last three months are being collated with the support of the strategic people partner and interim FTSUG. This will be shared once completed with actions included in the Maternity and Neonatal Improvement Plan.	
3) Perinatal culture work (SCORE)	The remaining actions associated with the SCORE survey will be included within the	This will provide assurance and oversight of the actions and will enable	Communication strategy and continuing work with civility toolkit will also support the work to continuously	

	perinatal improvement plan	continuing progress around cultural safety.	improve culture. The Health Innovations team are also hoping to continue work with the service in 26/27.	

Safety Champions meetings - Table 1-

Table 1

Date	Attendees	Feedback
February 2026	Board Safety champion- NED. Maternity Safety Champion Neonatal Safety Champion, MNVP Trust lead,	Labour ward visit The safety champion walkaround highlighted a continued focus on cultural improvement, clinical training needs, and understanding rising clinical pressures. A key theme was the increase in preterm births, prompting a deep-dive review with national input to identify contributory factors and strengthen care processes. Staff discussions emphasised PROMPT training challenges for anaesthetic doctors, though the strong support from the maternity education team was recognised. The MNVP expressed a desire to better capture women's experiences of obstetric anaesthesia, particularly regarding pain-relief interventions. Workforce reflections included positive feedback from the seconded labour ward coordinator, who noted a difference in culture and staff experience.

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.	3	These flags have been raised more frequently during January and February than is usual, this is in relation to several occasions of very raised acuity on the labour ward where prioritisation of need lead to delays for less critical tasks.
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).	1	
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.	5	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.	1	Activity reviewed when this flag raised and all women needing 1:1 care were provided for this flag does not correspond with dashboard data. Pressured day with no clinician at handover for the second planned caesarean section on the list and

		redeployment of management staff, all labourers had 1:1 care.
Labour Ward Coordinator (LWC) is not supernumerary	1 – not providing 1:1 care 0 – providing 1:1 care	This is for a short period 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.	Support has been provided during the period by locum staff to ensure 24/7 cover from Obstetrics.
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.	2 staff members mid-way through QIS training and beginning work-based placements. Place holder request submitted to network for next cohort. Collaboration with recruitment and attraction team to enhance current recruitment

Medical staffing	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. 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	strategy, cost neutral measures implemented with further potential options to pursue if no success. B6 and B5 vacancies advertised in February have attracted candidates to interview Organisational change process ongoing to redesign establishment structure to ensure workforce is fit for purpose for now and the future. 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. Agile incentive payments are in place for substantive staff to support roster sustainability in short term Meeting with Senior Leadership team has taken place to begin scoping options to meet standards and the cost implication for doing so. Devon wide MNIP review and costing meeting scheduled for end of April which will include impact of new standards.

3.2.1 Safe Maternity Staffing- Fill rates – planned verses actual

	Day		Night	
	Midwives %	MSW's %	Midwives %	MSW's %
January 2026	71.2	92.0	77.6	101.5
February 2026	79.7	95.2	89.2	80.6

*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. This month the teams have also had to mitigate the gaps caused by Epic training for all staff.

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.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Request additional support from the maternity matrons/managers.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for 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 uplift identified is required to support these complexities with additional specialist midwifery roles.

The finalised calculations have been presented to the Board and are based on a 25% uplift which gives an overall deficit of 3.81 WTE. This uplift requirement has formed 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.

3.2.3 Birthrate Plus Methodology Independent Review Report

An Independent Birthrate Plus® methodology review was published in February 2026 drawing on feedback from over 160 midwifery and maternity leaders. It confirms that the Birthrate Plus workforce planning approach remains robust and fit for purpose, while recommending enhancements to better reflect contemporary practice. The review highlights rising administrative and non-clinical workload, increasing intrapartum complexity, and growing antenatal activity as key pressures that need fuller recognition in workforce modelling. The Birthrate Plus Board has accepted all recommendations, with implementation now underway.

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	87%	94%	89%	95%	86%	92%
Midwives	88%		89%		92%	
Maternity Support Workers	88%		NA		94%	

Obstetric Consultants/ Registrars	73%	100%	92%	100%	62.5%	75%
Anaesthetists	97%		NA		NA	

The slide outlines progress and gaps in maternity mandatory education across multiple domains. EPIC training is now being rolled out trust-wide from January to April, with prioritisation and reallocation of staff time underway. This has been highlighted as a risk to training compliance and is captured on the risk register. Fetal monitoring training shows 89% compliance, supported by consultant-delivered teaching due to long-term sickness of the lead midwife. PROMPT MDT training remains a major component of the face-to-face day, focusing on Impacted fetal head considering the implementation of the Avoiding Brain Injuries (ABC) approach. It also includes caring for and assessing the deteriorating patient and SEPSIS, which is run in real time in the clinical areas and attended by an MDT. The training also looks at human factors and the potential impact these have on clinical situations, psychological and team safety. A consistent theme is the impact of workforce pressures on attendance, requiring bespoke sessions to maintain >90% compliance across staff groups. Safeguarding level 3 remains a focus for the obstetric workforce with some difficulty in being able to attend available dates. Additional modules—bereavement training, Lullaby Trust safe sleep, paediatric and neonatal simulations—are being actively promoted, with managers receiving monthly compliance reports to maintain oversight and drive completion

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 for update

4.2 Neonatal care outside agreed pathways

In this reporting period there were no babies born in Torbay and South Devon at less than 27 weeks' gestation. These babies must be delivered in a level 3 Neonatal intensive care unit. There were four babies born between 28-32 weeks who delivered at Torbay; in utero transfers were not possible. Sadly, one of the births resulted in a neonatal death. This incident is being reviewed as a PSII by the central patient safety team. The other incidents are being reviewed as PSR's completed by perinatal team. Exceptions are reviewed and reported on monthly to provide rationale, with oversight of the SW Neonatal network. The maternity governance team are currently undertaking a thematic review to look for any common themes within these and all cases of neonatal care outside of agreed pathways in the past 12 months.

4.3 Safety Improvement Plan –Maternity and Neonatal Improvement Support Team

The MSSP has now transitioned to Maternity and Neonatal Improvement Support Team (MatNeolST). 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:**
 - o Obstetric leadership and capacity
 - o Culture and leadership
 - o Governance and board effectiveness
- **Work with the allocated Midwifery and Obstetric Improvement Advisors.**

The Trust are now in a monthly rhythm of executive attended meetings with monthly update shared (see Table 2)

Table 2

Maternity and Neonatal Improvement Support Team		Monthly Update Report		
Trust name:	Torbay & South Devon FT	Report date:	February 2026	
MIA(s):	Suzanne Cunningham Enum Khan	Level of support:	Targeted	
Site visits in past month:	February 25 th & 26 th	Support start date:	01/01/2026	Support end date: 01/07/2026
Achievements and progress of milestones				
- Obstetric job planning process completed- identified shortfall and advert live for 2 consultant posts – One new post one replacement. - RCOG Obstetric leadership role descriptors reviewed, prioritised. Gap identified. - SOP for huddles ward rounds and handovers- completed ready to upload and launch. - Reviewed leadership portfolios and considering perinatal leadership roles. MNVP to join as able. - DOM- JD reviewed and matched at B9. Process for appointment understood not completed. - HOM role job matched but appeal in process. - Perinatal compliance lead commenced in post. Creating TSDFT perinatal governance framework. Matched against toolkit -75% complete – MIA feedback given.				
- Quality and safety midwifery leadership and oversight strengthened with focus on implementing framework and Incident review /management - Lessons learnt* systems and processes being mapped – midwifery & governance complete - Perinatal deaths learning review postponed to 19th March by national team – include mw, obstetrics and neonatal and governance Teams. - Feedback from staff through SCORE, Exec listening events and other routes now being themed. - Mapping of Psychological support available for staff mapped and to be included in workforce strategy				
Escalations				
- Process for HOM/DOM appointments – timeline delays due to consultation and appeal process. - Obstetric leadership roles to have objectives for each leadership role to ensure that all areas of service have the appropriate resources for the priority areas. - Delay in loading refreshed guidelines on to intranet - agree prioritisation and refine system. - Roles and responsibilities for governance – priority to ensure that PMRT & ATAIN always has Consultant obstetric and neonatal representation				

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	• 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.

	• Estates work almost complete- some minor delays experienced, due for completion early March. • All staffing appointed to and opening hours increased.	
Obstetric theatre	• Dedicated emergency theatre • Improved process for out of hours theatre provision • Formal regular review meetings between leads • Ongoing audit of theatre cases and decision to delivery intervals. • Review of DATIX if delays to theatre noted in practice. • Progress with recruitment of ODP (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. • Recent risk register review has resulted in a lower score of 15 (down from 20) due to new mitigations.
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	

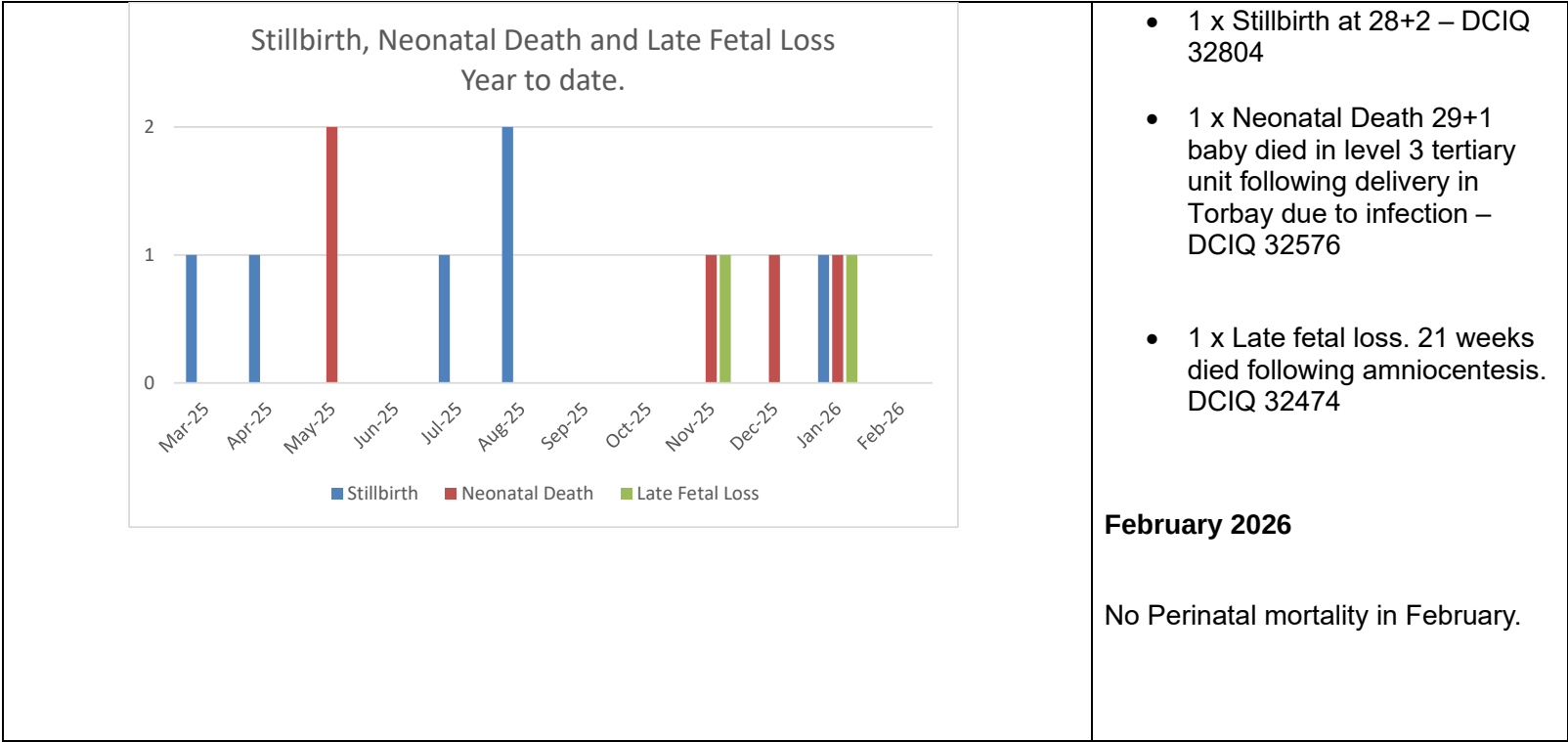
Use of Electronic MEOWS system	• Increased surveillance and support of system to improve the completion. • New digital midwife now in place to ensure work can continue in this area. • QI project complete, no on regular audit cycle • Action Closed on action tracker	
Medical staffing	• Business case to 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.	• Safeguarding Children level 3. An additional e learning module for doctors is being considered to improve safeguarding compliance.

	Bespoke, local safeguarding input as part of induction	
Governance oversight and assurance	New governance structure embedded following internal audit recommendations.	- 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, progress slow but steadily improving. - Implementation of NHSE governance tool kit in progress. - DOM visit to unit with CQC Outstanding rating has identified areas for improvement in governance processes.

4.5 Patient Safety

4.5.1 Perinatal Morbidity and Mortality Summary for the period

	1st January 2026 – 28th February 2026 January 2026



4.5.2 Patient Safety Incidents

PATIENT SAFETY Incidents (PSI)	Number	Key themes/ trends/ escalations

Serious Incidents	3 in total	1st January 2026 – 28th February 2026 January 2026 • 1 x Death Caused by the incident - 1 x Stillbirth at 28+2. History of reduced fetal movements. PMRT review to be completed by July 2026. DCIQ 32804. • 1 x Death Caused by the incident - 1 Neonatal Death. Cervical Suture in situ, infection causing preterm labour, LSCS for fetal distress. PMRT Review was held in conjunction with tertiary unit. Awaiting the final report. PSII Review by Central Patient Safety Team. - DCIQ 32576 • 1 x Severe – Woman transferred in from home birth with independent midwives, 6 Hour second stage baby born by Cat 1 LSCS in poor condition, transferred to tertiary unit for therapeutic cooling. MNSI Investigation in progress. DCIQ 32787. February 2026: • No Serious incidents reported in February.

Moderate Incidents	1 in total	January 2026: 1 Moderate Incidents reported. 1 Moderate – Woman required a return to theatre for management of a large volume haematoma, day 2 following cat 4 LSCS. DCIQ 33226 February 2026: No Moderate Incidents reported.

PATIENT SAFETY	Number	Key themes/ trends/ escalations
New referrals to MNSI	1	1 Referral for therapeutic cooling, Woman transferred in from home birth with independent midwives, 6 Hour second stage baby born by Cat 1 LSCS in poor condition, transferred to tertiary unit for therapeutic cooling. MNSI Investigation initiated. Staff Interviews to be completed - DCIQ 32787
Findings of final MNSI reports returned (themes only)	0	No reports were received by MNSI in January or February 2026.

Findings of cases reviewed under PMRT. (themes only)	2	2 PMRT cases were reviewed in this period from Deaths in 2025. - Datix No: 26900 - CNST SA1 (a) met, (b) met (c) met. There were external panel members at the meeting. PMRT MDT was held on 29th January 2026, Report completed 30th January 2026. The MDT were unable to identify a cause of death. One care issue was discussed at the meeting which was that the mother had not been asked about domestic abuse in her pregnancy, but it was determined that this made no difference to the outcome for the baby (See table 4). - Datix No: 27496 - CNST SA1 (a) met, (b) met (c) met. – There were external panel members at the meeting. PMRT MDT was held on 5th February 2026, Report completed 12th February 2026. The cause of death of the baby was determined to be, placental anomalies leading to severe growth restriction. The review group concluded there were no care issues for mother or baby. 1 PMRT MDT meeting was held in this period with the report still pending. - Datix No: 30963 - CNST SA1 (a) met, (b) met (c) met. – There were external panel members at the meeting, PMRT MDT was held on 19th February 2026, Report date tbc, due by 14th May 2026. 1 PMRT review is pending.

		Date due for completion: - Datix No: 32804 - CNST SA1 (a) met, (b) met (c) partially met – 100% Factual Questions complete, PMRT MDT meeting to be held date tbc, Report due by 11th July 2026. Will be met once PMRT MDT meeting held. PMRT Reviews led by other trusts for babies that delivered in Torbay. - Datix No: 30224 - PMRT MDT meeting held 20th January 2026 at University Hospitals Plymouth. (This is also referred to above as MNSI case 049022 – Report awaited. - Datix No: 32576 - PMRT MDT meeting held 24th February 2026 at University Hospitals Plymouth. – Report awaited. PMRT Reviews led by other trusts for babies that received antenatal care in Torbay. - Datix No: 32978 - PMRT MDT meeting held TBC at Bristol and Weston NHS Trust.

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

Table 3

Datix Number	Ethnicity	Deprivation Score
26900	White British	5
27496	White Other (Finland)	3
30963	White British	2
30224	White British	3
32804	White British	5
32576	Black - Other	2
32787	White British	7
33226	White British	4
32978	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	Communication	This woman was not asked about domestic	Discuss at Mandatory Training around lessons learnt from incidents to	Clinical Governance Coordinator	Completed

		abuse in her pregnancy	communicate the importance of asking about DV at any contact where the woman attends alone send information via Clinical Updates WhatsApp group and email. – Consider an audit of DV enquires in pregnancy.		
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	30.04.2026

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 addressed as part of a wider project around improvements in documentation.	Continue with updates to policies around record keeping in maternity, continue with ongoing notes audits and highlight importance of documentations as part of EPIC launch. Consider documentation workshop/learning session in conjunction with litigation team?	Inpatient Matron and Clinical Governance Coordinator(s)	30.04.2026
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	Scanner has now been upgraded and replaced.	Labour Ward Manager	Completed

		not working properly			
Datix No: 22736	Labelling Error	Due to the placentas not being correctly labelled, the genetics for Deceased twin reported his sex as female, additional distress was caused to parents.	Action plan produced by bereavement midwives. Correct labelling protocol to be updated in relevant guidelines.	Bereavement Midwives	Completed
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	Labour ward coordinator to be reminded to be mindful to notify paediatrics when a woman attends the unit preterm with complications	Inpatient Matron	Completed

		preferred to be more prepared for a potential twin delivery.	in her pregnancy. Inpatient matron to highlight at next Labour Ward coordinators meeting.		
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 from the staff involved at the time of the event.	Governance team to ensure that memory captures are sent to staff who are involved in serious events, shortly after the event. This will help with gathering facts for the case as well as prove to be good practice for those involved in reflective practice.	Maternity and Child Health Clinical Governance Coordinators.	Ongoing
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 of Death	Summary
Maternal Death	14.11.2023	Woman found deceased at home at 9 days postnatal. Multiagency report being finalised by ICB.
TOP for medical reasons	11.01.2025	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.
NND	19.05.2025	Term neonate with Hypoxic Ischemic Encephalopathy, unexpected poor condition at birth.
NND	07.12.2025	Spontaneous miscarriage 18+0/40 gestation, born with signs of life at 04.25 for 45 minutes

NND	12.11.2025	Spontaneous onset of labour in a term baby. Delivered in the birthing pool. Suspected intrapartum haemorrhage. Delivered with no signs of life. Required full resuscitation with intubation and ventilation, CPR, 3 rounds of adrenaline and a blood transfusion. Heart rate first heard at 41 minutes of age. Transferred to Neonatal Intensive Care, Derriford Hospital and later died

4.6 Saving Babies Lives Care Bundle

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

For 2025-26 Q3 (September 25 - December 25) we continue to be 91.3% compliant. Due to capacity the DLMNS are yet to assess our compliance for this quarter.

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. Now that the capacity within the MNVP has increased they will also be able to attend these meetings from now on. Bimonthly meetings also occur with the QUAD and the safety champions including the Board level champions and Maternity and Neonatal Voices Partnership (MNVP) lead. The QUAD met with the Board safety champions in January 2026 and will be renaming the meeting Perinatal Safety Champions. There has been collaboration with the Trust MNVP lead with attendance at Quality meetings, PMRT meetings and Perinatal Improvement Baord meeting in February 2026.

Topics addressed and activities of QUAD included.

- Safety Champion walkaround discussed
- Improvement Work: the change from MSSP to Maternity and Neonatal Improvement support team and the areas of focus as described in 4.3
- Presented Q3 score card and reviewed triangulation.
- 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 Devon and Cornwall Cluster ICB Perinatal safety and governance 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 January and February 2026, the trust has not received any alerts from MOSS.

The SOP for MOSS has recently gone live, and the maternity governance team is working on how this is implemented within the maternity service.

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

Year 7 concluded on 3rd March 2026. Following board overview a declaration of full compliance for all ten safety actions was submitted. A perinatal compliance lead is now in post to support the assurance and oversight required for perinatal services and they will continue to work with the team to enable ongoing compliance.

NHS Resolution has issued advance notice of upcoming MIS Year 8 guidance, to be formally published 31 March 2026. Trusts are encouraged to begin early preparation; resources and discussions will continue through the MIS Future NHS workspace.

Year 8 is expected to build on Year 7 requirements with a continued focus on equity, safety actions, and training compliance

5.0 Actions to improve care for women and families.

5.1 Neonatal Deaths – Safety Measures and Escalation- update

During the last nine months, the Trust experienced four 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. As part of the ongoing executive and board oversight and assurance, an update on the actions that were taken are as follows:

- **Thematic Review and External Scrutiny**

Given the clustering and nature of the incidents, a thematic learning review is in progress, facilitated by NHSE to synthesise learning from previously completed neonatal death and stillbirth reviews to inform local, regional, and national improvement actions. This escalated review aligns with national scrutiny of maternity services and early feedback around culture and leadership raised by the national team. The formal review meeting is taking place on the 19th of March 2026 with the final report anticipated in mid-May 2026.

- **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.

Monitoring demonstrates improved escalation with evidence that emergency responses are timely and appropriate. A rapid review process is in place to address any occasions when this does not happen.

- **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 of the service: This includes the regular safety champion walkarounds with the board level safety champions, oversight by the CNO via the perinatal improvement board as well as a shadow shift by the CEO in January on labour ward.
- Strengthened governance participation with the introduction of NHSE governance framework
- Initiated leadership development and psychological safety interventions.

These actions support the Trust's commitment to strengthening safety culture and transparent learning.

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.

6.1 Assurance and Recommendations (refer to Executive summary paper)

Overall, there is a limited level of assurance with an improving trajectory around perinatal surveillance for quality and safety. This is due to ongoing oversight around perinatal mortality and culture. Improvement is evident by a reduction in the perinatal mortality and morbidity within this reporting period with evidence of improving escalation processes as well as extensive work on addressing psychological safety.

Recommendation:

- Confirm the assurance rating

- Note the overall progress in maternity safety, quality, and culture.
- Continue the oversight of quality and safety risks, including PMRT findings and MNSI investigations,
- Note the continued oversight of the service by NHSE via the MatNeo Improvement Support team which is being supported at executive level by the monthly progress meetings.
- Note the training compliance risk that is being influenced by Epic training requirements
- Note the thematic review that is being conducted into preterm births that occur outside the commissioned service for a level 1 special care baby unit
- Continue to Support the ongoing culture and wellbeing initiatives

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

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Integrated Performance Focus Report (IPR)



Torbay and South Devon
NHS Foundation Trust

April 2026: Reporting period March 2026 (Month 12)

		Page
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	NOF 4 Performance Summary - Urgent and Emergency Care	3
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Working with you, for you

Oversight Framework - Introduction

National Oversight Framework:

Quarterly assessments against the Framework reflecting performance in Q3 2025/26 has been published. The overarching score and national ranking across the six domains for the Trust in Q3 is Segmentation 3 and ranked 83 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.

NHS England is developing an updated Oversight Framework for 2026/27; this will be reflected in this report when confirmed.

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.

Performance Summary

Overall Position

- Urgent and Emergency Care (UEC) performance remains under significant pressure, with deteriorating delivery against national standards driven by sustained demand, constrained flow, and workforce pressures.
- Elective Recovery shows continued improvement, particularly in long-wait reductions (RTT>65 weeks), though delivery risk remains high.
- Cancer performance is mixed: Faster Diagnosis has improved, but 62-day performance and backlog remain a concern.

Key Areas of Concern

- UEC Flow & Timeliness
 - 4-hour ED performance 66.6% vs 78% trajectory; Type 1 ED at 50.7%.
 - Ambulance handover delays worsening: 434 >45-minute handovers in March, Trust ranked 104/123 nationally.
- Discharge and bed capacity
 - Pre-noon discharges at 20% (target 33%); escalation capacity in near-continuous use.
 - Ongoing use of non-standard bedded areas impacting flow, safety, and experience.
- Cancer 62-Day Standard
 - Performance below standard (73%) with a growing backlog, driven by capacity and staffing constraints.

Key Areas of Improvement

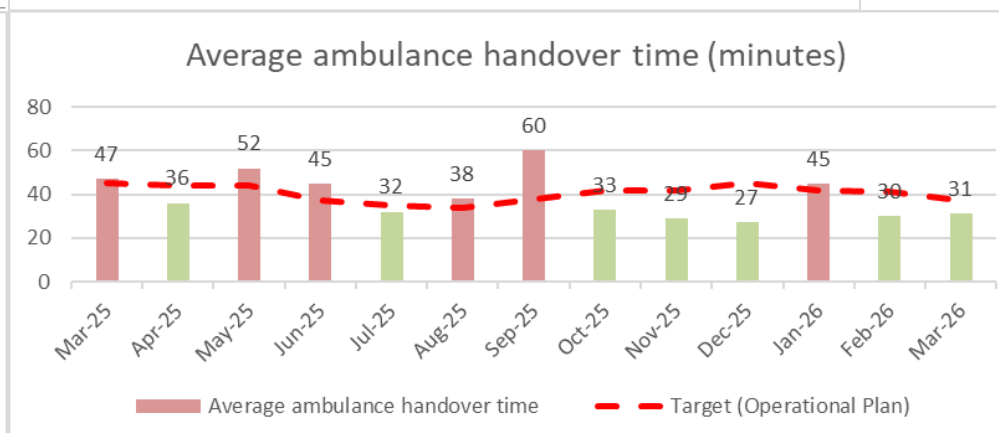
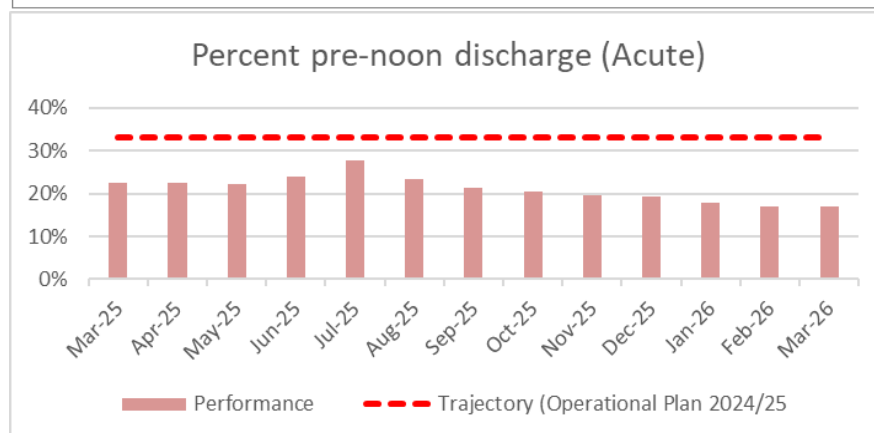
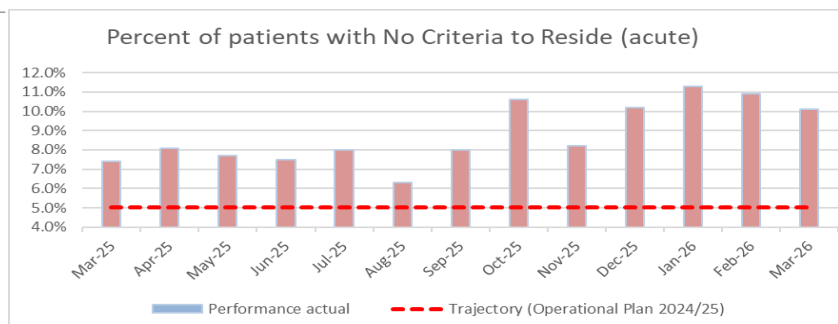
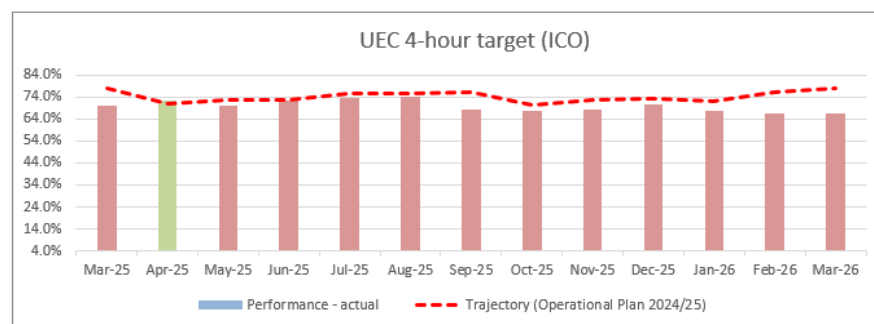
- Elective Recovery
 - Significant reduction in long waits: 65-week waits reduced from 141 to 47 year-on-year.
 - Continued delivery through elective sprints, insourcing and outsourcing (notably T&O).

National Oversight Framework– Urgent and Emergency Care Performance Summary

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Operational Plan trajectory Mar 2026
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1981		1268	839	1530	1159	725	943	1823	810	624	559	1283	621	755	1980
Average handover time (mins)	45 mins		47	36	52	45	32	38	60	33	29	27	45	30	31	37
Total average time in ED (hours/minutes)			05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	06:10	06:06	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		615	415	688	494	457	426	655	585	549	520	918	740	734	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.7%	7.4%	13.3%	11.5%	10.1%	6.1%
UEC 4-hour target (RAG against local trajectory to national target)	78%		70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	78.0%
% patient discharges pre-noon	33%		22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%		7.4%	8.1%	7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	5%

Trajectories have been agreed as part of the 2025/26 Operational Plan submission. The latest month trajectory, where applicable, is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories.

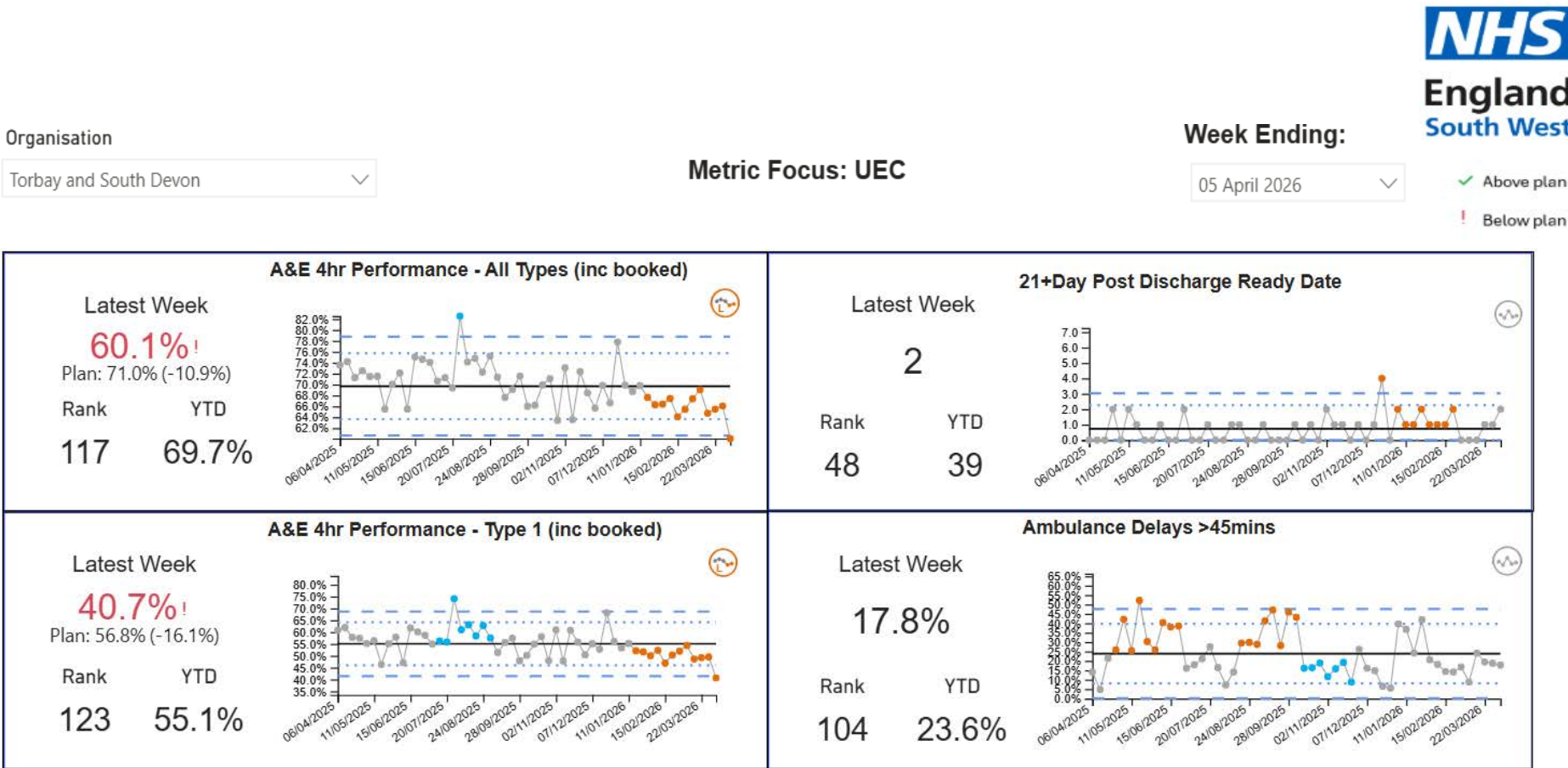
RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory



Urgent and Emergency Care Performance Summary - NHS England monitoring report

The reports below have been taken from the national NHSE Southwest weekly performance dashboard which monitors performance against key UEC metrics. These metrics form the basis of the weekly performance reviews with NHS England.

The latest report shows ambulance handover delays over 45 minutes and the recent weekly ranking of 104 out of 123 trusts (as of 5 April 2026) from rank 92 last month.



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

The total number of ambulance conveyances to the ED in March was 2,667; this is the highest recorded number of handovers in a month. March's handover average was 31mins 16secs. The number of handovers over 45mins has increased to 434 in March from 361 in February.

Average handover time – rolling 30 day (as at 7 April 2026)**Rolling 30-day position as at 07 April 2026***click on a bar to highlight site on the trend chart*

Ambulance Trust	Site Name	
South East Coast	Farnham Road Hospital	1:06:21
South East Coast	University Hospital Lewisham	0:54:10
South East Coast	Basingstoke Hospital	0:53:05
South Western	Derriford Hospital	0:49:50
South Western	The Great Western Hospital	0:46:20
South Western	Royal United Hospital	0:40:38
South Western	Torbay Hospital	0:36:13
South Western	Royal Bournemouth Hospital	0:34:47
South Central	Royal Bournemouth Hospital	0:33:39
South Western	Royal Cornwall Hospital (triliske)	0:33:07
South East Coast	Croydon University Hospital	0:32:10
South Western	Southmead Hospital	0:29:29
South Western	Yeovil District Hospital	0:27:53
South Western	Poole Hospital	0:26:40
South East Coast	Bt Accident Emergency	0:26:25
South Western	North Devon District Hospital	0:26:22
South East Coast	St Helier Hospital	0:26:19

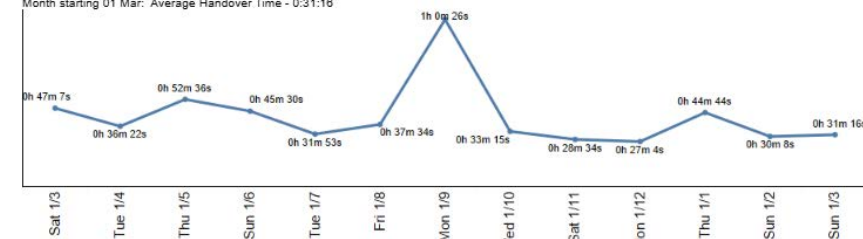
Operational update

Ambulance handovers remain a key focus for the Trust and Timely Handover Process (THP@45).

Through March, winter pressures continued and has escalated with the highest ED handover from SWAST that the organisation has faced. There is a new clinical pathways lead for SWAST for South and West, who the UEC team will build on the pathways programme of work that is in place led by an AIM PA.

Average ambulance handover time

Saturday 1 March 2025 - Tuesday 31 March 2026 - Monthly data
 Month starting 01 Mar: Average Handover Time - 0:31:16

**Actions to complete next month**

- Post Epic Go Live, the UEC team with those they collaborate with will take the opportunity to reinvigorate a stabilisation plan for the new financial year, the embedding of the new ED footprint and workforce, and to work within a fully electronic patient management system.

An initial 6-month plan is about to be implemented with the ED team, which will closely be followed by the (acute internal medicine) AIM team.

The organisation Inter-professional Standards are about to be piloted across UEC with 50 agreed specialty pathways to support direct referral to specialty and ease the process of getting it right first time for the patient and staff.

Risks/issues

- Financial balance of locums versus substantive staffing, and short notice escalation cover.
- Impact and embedding of the new Epic EPR on the teams and services.
- 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.

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

Performance			Operational update																																																																																																		
	March 2025	March 2026	Opel score March 2026 <table><tr><td>Mon</td><td>Tue</td><td>Wed</td><td>Thu</td><td>Fri</td><td>Sat</td><td>Sun</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td>1 L3</td></tr><tr><td>2 L4</td><td>3 L4</td><td>4 L3</td><td>5 L3</td><td>6 L3</td><td>7 L3</td><td>8 L4</td></tr><tr><td>9 L4</td><td>10 L3</td><td>11 L4</td><td>12 L4</td><td>13 L4</td><td>14 L3</td><td>15 L4</td></tr><tr><td>16 L3</td><td>17 L3</td><td>18 L4</td><td>19 L3</td><td>20 L4</td><td>21 L4</td><td>22 L4</td></tr><tr><td>23 L4</td><td>24 L4</td><td>25 L3</td><td>26 L3</td><td>27 L4</td><td>28 L4</td><td>29 L4</td></tr><tr><td>30 L3</td><td>31 L3</td><td></td><td></td><td></td><td></td><td></td></tr></table> March 2025 <table><tr><td>Mon</td><td>Tue</td><td>Wed</td><td>Thu</td><td>Fri</td><td>Sat</td><td>Sun</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td>1 L3</td><td>2 L3</td></tr><tr><td>3 L3</td><td>4 L4</td><td>5 L4</td><td>6 L3</td><td>7 L3</td><td>8 L3</td><td>9 L3</td></tr><tr><td>10 L3</td><td>11 L4</td><td>12 L3</td><td>13 L3</td><td>14 L3</td><td>15 L3</td><td>16 L3</td></tr><tr><td>17 L3</td><td>18 L3</td><td>19 L4</td><td>20 L3</td><td>21 L3</td><td>22 L3</td><td>23 L3</td></tr><tr><td>24 L3</td><td>25 L4</td><td>26 L3</td><td>27 L3</td><td>28 L3</td><td>29 L3</td><td>30 L3</td></tr><tr><td>31 L3</td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>	Mon	Tue	Wed	Thu	Fri	Sat	Sun							1 L3	2 L4	3 L4	4 L3	5 L3	6 L3	7 L3	8 L4	9 L4	10 L3	11 L4	12 L4	13 L4	14 L3	15 L4	16 L3	17 L3	18 L4	19 L3	20 L4	21 L4	22 L4	23 L4	24 L4	25 L3	26 L3	27 L4	28 L4	29 L4	30 L3	31 L3						Mon	Tue	Wed	Thu	Fri	Sat	Sun						1 L3	2 L3	3 L3	4 L4	5 L4	6 L3	7 L3	8 L3	9 L3	10 L3	11 L4	12 L3	13 L3	14 L3	15 L3	16 L3	17 L3	18 L3	19 L4	20 L3	21 L3	22 L3	23 L3	24 L3	25 L4	26 L3	27 L3	28 L3	29 L3	30 L3	31 L3						
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MIU/UTC attendances	3512	3473																																																																																																			
MIU/UTC performance	98.8%	99.9%																																																																																																			
ED (type 1) attendances	7046	7277																																																																																																			
ED (type 1) performance	55.8%	50.7%																																																																																																			
ICO attendances	10558	10750																																																																																																			
ICO performance	70.1%	66.6%																																																																																																			
																																																																																																					
Actions to complete next month			Risks/issues																																																																																																		
We remain committed to improving the two main causes of patient flow imbalance and improving performance by increasing the number of patient discharges before noon and increasing the number of patient weekend discharges. Post Epic Go Live, the UEC team with those they collaborate with will take the opportunity to reinvigorate a stabilisation plan for the new financial year, the embedding of the new ED footprint and workforce, and to work within a fully electronic patient management system. An initial 6- month plan is about to be implemented with the ED team, which will closely be followed by the AIM team. The organisation Interprofessional Standards are about to be piloted across UEC with 50 agreed specialty pathways to support direct referral and ease the process of getting it right first time for the patient and staff.			- Financial position of the Care Group and organisation and the impact on temporary versus substantive staffing, plus escalation. - Winter pressures with associated IPCC issues for staff and patients. - Impact of Industrial Action on the senior workforce. - Impact and embedding of the new Epic EPR on the teams and services. - The delay in the new ED Wraparound build of up to 16 weeks will have a continued impact on flow and staff/patient experience. - Sustained increase in demand above historical trend.																																																																																																		

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

Performance	Operational update
Performance Analysis: March 2026 Pre-Noon: 20% of patients in the acute hospital were discharged pre-noon. Pre-5PM: 68.9% of acute patients were discharged pre-5pm.	Escalation spaces have remained in continuous or near-continuous use. Prolonged escalation continues to place pressure on staffing models, clinical oversight, and patient experience increasing short stay patients LOS. Workforce capacity remains a key constraint, driven by: - Vacancy levels and sickness absence across MDT - Sustained reliance on temporary staffing in escalation areas. - EPIC pre go-live, a significant proportion of the workforce engaged in: - Mandatory training - Readiness activity - Super User preparation and backfill arrangements
Actions to complete next month	Risks/issues
- Working with workforce on stabilisation post-implementation of EPIC. - Focus and drive on EDDs and discharge planning via discharge milestones and bottlenecks. - Review ward processes with EPIC and changes. ?new processes that have been introduced and sharing best practice	We continue to not meet the 33% pre-noon target for acute wards. Stabilisation post-implementation of EPIC.

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

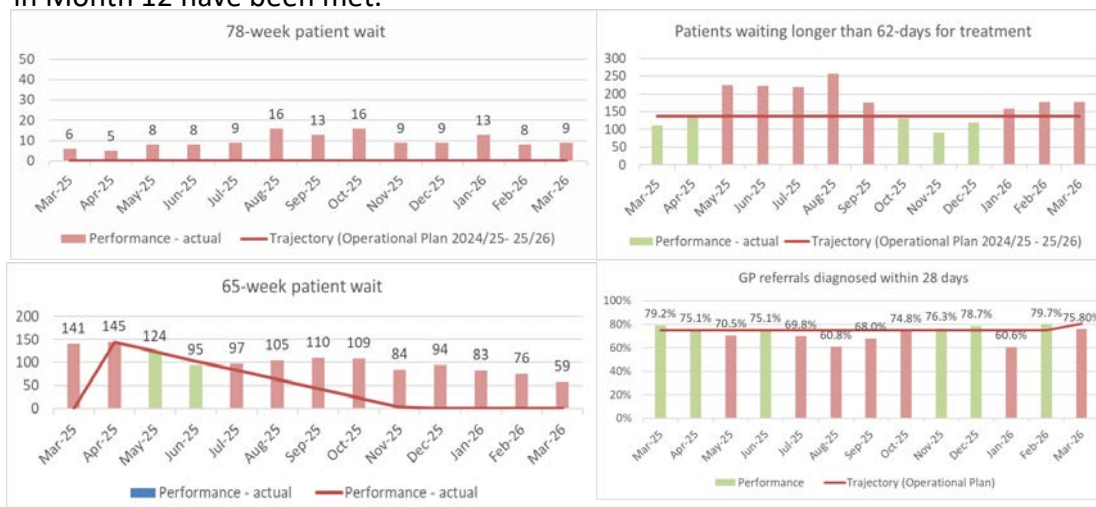
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Operational Plan trajectory Mar 2026
Oversight Framework																
Elective recovery																
RTT 78 week wait incomplete pathway	0		7	4	8	8	9	16	13	16	9	9	13	8	7	0
RTT 65 week wait incomplete pathway	0		141	145	126	95	97	105	110	109	84	94	83	76	47	0
RTT 52 week wait incomplete pathway	268		931	914	805	740	615	618	615	647	607	663	604	607	600	268
RTT % Incomplete pathways <18 wks	66.8%		63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	67.0%	66.8%	66.4%	66.8%
RTT Wait for first appointment <18 weeks	70.3%		70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	69.9%	70.3%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	78.7%	60.6%	79.7%	75.8%	80.5%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	75.2%	67.1%	66.2%	75.1%
Cancer: No of patients waiting >62 days to start treatment	138		111	133	225	223	220	257	176	132	91	119	159	177	177	138
Cancer: % of patients > 62 days to start treatment	tbc		6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	5.9%	7.6%	8.1%	7.2%	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; 0 of the 8 trajectories in Month 12 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 end of March 2026. This required 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 – completed – forward plans now to focus on full activity restoration on EPIC go live.
- Outsourcing T&O patients to North Bristol.

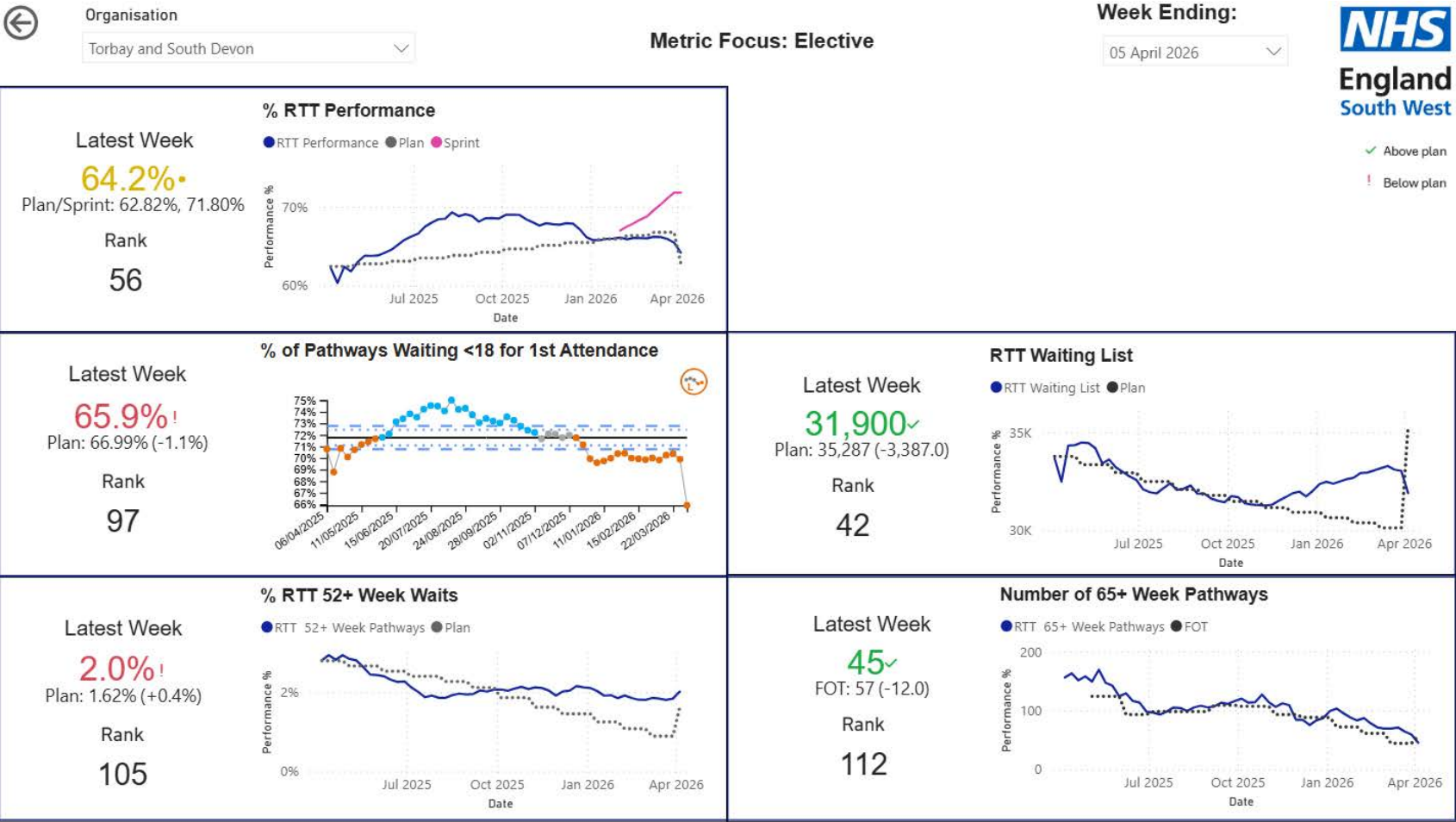
Risks and Barriers

- 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. Ophthalmology consultant sickness.
- 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.
- Competing demands with EPIC.

Elective Care Performance Summary - NHS England monitoring report

The reports below have been taken from the national NHSE Southwest weekly performance dashboard which monitors performance against key elective care metrics.

Data source: NHSE SW Weekly Performance Dashboard



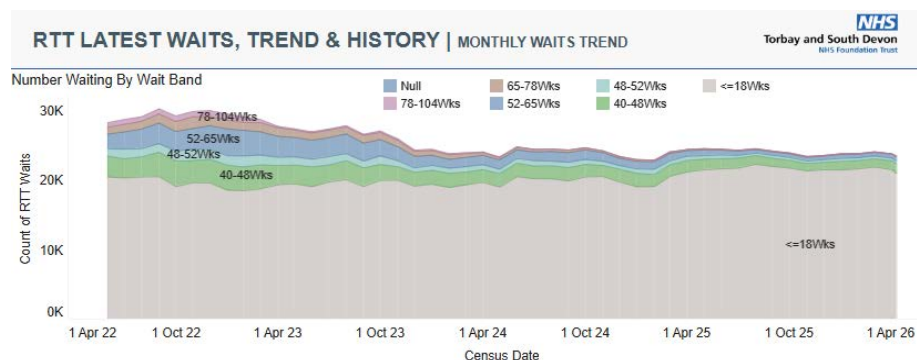
The Published reports showing latest performance and trust ranking (134 Trusts) against the RTT waiting time metrics and our submitted operational planning trajectories confirm the good performance seen to date this year.

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

Performance

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

	March 2025	March 2026
78 weeks	7	7
65 weeks	141	47
52 weeks	931	600



Operational update

78 week: At the end of March (provisional figures) there are 7 breaches (x1 Cardiology, 4x T&O, 1x UPGI and 1x Ophthalmology).

65 week: In March (provisional figures) there were 47 breaches – with the majority sitting within T&O (30) and Ophthalmology (8).

New 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. External consultant support to help with service for three months.

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 March 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

STAGE OF TREATMENT WAITING LISTS NEW OP & PENDING							
New Outpatient & Pending List as at 19/04/2026 (based on current wait)							
Module	Treatment Function	0-18 weeks	>18-26 weeks	>26-52 weeks	>52-65 weeks	>65-78 weeks	>78 weeks
(All)	120 - ENT	1,325	462	901	92	5	13
Local Treat. Functn.	130 - OPHTHALMOLOGY	1,230	477	868	83	8	5
(All)	330 - DERMATOLOGY	1,249	201	423	2	1	1,876
Clinic or List	340 - RESPIRATORY MEDICINE	714	207	207	96	100	188
(All)	140 - ORAL SURGERY	798	296	373	11	4	1,483
WLMDS Pathway	110 - TRAUMA & ORTHOPAEDICS	627	269	395	49	20	51
(All)	101 - UROLOGY	620	247	335	1		1,203
NAVIGATE	400 - NEUROLOGY	624	194	210	24	24	27
Cover Page	320 - CARDIOLOGY	766	114	78	11	9	31
New OP & Pending	410 - RHEUMATOLOGY	648	175	86	3		912
All New Waits	191 - PAIN MANAGEMENT	420	131	229	21	2	805
Follow Up Pending	420 - PAEDIATRICS	546	127	88	6	2	770
IPDC	650 - PHYSIOTHERAPY	581	81	81	5	1	752
OP Trends	302 - ENDOCRINOLOGY	302	96	209	88	47	748
OP Totals	104 - COLORECTAL SURGERY	390	78	109	9	1	587
	840 - AUDIOLOGY	336	33	32		1	402
	301 - GASTROENTEROLOGY	353	14	19	1		387
	502 - GYNAECOLOGY	298	31	17			346
	655 - ORTHOPTICS	271	7	10	7		295
	106 - UPPER GASTROINTESTINAL SURGERY	201	17	12		1	232
	430 - GERIATRIC MEDICINE	64	38	68	10		181
	401 - CLINICAL NEUROPHYSIOLOGY	127	8	2			137
	656 - CLINICAL PSYCHOLOGY	96	16	24			136
	103 - BREAST SURGERY	109	1				110

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, 3784 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 March RTT position is 65.4% against a March trajectory of 66.8%.

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

Improve the percentage of patients waiting no longer than 18 weeks for first activity to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement



Torbay & S Devon: Wait to first by specialty

Specialty	0-18 weeks	First activity	Wait to first	Baseline	Target
Elderly Medicine	134	292	45.9%	-19.4%	-24.4%
Neurology	541	1,038	52.1%	-13.2%	-18.2%
Oral Surgery	900	1,678	53.6%	-11.6%	-16.6%
General Medicine	28	46	60.9%	-4.4%	-9.4%
Other - Other Services	45	73	61.6%	-3.6%	-8.6%
ENT	1,496	2,254	66.4%	1.1%	-3.9%
Cardiothoracic Surgery	2	3	66.7%	1.4%	-3.6%
Trauma & Orthopaedics	654	969	67.5%	2.2%	-2.8%
Other - Medical Services	1,088	1,589	68.5%	3.2%	-1.8%
Cardiology	1,395	1,999	69.8%	4.5%	-0.5%
Other - Surgical Services	967	1,214	79.7%	14.4%	9.4%
Ophthalmology	1,796	2,254	79.7%	14.4%	9.4%
Thoracic Medicine	616	725	85.0%	19.7%	14.7%
Gastroenterology	775	904	85.7%	20.5%	15.5%
Dermatology	1,481	1,662	89.1%	23.8%	18.8%
Gynaecology	672	739	90.9%	25.7%	20.7%
Urology	804	878	91.6%	26.3%	21.3%
Rheumatology	592	642	92.2%	26.9%	21.9%
Plastic Surgery	25	26	96.2%	30.9%	25.9%
Other	21	21	100.0%	34.7%	29.7%
Total pathways	14,032	19,006	73.8%	8.6%	3.6%

Data Source: WLMDS for w/e 29-Jun-25
Baseline is the WLMDS w/e 01-Dec-24

Below baseline Above target

The Trust achieved 69.9% in March 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

Performance					Actions to complete next month
	January 2026	February 2026	March 2026*	April 2026**	- Continuing insourcing, waiting list initiative and locum activity in core specialties (Colorectal, Urology and Dermatology). - Risks to position delivery in April and May due to Dermatology capacity (related to Easter/Epic), working with the Dermatology team to model solutions to this by flexing routine workload and insourcing capacity. - Recover reporting and administrative review capability following Epic. This is currently leading to reduced reporting capabilities.
28-day FDS	60.6%	79.7%	75.8%		
31-day treatment	92.7%	96.3%	94.1%		
62-day cancer RTT	75.2%	67.1%	64.3%		
62-day backlog	159 (7.6%)	177 (8.1%)	170 (7.6%)	305 (10%)	
*as at 21 April 2026 (not fully validated) **data under development/review due to EPR Go Live Faster Diagnosis Standard (FDS): March forecast at 75.8%, which would achieve previous 75% standard, but standard due to rise nationally to 80% (therefore non-compliant). For April, due to a drop in capacity, Dermatology is forecast to be less than 20%, which would result in a Trust position of under 50%. 62-day Cancer Referral to Treatment: March performance is at 64.3%, this is due to a downturn in Urology performance with delays to biopsies and histology being the predominate cause,					
Risks/issues					
EPR activity reduction and annual leave over Easter has reduced clinical availability for additional sessions, increasing waiting times across multiple specialties.					

13

Operational Performance Indicators - dashboard of key metrics

Key									
↑ = Performance improved from previous month ↓ = performance deteriorated from previous month ↔ = no change									
Not achieved	Under-achieved	Achieved	No target set	Data not available	NHSI Indicator				
Cancer – 2 week wait from referral to date first seen – regional reporting			↓		Ambulance handover delays > 30 minutes			↓	
Cancer – 28-day faster diagnosis standard			↓		Ambulance handover delays > 60 minutes			↓	
Cancer - 31-day wait from decision to treat to treatment - national reporting			↓		UEC - patients seen within 4 hours			↑	
Cancer - 62-day wait for treatment - national reporting			↓		ED patients with >12-hour visit time pathway			↑	
Cancer - Patient waiting longer than 104 days from 2 week wait			↔		Time to Initial Assessment within 15 mins – Emergency Department			↓	
Referral to treatment - % Incomplete pathways less than 18 weeks			↓		Clinically Ready to Proceed delay over 1 hour - Emergency Department			↓	
RTT 52-week wait incomplete pathway			↔		Non-admitted minutes mean time in Emergency Department			↓	
RTT 65-week wait incomplete pathway			↑		Admitted minutes mean time in Emergency Department			↑	
RTT 78-week wait incomplete pathway			↓		Diagnostic tests longer than the 6-week standard			↓	
RTT 104-week wait incomplete pathway			↔		Dementia Find			↓	
On the day cancellations for elective operations			↑		Care Planning Summaries % completed within 24 hours of discharge – Weekday			↑	
Cancelled patients not treated within 28 days of cancellation			↔		Care Planning Summaries % completed within 24 hours of discharge – Weekend			↑	
Theatre utilisation			↓		Clinic letters timeliness - % specialties within 4 working days			↑	
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)			↓						

Quality and Safety Indicators – dashboard of key metrics

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

HSMR		↓	Safer Staffing - ICO – Daytime (90% - 110%)		
SHMI	M7	↔	Safer Staffing - ICO – Night-time (90% - 110%)		
Never events		↔	Care Hours Per Patient Day (CHPPD): Day		
Reported incidents: death		↑	Care Hours Per Patient Day (CHPPD): Night		
Reported incidents: severe		↑	Follow-ups 6 weeks past to be seen		↓
Reported incidents: moderate		↑	Nutrition audit compliance		↑
Number Patient Safety Incident Investigations		↑	Admission to stroke unit within 4 hours	M11	↑
Medication incidents resulting in mod or more severe harm		↑	Fracture Neck Of Femur - Time to Theatre <36 hours (>90%) - one month in arrears	M11	↑
Falls per 1000 bed days	M11	↑	Maternity: 1:1 care in labour	M10	↔
Number of Healthcare Assoc Infection: MRSA	M11	↔	Maternity: Admission to SCBU (full term)	M10	↑
Number of Healthcare Assoc Infection: E-Coli		↑	Maternity: Stillbirths and perinatal deaths	M10	↓
Number of Healthcare Assoc Infection: MSSA		↑	Maternity: Smoking at time of delivery	M10	↔
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)		↔	Maternity: 3rd and 4th degree tears	M10	↔
Formal complaints		↑	Maternity: PPH>1500mls	M10	↔
Compliance with complaints acknowledge in 3 days			Maternity: Birth rate		↓
Compliance with complaints closed in 6 months					
Mixed sex accommodation breaches (0)		↓			

Quality and Patient Safety Summary

Areas of deterioration and risk

Non-clinical spaces (corridor care) and patient safety incidents

The Trust will report numbers of patients receiving corridor care via EPIC. Currently spaces in ED airlock, ED corridors and ward day rooms are utilised but reporting stays of 45 minutes in line with NHSE guidance has not been possible. Staff reported 5 incidents associated with corridor care during March all of which were low harm, no harm, or near misses.

Incidents: Discharge/ transfer of care

150 incidents related to 'Discharge' or 'Transfer' were reported in the last quarter. As an emerging theme this is likely to form a new PSIRF Local Priority.

Stroke care

Performance in stroke remains inconsistent and below national expectations. The ICB have requested detail of the Stroke Improvement Plan.

Maternity

In March there were no neonatal death or stillbirths. The Trust central safety team thematic review of recent cases is underway.

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 to 125 but further work is needed with a focus towards completing complaint responses within 6 months.

Infection Control

Rates of MSSA and e-coli remain above target thresholds. The IPC team is strengthening oversight of lapses and will work with NHS SW on a regional project re MSSA.

Areas of stable or improving performance

Safer Staffing

February data is within the NHSE suggested tolerance of 80-120% and also within the TSDFT tolerance of 90-110% fill rates.

Mixed sex accommodation breaches

Numbers appear to have slightly increased but are not outside recent variance.

The central safety team has established a robust system for tracking any safety concerns associated with the transition to EPIC.

Regulatory Compliance Update

CQC 2023 Well Led Inspection May – September 2023

The current position for the Well Led Must Do and Should Do action completion is 86.27%, of which there are only two open remaining Must Do actions. The outstanding Must Do actions related to the EDI agenda and outpatient waiting list times. 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 has been accepted by the MHRA and will report through the External Review Oversight Group from April 2026 (March's meeting was stood down due to operational challenges, imminent EPIC go live, and industrial action preparations).

Adult Social Care CQC Action Plan

This will start reporting through the External Review Oversight Group from April 2026.

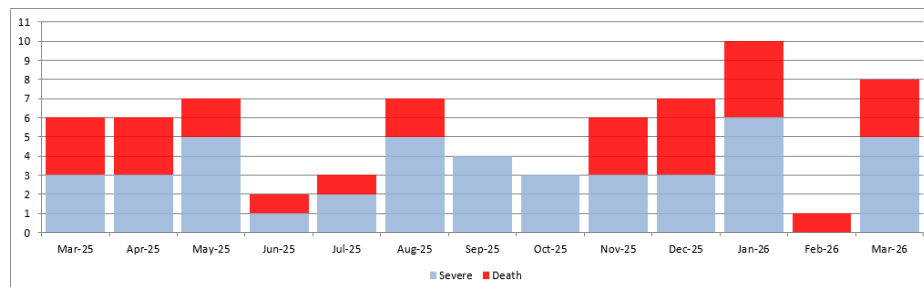
Audit South West – Draft CQC and Service Accreditation Report

This is currently being reviewed for factual accuracy and drafting of associated actions. It has highlighted that there needs to be consideration of meeting reporting structures to avoid duplication and strengthening of ward and service accreditation processes as a test of CQC readiness.

Quality and Safety exception reports – Reported incidents

Reported Incidents - Severe and Death

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Severe	3	3	5	1	2	5	4	3	3	3	6	0	5
Death	3	3	2	1	1	2	0	0	3	4	4	1	3



In March 2026, 5 incidents of death, and 3 incidents of severe harm were reported.

[Death] - Historic incident (2022) (regulation 28 case), delayed incident reporting – oxygen supply stopped prior to deterioration and death.

[Death] - Patient undergoing high-risk interventional procedure went into cardiac arrest and despite prolonged resuscitation, died.

[Death] - Patient with LD/Autism did not recover from a GA – CT identified a severe untreatable subarachnoid haemorrhage. Transferred to ITU where they subsequently died.

[Death] - Admitted with sepsis. Delay in starting the sepsis bundle. Patient transferred to ITU, later went into cardiac arrest and died. Meets national patient safety incident investigation criteria (PSII).

[Death] - Patient attended for a scan, became unresponsive post-scan and subsequently died. TEP form noted and not for CPR.

[Severe] - Incidental scan findings not acted on, impacting follow-up care and delaying secondary cancer diagnosis.

[Severe] - Unwitnessed fall resulting in fractured NoF.

[Severe] - Unwitnessed fall resulting in subdural haematoma and maxillary and orbital fractures.

Areas to escalate

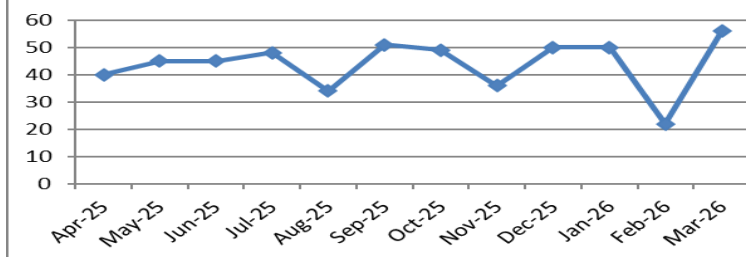
EPIC/EPR implementation: The central Patient Safety team developed an Epic incidents dashboard, monitored daily. The team have engaged with the digital clinical safety team to ensure that patient safety data is reviewed and escalated throughout the go-live and major incident phase of the rollout.

Building on previous collaborations around the domestic homicide review (DHR) process, the Trust Patient Safety and Legal teams are meeting to review inquest activity and any requirement for patient safety reviews. Alongside this, discussions with HM Coroner have also taken place and Coroner's Officers will join these meetings.

Patient safety incidents associated with Corridor Care and discharge from hospital continue to be monitored. Incidents with moderate harm, noted (chart above), have increased but this does not correlate with the number of related Corridor Care incidents reported in March (n=5), none of which had moderate harm. With 150 incidents reported in Q1 of 2025-26, discharge and transfer incident activity is a focus for patient safety and is likely to be approved as a new PSIRF Local Priority for the Trust.

Response shared to coroner in response to prevention of future deaths regulation 28 notice.

Moderate Harm Incidents Trustwide



Patient Safety Incident Response Framework (PSIRF) :

There are 10 patient safety incident investigations (PSII) underway; 6 meet national priorities and 4 meet local priorities.

A further local priority PSII is deferred pending the outcome of a Maternity Safety Support Programme (MSSP) thematic review. PSIRF to be updated to include safe discharge as a local PSII priority

Quality and Safety exception reports – Hospital Standardised Mortality Ratio HSMR

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.

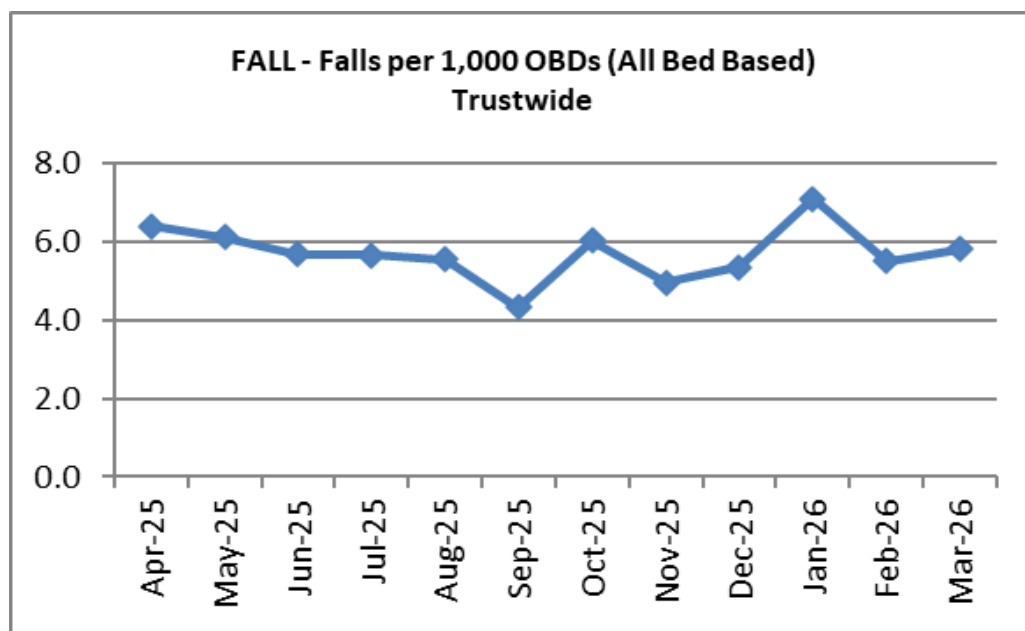
HSMR+: Regional Peers (Acute non-specialist) - The Trust is 1 of 5 trusts that are within the expected range (out of 13).



- The latest HSMR+ 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



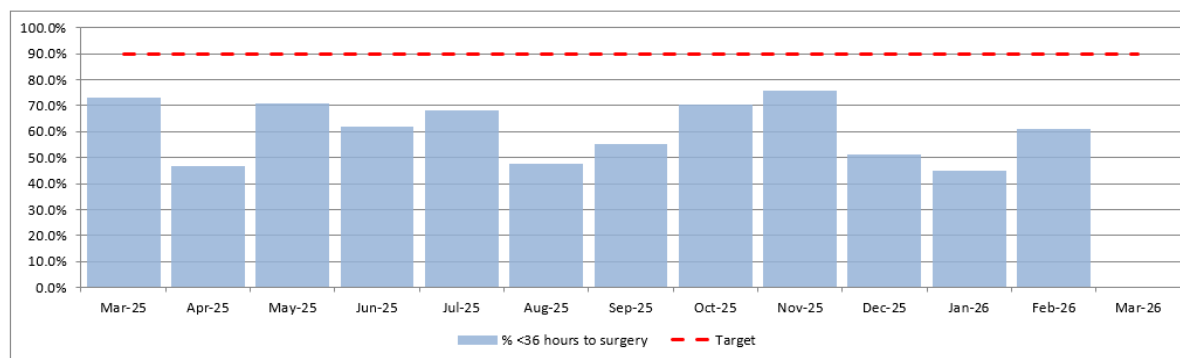
Falls

In the month of March there has been an increase in the number of falls sustained whilst in our care, two of which have resulted in a harm level of severe detailed below:

- 1 Fall in community rehabilitation, AAR was completed with Falls Lead, no further investigation required as no significant learning identified following the review,
- 1 Fall in UCE remains under investigation.

Fractured neck of femur - <36 hours to surgery

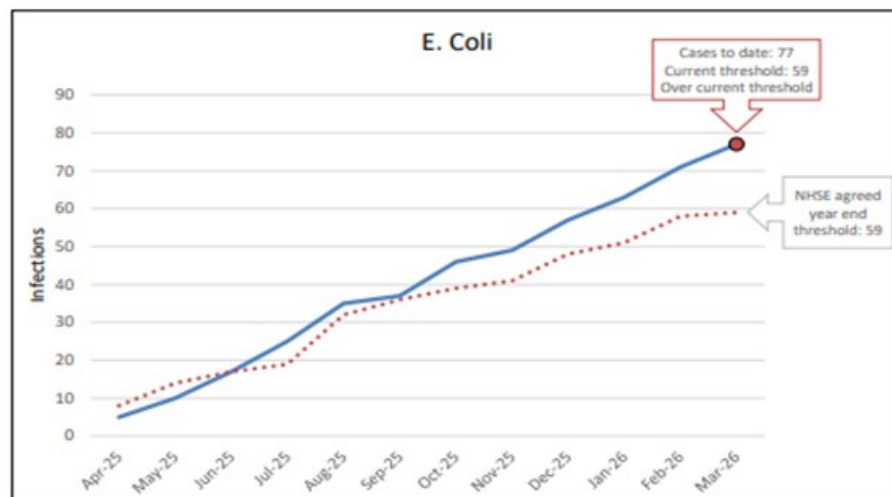
	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
% <36 hours to surgery	73.2%	46.5%	70.7%	61.8%	68.1%	47.4%	55.0%	70.3%	75.8%	51.0%	45.0%	60.9%	N/A
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Fractured Neck of Femur (one month in arrears – Month 12 data not yet available on National Hip Fracture Database).

March 26 data shows 35 hip fractures plus 6 other femoral fractures admitted. This will include the complex periprosthetic fractures. Average time to theatre for the hip fractures was 35 hours which is within the target 36 hours from admission to theatre.

Quality and Safety exception report - Infection control

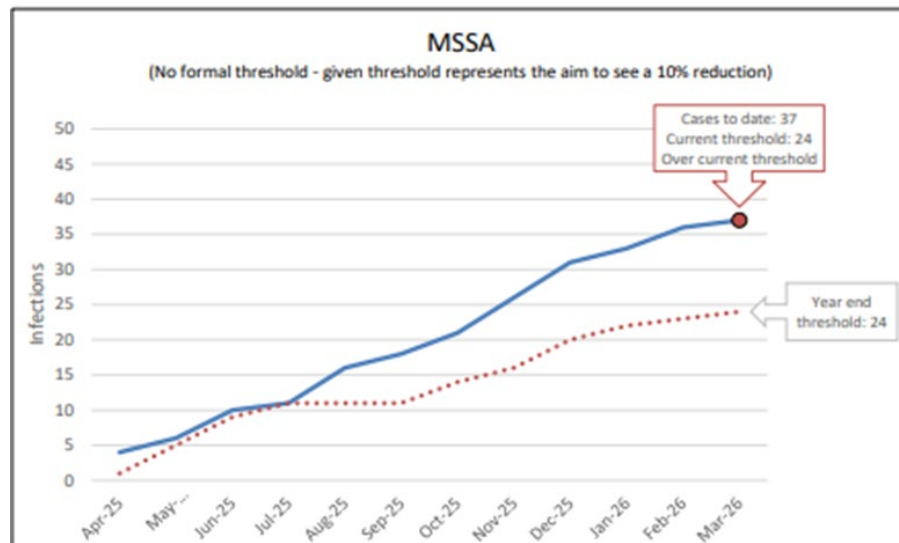


Escherichia Coli (E.Coli)

NHSE gave the Trust a 10% reduction in E.Coli blood borne viruses target (59 cases this year). At year end the Trust is 18 cases above threshold.

The primary source of infection across all areas indicates urinary tract infections remain the most significant source of E.Coli Bacteraemia's.

The IPC team is working to strengthen oversight of lapses in care and improvements.



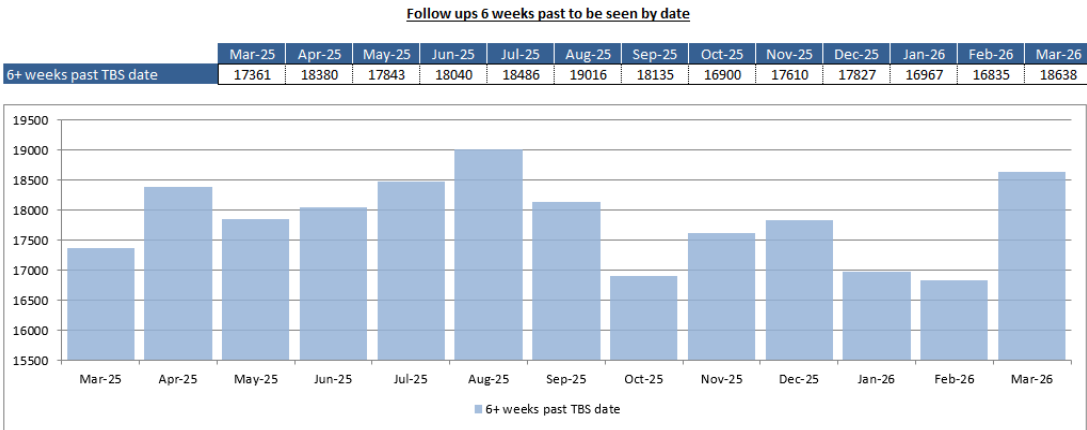
MSSA (Methicillin-Sensitive Staphylococcus aureus)

NHSE gave the Trust a target of 10% reduction in MSSA blood borne viruses (24 cases). At year end the Trust is 13 cases above threshold. Local review suggests no consistent causes of this and the national trend of MSSA is increasing. NHS SW will be leading a regional improvement programme which the Trust will be part of.

Other monitored infections

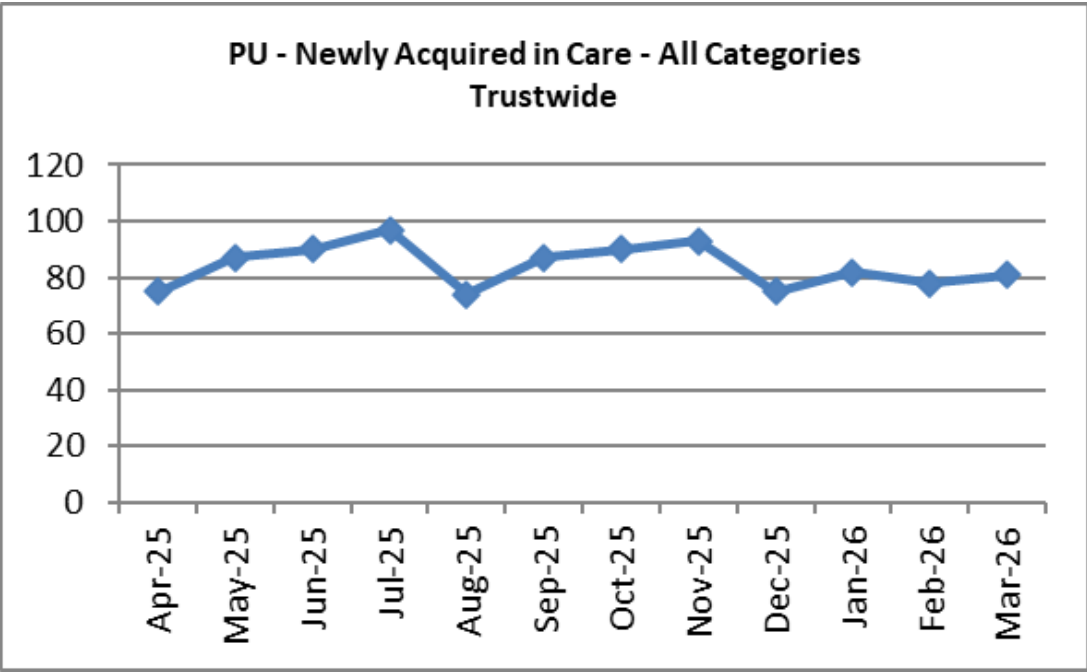
Rates of MRSA, Klebsiella, C-Difficile and pseudomonas are all below target levels set at a 10% reduction against last year's infection rates.

Quality and Safety exception reports – follow-ups past to be seen by date/ pressure ulcer



Follow-ups past 6 weeks to be seen

There was an increase in the number of patients waiting longer that 6 weeks past their 'to be seen by date' in March with specific issues with consultant absence within ENT and Ophthalmology.

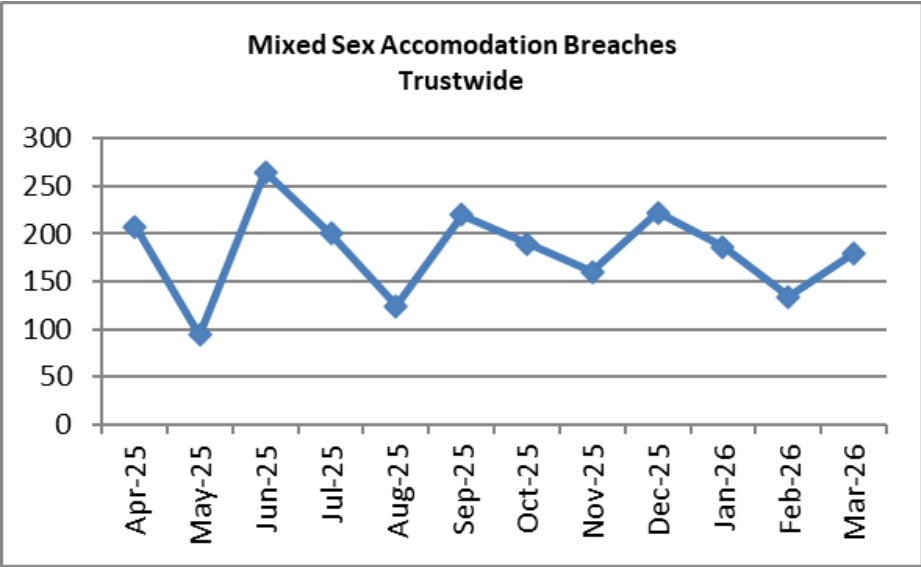


Pressure ulcer

Incidents of pressure ulcers acquired in our care shows a fairly stable picture.

Trustwide compliance with pressure ulcer assessment within 4 hours currently sits at 87%.

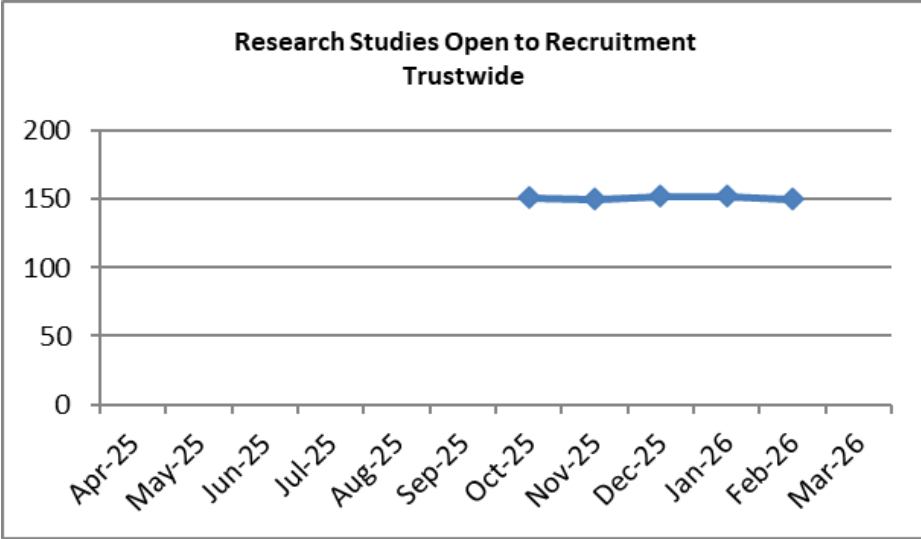
Quality and Safety exception report – Research involvement / Mixed Sex Accommodation



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.

From January 2026 we adopted guidance where we operate a 'clock stop' on breaches between 10pm and 7am in line with NHSE guidance. This appears not to have impacted on our reporting to date.



Research involvement

The number of research studies open to recruitment remains steady at 150 studies.

Quality and Safety exception report – TSDFT stroke standards

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

Time critical Stroke Standards	Natl. average Oct-Dec 2025														
		Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of patients (N)		46	56	55	62	54	50	58	53	57	44	51	56	40	60
% Scanned within 20 minutes updated target	32.1%	14.9%	23.2%	16.4%	29.0%	43.1%	24.5%	29.3%	39.6%	27.3%	22.7%	36.5%	37.5%	27.5%	37.70%
% Admitted to Stroke Unit within 4 hours	50.2%	24.40%	50%	37%	37%	47.30%	28%	46.40%	50%	49.1%	34.1%	52.90%	34%	38%	49.10%
Median time to reach the stroke unit (hours:mins)	03:47	09:23	03:45	06:00	05:31	04:16	06:17	04:18	03:40	03:45	06:55	03:43	05:55	09:09	04:01
% of patients spending 90% of their time on the Stroke Unit	82.3% (Team)	70.20%	83.60%	69.10%	77.40%	75.90%	78.90%	81%	81%	88.9%	65.9%	74.50%	60.70%	71.80%	73.30%
% Patients given formal swallow assessment within 24 hours	54.9%	4.3%	19.0%	7.3%	8.1%	8.5%	7.5%	5.2%	5.70%	5.50%	40.00%	58.40%	69.60%	71.90%	73.50%
% (No.) Patients that received Thrombolysis	13.5%	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)	12.5% (7)	17.5% (7)	3.3% (2)
Median time between clock start and thrombolysis (hours:minutes) New target	00:55mins	01:08	01:06	01:36	01:17	01:08	01:07	01:17	01:27	00:58	00:57	00:53	01:10	00:48	00:58

SSNAP results have been released for Q3 2025/26. George Earl Ward remained an E but improvements were seen in three domains and no domains worsened. Newton Abbot remained a D but improved in 2 domains and no domains worsened. Nationally averages for the time critical standards we regularly report on (see above) improved in two areas (green) and worsened in three areas – albeit marginally in two of those (red) and stayed the same in one (black). Positives for performance for March (as measured in the DIY tool) included an improvement in patients scanned within 20 minutes and patients receiving a formal swallow assessment within 24 hours – both above the national average. Also improvements in the time taken to reach the stroke unit and median time to reach the stroke unit which was just outside the national average and the target of 4 hours.

The proportion of patients receiving thrombolysis was very low in March; feedback from the team is that there was a higher number of strokes caused by a bleed. Numbers for April are already triple the numbers for the whole of March.

Stroke Actions:

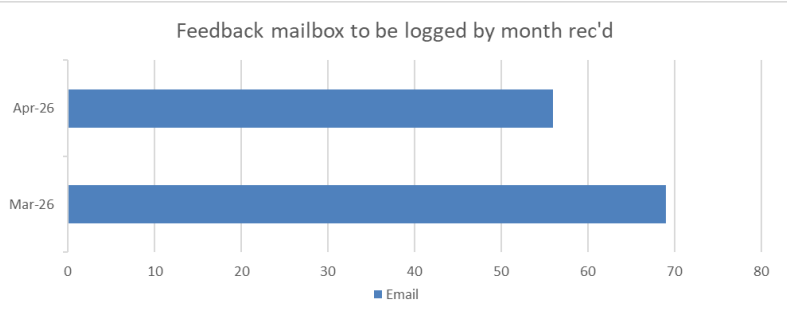
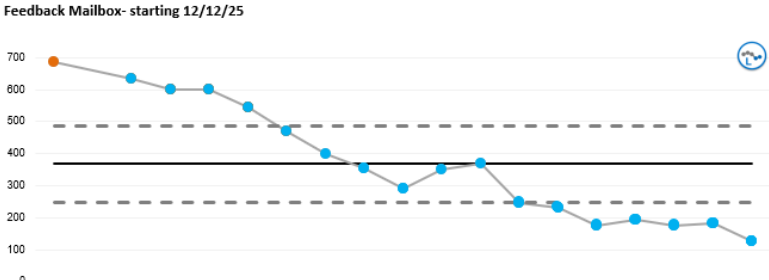
- Capture Stroke to soft launch on 15th May. The team from Capture Stroke will base themselves at Torbay and Newton Abbot to support the implementation. Full implementation is still planned for after Epic “go live” in UHP (due to IT team resource).
- Ringfencing our three hyperacute stroke beds on George Earle, draft Standard Operating Procedure was sent to clinicians, site team, and senior operational team and requires some revision before it can be signed-off; this will be done in the next 4 weeks.
- Positive meeting held with ED, SWASFT, and radiology colleagues on 16th March to discuss further improvements to the hyper-acute pathway. Small changes have already been implemented to support. Further updates have been made to the improvement plan.

Other work

- Workforce modelling for specialist stroke nursing, speech and language therapy and dietetics planned over next 2-3 months.
- Identifying how to deliver out of hours support for reperfusion decision making has stalled but discussions will be picked up again.
- Discussions are planned to identify whether a pilot of pre-hospital telephone triage is possible; full implementation would not be possible with current staffing.

Quality and Safety exception report – Feedback and engagement

There are currently 125 emails in the Feedback Mailbox (March and April). Weekly figures are collected to monitor the effectiveness of interventions and improvements made as we redevelop of PALS/Complaints service and processes.

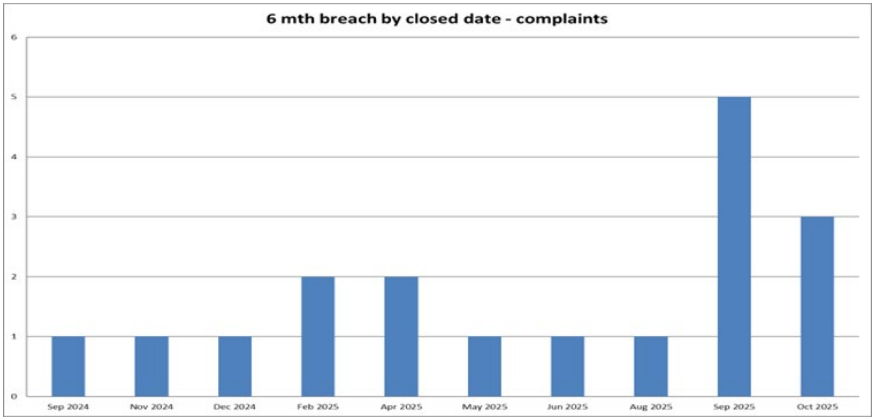
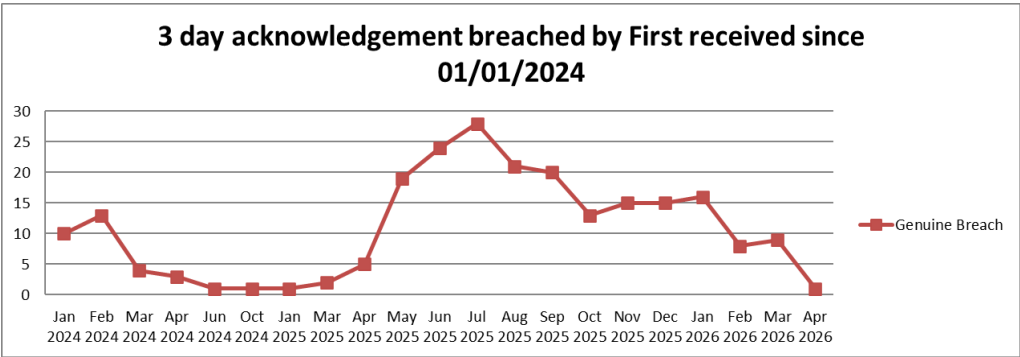


- Current actions in progress to improve efficiencies:
- Upcoming(May 2026) redevelopment of Feedback DCIQ module to reduce unnecessary admin.
 - Two-step pack has been removed and replaced with new letter template.
 - Removal of the term 'concern' and replacing with PHSO terminology Complaint (Formal/Informal) – trialling early resolution template from PHSO.

Complaint Metrics

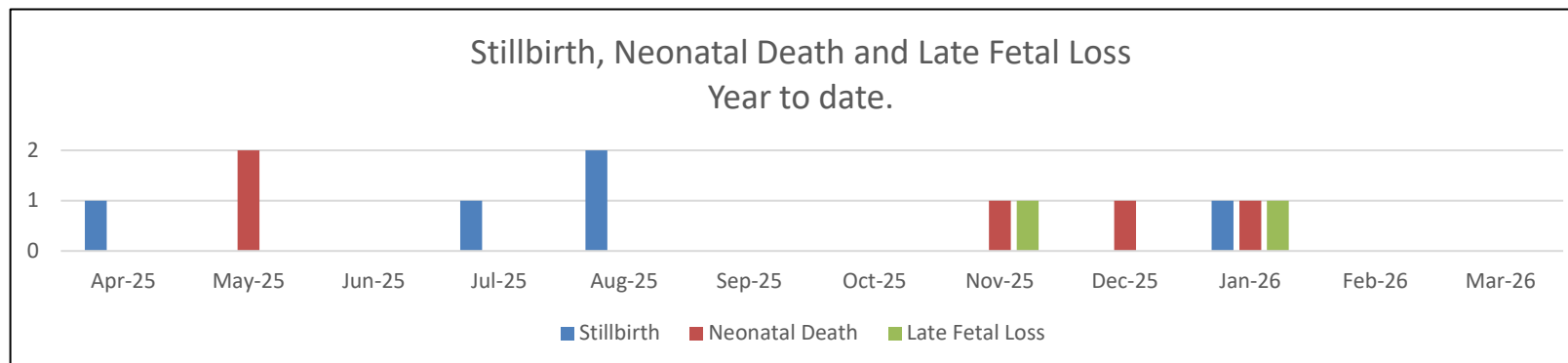
- The Trust is required to report on two complaint standard metrics;
- Acknowledge complaint within 3 working days
 - Formal response within 6 months (internal deadline 12 weeks)

It was previously reported that the Trust cannot accurately report on the quality standard for 3-day acknowledgement of complaints due to the large volume of unactioned correspondence within the mailbox. As this is being addressed the 3-day acknowledgement position is improving. The six-month complaint response standard data is collated upon closure. September and October demonstrates an increase compared to previous months. It is expected due to the backlog in processing complaints this will have an impact but the data is not yet available.



Quality and Safety- Perinatal Clinical Quality Surveillance April 2026 (March 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:

- **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. 1 x stillborn baby at 26 weeks' gestation.
- **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.
- **January 2026** – 1 x Stillbirth at 28+2, 1 x NND 29+1 baby died in UHP following delivery in Torbay due to infection, 1 x Late fetal loss. 21 weeks died following amnio. Confirmed chromosome anomaly.

Incidents moderate and above Incidents moderate and above = 2

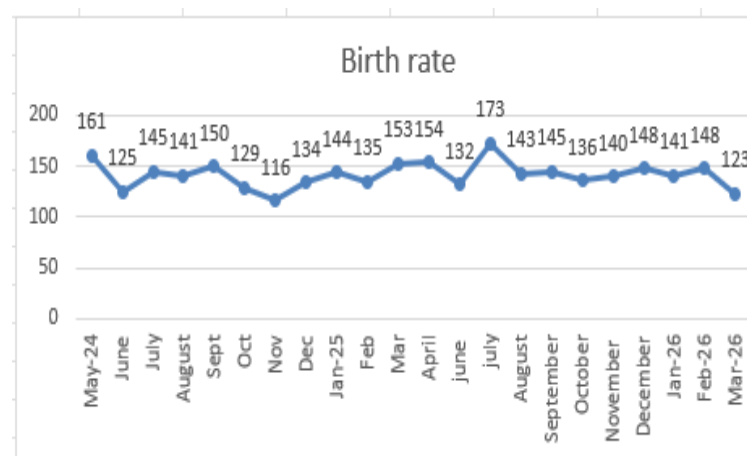
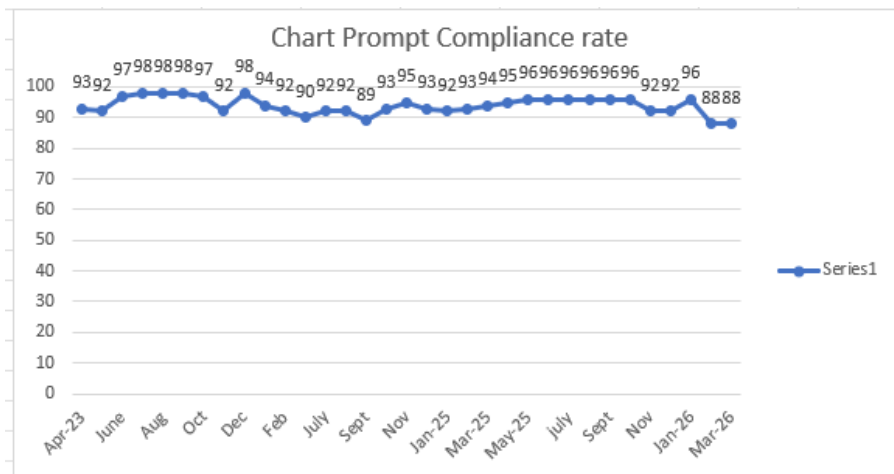
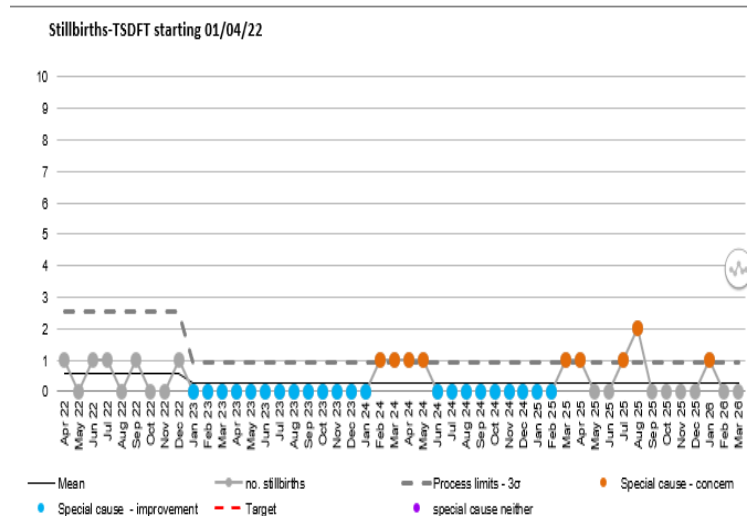
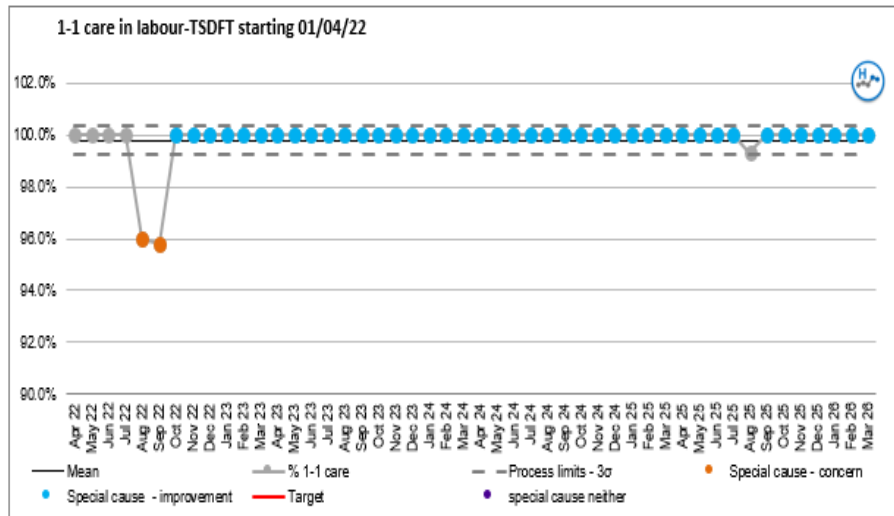
- 35055 – Severe – Woman developed immune Anti D antibody between pregnancies, unknown sensitising event.
- 35495 – Moderate – Forceps Delivery @ 37/40, developed haematoma, return to theatre.

MNSI – None

CQC – None

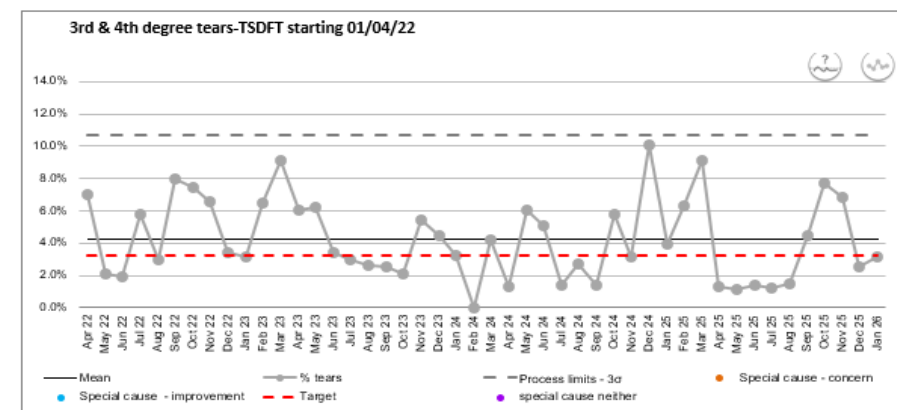
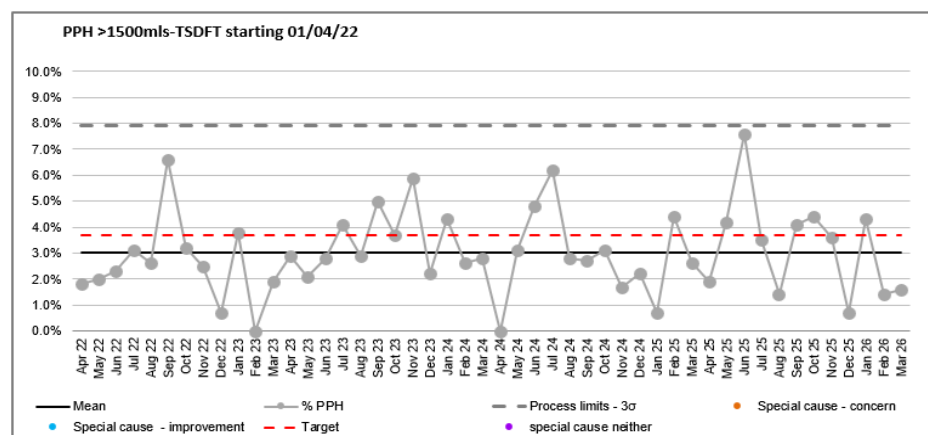
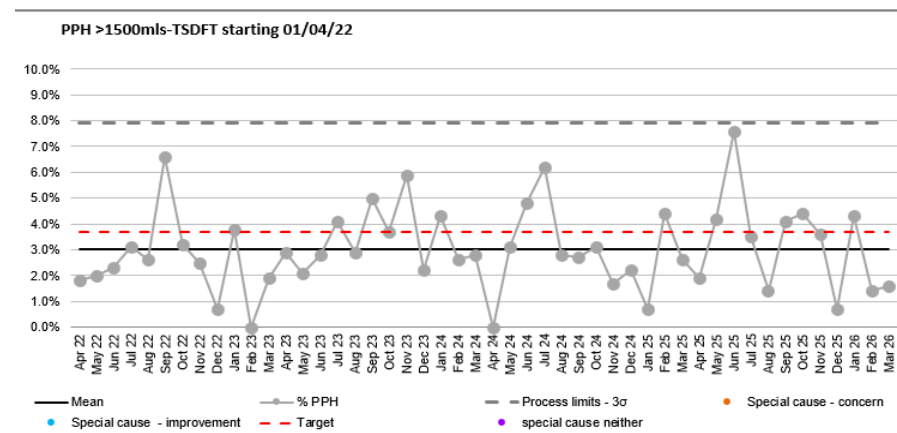
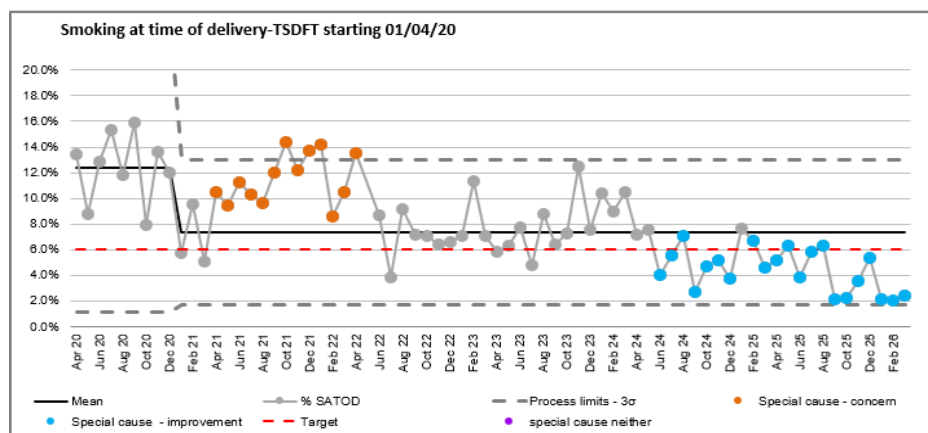
Coroner referral – None

Quality and Safety - Metrics relating to the provision of quality maternity care- March 2026



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

- Births in March: 123
- Continuing to maintain remarkable results for the month of March in smoking at delivery 2.4%. Quarterly average of 2.16% well below the National target of 6%.
- No Stillbirths or neonatal deaths in the month of March.
- Decrease in the number of 3rd/4th degree from 5.6% in February to 3.0 in March Quarterly average of 3.9% national target average is 3.2%.
- Marginal increase in the incidence of PPH>1500mls from 1.4% for February to 1.6% in March, quarterly average @ 3.43 % below the National target of 3.7%.
- An increase in term baby admissions to SCBU to 8.8%. National target is 5% or less . (quarterly average of 8.03%) QI work in place to reduce rate- Screen and Treat at bedside.



Quality and Safety – Safer Staffing – Dashboard February 2026 (one month in arrears)

Inpatient Wards (All)

Staffing Metrics					
Beds		Establ. Beds		518	
		Bed Occ.		96.0%	
Staffing Fill Rates		Days	RN / Midwives	90.4%	
			Care Staff	94.6%	
		Nights	RN / Midwives	95.4%	
			Care Staff	103.7%	
Actual Staffing Split		Days	% RN / Midwives Hours	54.2%	
			% Care Staff Hours	45.8%	
		Nights	% RN / Midwives Hours	54.5%	
			% Care Staff Hours	45.5%	
Care Hours Per Patient Day (CHPPD)		Days	RN / Midwives	Planned	2.4
				Actual	2.2
			Care Staff	Planned	2.0
				Actual	1.9
		Overall Day	Planned	4.4	
			Actual	4.1	
		Nights	RN / Midwives	Planned	1.9
				Actual	1.8
			Care Staff	Planned	1.4
				Actual	1.5
		Overall Night	Planned	3.3	
			Actual	3.3	
HR Metrics		Sickness Rate	(Jan-26)	6.4%	
		Turnover Rate		9.6%	
		Vacancy Rate		2.3%	
Temporary Staffing		Prop. Bank Hours		14.0%	
		Prop. Agency Hours		5.4%	
Patient Sensitive Indicators					
Safety		Red Flags Raised	EToC Red Flags	2	
			All Red Flags	19	
		Mod. Harm Incs and Above		11	
		PUs G2+ Acq. in Our Care		0	
		Falls	No Harm	42	
			Harm	31	
		Medicine Errors		30	
		% Obs Taken on Time		90.8%	
Feedback	Patient Complaints		0		
	FFT	% Positive Resp.	(Jul-25)	98.9%	
		Number of Resp.	(Jul-25)	265	

Emergency Care (ED Only)

Staffing Metrics				
Number of Attendances				6,443
Staffing Fill Rates	Days	RN / Midwives		91.7%
		Care Staff		88.3%
	Nights	RN / Midwives		94.4%
		Care Staff		80.5%
Actual Staffing Split	Days	% RN / Midwives Hours		63.0%
		% Care Staff Hours		37.0%
	Nights	% RN / Midwives Hours		65.7%
		% Care Staff Hours		34.3%
HR Metrics			Sickness Rate (Jan-26)	9.6%
			Turnover Rate	12.4%
			Vacancy Rate	-3.5%
Temporary Staffing			Prop. Bank Hours	17.7%
			Prop. Bank Hours	16.7%
Patient Sensitive Indicators				
Number of Unplanned Reattendances				220
Service Delivery Times			% Waiting > 4 Hrs	49.3%
			% Waiting > 12 Hrs	11.5%
			Avg. Triage Time (mins)	15
			Amb. Handovers < 30 mins	58.8%
Safety			All Red Flags	0
			Mod. Harm Incs and Above	3
			Medicine Errors	4
			PUs G2+ Acquired in Our Care	0
	Falls	No Harm		3
		Harm		7
	Sepsis	% Overall Sepsis 6 Compliance		82.0%
		% Antibiotics within 1 Hour		100.0%
Feedback			Patient Complaints	2
	FFT	% Positive Resp. (Jul-25)		100.0%
		Number of Resp. (Jul-25)		28

CHPPD data 26

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
	7.45	4.14	0.02	3.28	7.50	4.05	0.04	3.41
Total Planned Beds / Day	522							
Days in month	28							

Quality and Safety – Safer Staffing – Dashboard February 2026

CHPPD- Satisfactory Assurance

The Trust overall actual CHPPD is 7.45 this is slightly over the planned target of 7.37. The actual CHPPD for RN/Midwives in February 2026 is 3.98 this is slightly under the target of 4.14. The overall actual CHPPD for HCSW is 3.35. This is slightly over the planned target of 3.28.

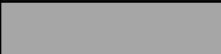
February's data remains within the NHSE suggested tolerance of 80-120% and within the TSDFT tolerance of 90-110% fill rates. RN numbers are at the lower end for the days with an average of 90.4%. The average registered fill rate for nights has remained stable at 94.6%. Care staff fill rates on day shifts has decreased by 2.3% to 94.6%. The care staff fill rate for nights is 103.7% this is a decrease of 2.7% from January 26. The increase in fill rates for Care Staff, reflects the increase in demand for the Care staff shifts requested to backfill vacancies, sickness, maternity leave and escalation areas. Lower fill rate is concentrated to our fragile services where recruitment of staff is complex. ED has had a successful RN recruitment event and bespoke Care staff recruitment dates are planned for April 26.

Organisational absence currently resides at 6.4% this is a decrease of 0.5%. Turnover rate has increased to 9.6% (an increase of 0.3%) from January 26. Vacancy rate has increased to 2.3% a rise of 0.2% from January 26. Focused recruitment campaigns and reduction in the onboarding timeline have supported this decrease within the Nursing workforce. On boarding days reside at an average of 50 days for HCSW and 60 days for RNs. The reduction in the onboarding timeline will support our fill rates whilst reducing our reliance on the use of temporary workforce currently being used to back fill the on-boarding timeline.

The current proportion of temporary workforce hours supporting pipelines currently resides at: bank proportion 14% this is an increase of 1.6% from January 26. Agency proportion has also increased to 5.4% this is an increase of 2.2% from last month. Focused work is being undertaken to support the migration of agency staff onto NHSP. Currently 10 long standing agency workers have been migrated over to NHSP in the last 2 months. Requesting of agency shifts has also been reduced to 4 days, with prohibiting of direct booking of agency staff to areas that are currently high users. Substantive recruitment is also now a permanent fixture on the weekly bank and agency meeting with check and challenge. Exception reporting for use of temporary staffing remains a priority with the bank and agency meeting.

Community and Social Care Indicators - Summary of key metrics

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

Opiate users - % successful completions of treatment (quarterly - 1 quarter in arrears)		
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		
Community Hospital - Admissions (non-stroke)		
Community Hospital average Length of Stay (days)		↓
Community Hospital patient discharges pre-noon		↑
Urgent Community Response 2 hours		↓
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.

Community and Social Care Indicators – Community Waiting List – greater than 52 week wait

Community waiting times are reported monthly and indicate the number of people waiting less than 18 weeks, 18-52 weeks, and over 52 weeks across adult and children's service provision.

In March 257 people are reported as waiting over 52 weeks for an appointment (from 398 in February) with 95 people being under the Weight Management and Obesity Service.

There are a number of local and regional initiatives being led by the ICB looking to ease waiting times for Weight Management and Obesity Services, this includes redefining clinical thresholds for referral as well as validating the waiting list and potentially increasing capacity through additional funding.

Community Waiting Times

(A) Indicates Adult Service provision; (CYP) indicates Children / Young Person service provision

Torbay and South Devon NHS Foundation Trust (TSDFT)	< 18 weeks	18 - 52 weeks	52 - 104 weeks	over 104 weeks	Total
(A): Audiology services	280	15	21	0	316
(A): Podiatry and podiatric surgery	1,285	111	3	0	1,399
(A): Wheelchair, orthotics, prosthetics and equipment	0	0	0	0	0
(A): Rehabilitation services (integrated and uni-disciplinary) (physio, OT, speech and language therapy, etc)	0	0	0	0	0
(A): Therapy interventions: Speech and language	302	23	3	0	328
(A): Therapy interventions: Occupational therapy	221	33	15	0	269
(A): Therapy interventions: Dietetics	66	3	5	0	74
(A): Therapy interventions: Orthotics	32	7	1	0	40
(A): Therapy interventions: Physiotherapy	170	3	0	0	173
(A): Weight management and obesity services	64	147	95	0	306
(A): Musculoskeletal service	2,935	4	0	0	2,939
(A): Nursing and Therapy support for LTCs: Heart failure	1	0	0	0	1
(A): Nursing and Therapy support for LTCs: Tissue viability	0	0	0	0	0
(A): Nursing and Therapy support for LTCs: Respiratory/COPD	9	8	46	0	63
(A): Nursing and Therapy support for LTCs: Stroke	201	53	17	0	271
(A): Nursing and Therapy support for LTCs: MND	0	0	0	0	0
(A): Nursing and Therapy support for LTCs: Falls	115	9	0	0	124
(A): Nursing and Therapy support for LTCs: Lymphoedema	38	3	0	0	41
(A): Nursing and Therapy support for LTCs: Diabetes	0	0	0	0	0
(A): Community nursing services (including district nurses and homeless health)	119	5	6	0	130
(A): Urgent Community Response/Rapid Response team	0	0	0	0	0
(A): Intermediate care and reablement	24	0	0	0	24
(A): Adult safeguarding	0	0	0	0	0
(CYP): Audiology	141	43	16	0	200
(CYP): Vision screening	50	20	17	0	87
(CYP): New-born hearing screening	0	0	0	0	0
(CYP): Community paediatric service	118	122	3	0	243
(CYP): Wheelchair, orthotics, prosthetics and equipment	20	1	9	0	30
(CYP): Safeguarding	0	0	0	0	0
(CYP): Antenatal, new-born and children screening and immunisation services	0	0	0	0	0
TSDFT Total	6,191	610	257	0	7,058

Workforce – Executive Summary – Month 12

At year end, the Trust's workforce position is materially above plan, with total workforce at 6,688.19 WTE, concluding the year 277.67 WTE above the original operational plan. This position reflects sustained substantive over-establishment, alongside continued reliance on Bank and Agency staffing, and demonstrates limited progress in reducing workforce levels in line with planned year-end assumptions. The outturn reflects ongoing operational demand and the absence of an agreed cost-reduction (CR) scheme during the year.

The year-end workforce financial position is significantly adverse, with a total overspend of £35.78m. This is driven predominantly by substantive pay costs (£35.77m overspend), with a substantial element attributable to a non-recurrent year-end pensions cost gross-up, resulting in a pronounced spike in costs in the final month of the year. Bank staffing closed the year £0.92m over budget, reflecting continued dependency on temporary staffing, while Agency spend closed the year £0.91m under budget, partially mitigating the overall position despite Agency WTE remaining above plan.

Workforce performance indicators at year end remain mixed. Sickness absence closed at 5.17%, slightly improved compared to February but remaining above the <4.5% target, with an estimated annualised cost of £13.6m. Turnover closed at 16.88%, driven by the planned transfer of CFHD staff; excluding this transfer, turnover would be 12.2%, broadly in line with target. Appraisal compliance remains below expectation, with AfC at 77.65% and Medical at 72.00%, reflecting sustained challenges achieving year-end targets. Mandatory training closed the year above target at 87.75%, though continued gaps remain in Manual Handling and Information Governance compliance.

Employee Relations performance at year end demonstrates clear improvement and strengthening control. Across the final quarter, there has been a 36% reduction in maximum case completion time and a 46% reduction in average case completion time compared with the same period last year. Long-term sickness cases reduced by 24% quarter-on-quarter, with reductions observed across all care groups. Targeted manager training and hotspot deep-dives have supported improved attendance management, case progression, and early intervention in high-risk areas, contributing positively to workforce stability.

Overall, while there are positive improvements in Employee Relations outcomes and selected workforce indicators, the year-end position confirms entrenched structural workforce and financial pressures. Sustained substantive over-establishment and continued reliance on temporary staffing underpin a materially adverse outturn, reinforcing the need for strengthened workforce controls, delivery of planned establishment reductions, and continued focus on attendance, appraisal compliance, and early ER intervention as the Trust enters 2026/27.

Workforce Performance Summary - Month 12

	Current Month (Mar 26)	Previous Month (Feb 26)	Target	Change from previous Month	Performance against target	Local Benchmark comparisons
Sickness	5.17%	5.29%	<4.50%			5.4%
Sickness Cost	£13.6m	£13.9m	£12.5m			NA
Turnover	16.88%	11.55%	<12%			11.90%
AfC Appraisal	77.65%	78.52%	>90%			70.30%
Medical Staff Appraisal	72.00%	68.98%	>90%			NA
Combined Mandatory Training	87.75%	88.60%	>85%			84.60%
Infection Control	85.98%	87.16%	>85%			NA
Information Governance	83.20%	84.45%	>85%			NA
Manual Handling	67.25%	70.58%	>85%			NA
Safeguarding Children	86.28%	87.00%	>85%			NA
Safeguarding Adults	95.45%	95.65%	>85%			NA
Agency % of Budgeted Pay Bill	1.55%	1.44%	<1.91%			NA
Bank % of Budgeted Pay Bill	5.76%	5.34%	<5.19%			NA
Total Workforce Plan WTE	6688.19	6626.52	<6363.16			NA
Substantive Workforce Plan WTE	6279.74	6257.44	<5992.12			NA

Please note: WTE Targets are against Month 12 Plan

Workforce Position to Date

WTE						£					
	M12 2025/26 Bud WTE	M12 2025/26 Cont. WTE	M12 2025/26 Work. WTE	M12 2025/26 Contracted + Bank + Agency	WTE Variance to Budget	M12 Budget £	M12 Actual £	£ Difference to Budget	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Month 12											
Agency	62.78	0.00	75.05	75.05	12.27	£583,740.00	£474,592.45	-£109,147.55	£7,104,497.00	£6,190,243.19	-£914,253.81
Bank	308.41	0.00	333.41	333.41	25.00	£1,574,494.00	£1,760,816.45	£186,322.45	£19,265,622.00	£20,186,435.26	£920,813.26
Substantive	6039.33	6279.74	6301.40	6279.74	240.41	£28,402,747.00	£56,917,919.41	£28,515,172.41	£349,387,082.00	£385,161,001.56	£35,773,919.56
Grand Total	6410.52	6279.74	6709.85	6688.19	277.67	£30,560,981.00	£59,153,328.31	£28,592,347.31	£375,757,201.00	£411,537,680.01	£35,780,479.01

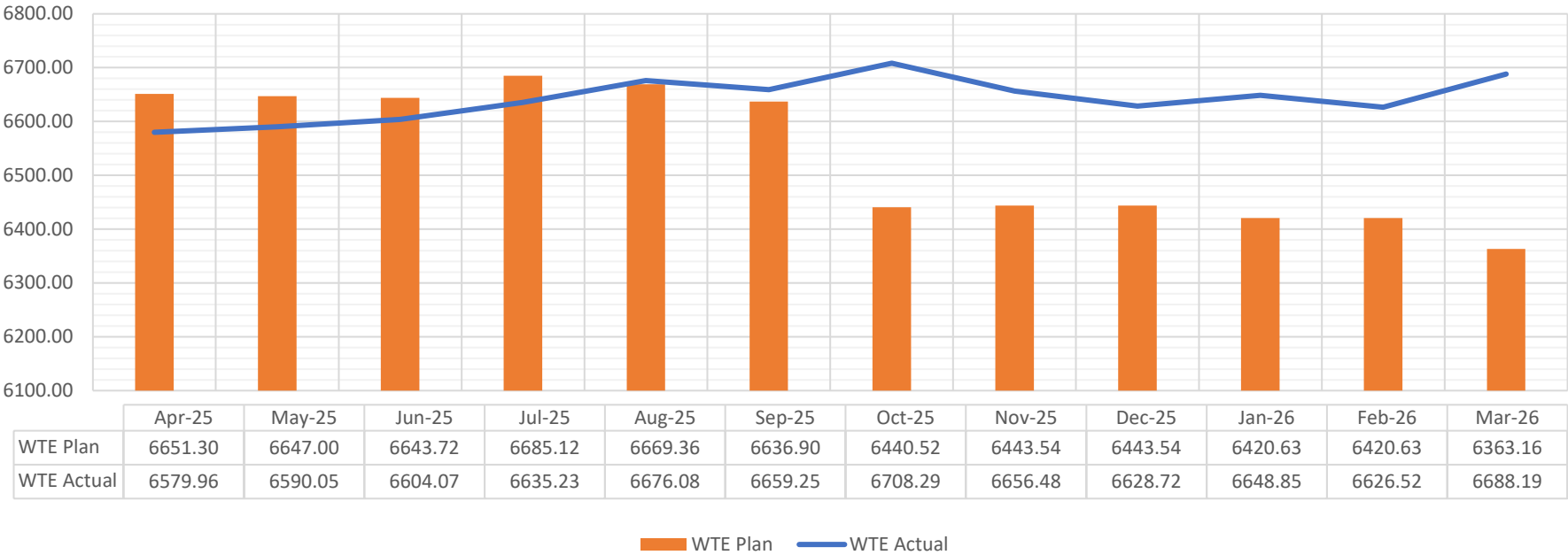
Total workforce in Month 12 is 6,688.19 WTE. Compared with Month 11, the Trust's overall workforce position deteriorated, with total WTE increasing by 61.67 WTE. This increase was driven primarily by higher Bank and Agency usage, alongside a continued rise in substantive working WTE. As a result, the variance to the original operational plan widened significantly, increasing from 215.45 WTE over plan in Month 11 to 277.67 WTE in Month 12.

The in-month overspend increased to £28.59m, driven predominantly by a significant increase in substantive staffing costs. A substantial element of this increase reflects a year-end pensions cost gross-up, which has resulted in an atypical spike in pay expenditure for the month.

While Agency expenditure remained favourable to plan (-£109k), Bank staffing overspent by £186k, indicating continued reliance on temporary staffing. However, these variances are secondary to the impact of the pensions adjustment in driving the overall in-month position.

While the in-month financial position has been significantly impacted by a non-recurrent pensions adjustment, the underlying workforce remains above funded levels, reinforcing the need for sustained workforce controls and tighter management of temporary staffing going into the new financial year.

Total Workforce Plan



The chart shows that actual workforce levels have remained consistently above plan throughout the period April 2025 to March 2026, with the gap widening in the second half of the year. From April to August 2025, both plan and actual WTE increased steadily; however, actual WTE rose at a faster rate, peaking at 6,706.08 WTE in August 2025 against a plan of 6,669.36 WTE. This indicates growing workforce pressure during the early part of the year despite planned growth being factored into the establishment.

From October 2025 onward, the planned WTE reduces sharply as part of the year-end control assumptions, falling from 6,636.90 in September to 6,363.16 by March 2026. In contrast, actual WTE remains elevated, fluctuating between 6,628 and 6,688 WTE, resulting in a progressively widening variance to plan. By March 2026, the variance reaches its highest point, with actual WTE at 6,688.19 compared to a plan of 6,363.16. This divergence highlights the increasing challenge of delivering planned workforce reductions and demonstrates sustained demand and structural workforce pressures that prevent actual staffing levels from reducing in line with plan.

Devon Benchmark – DPT: 74 WTE under, UHP: 51 WTE over, RDUH: 353 WTE over.

Bank WTE & Spend Analysis by staff group

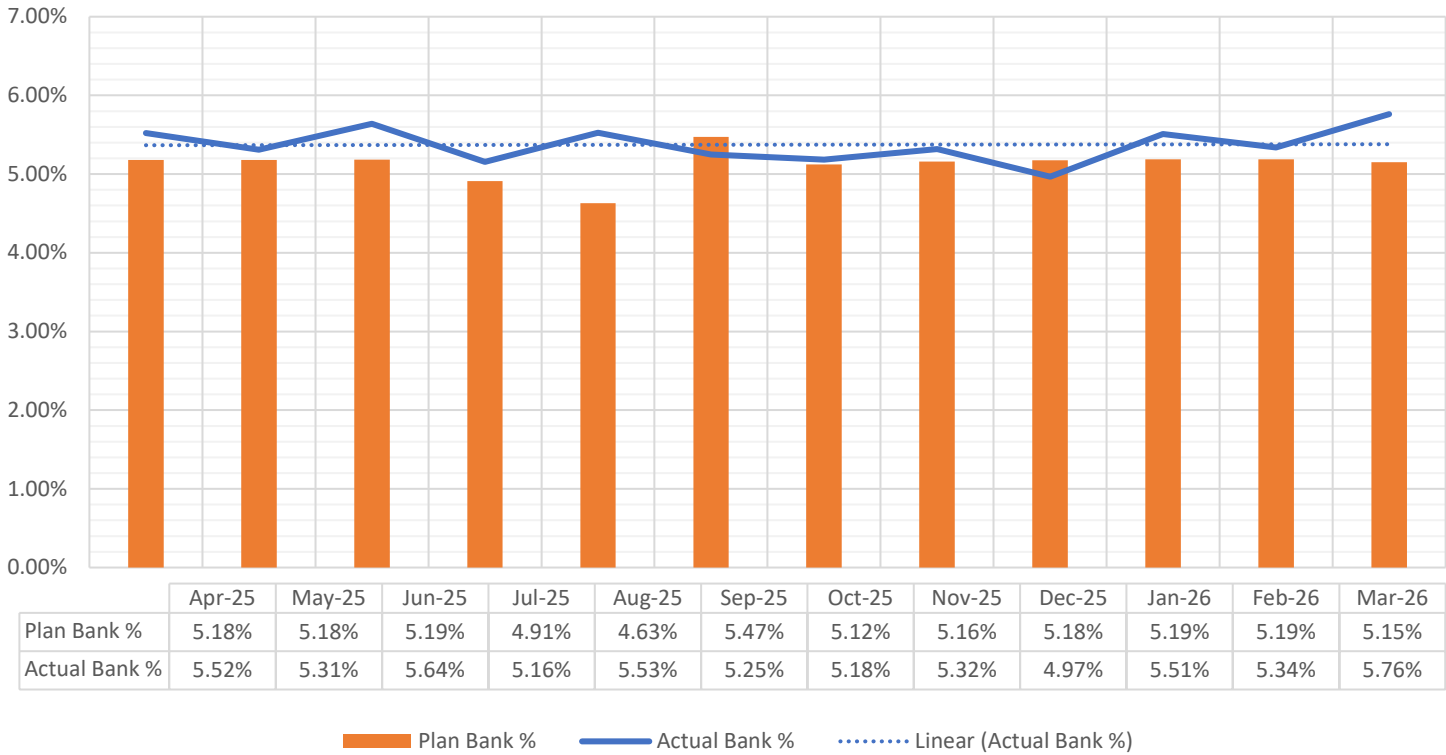
Month 12	M12 Budget WTE	M12 Worked WTE	Variance of worked to budget	M12 Budget £	M12 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Any other Staff (Board Members)	0.00	-0.19	-0.19	£0.00	-£462.73	-£462.73	£0.00	-£5,081.30	-£5,081.30
Medical and Dental	56.11	34.50	-21.61	£535,459.00	£494,498.35	-£40,960.65	£6,727,090.00	£6,517,599.36	-£209,490.64
NHS Infrastructure support	51.70	64.63	12.93	£231,059.00	£221,447.39	-£9,611.61	£2,849,956.00	£2,554,005.33	-£295,950.67
Registered Nursing, Midwifery and Health Visiting Staff	51.09	88.66	37.57	£314,482.00	£507,587.34	£193,105.34	£3,718,728.00	£4,705,921.16	£987,193.16
Registered Scientific, Therapeutic and Technical staff	6.91	7.98	1.07	£50,169.00	£29,344.16	-£20,824.84	£601,141.00	£329,291.94	-£271,849.06
Support to Clinical Staff	142.60	137.83	-4.77	£443,325.00	£508,401.94	£65,076.94	£5,368,707.00	£6,084,698.77	£715,991.77
Grand Total	308.41	333.41	25.00	£1,574,494.00	£1,760,816.45	£186,322.45	£19,265,622.00	£20,186,435.26	£920,813.26

Bank usage in Month 12 totalled 333.41 WTE, which is 25 WTE above budget. The largest contributor is Registered Nursing, Midwifery and Health Visiting staff, operating 37.57 WTE above plan. Infrastructure Staff usage was also 12.93 WTE over budget.

Financially, the month shows a £186k overspend, driven primarily by Nursing (£193k) and Support to Clinical staff (£65k). Year-to-date, Bank expenditure is £920k over budget, with overspends concentrated in Nursing (£987k) and Support to Clinical roles (£715k).

Overall, Month 12 reflects continued reliance on Bank staffing above planned levels, resulting in sustained financial pressure.

Bank Spend vs Budget



Mar 26 Bank is 25 WTE over plan and equates to a £186k overspend (Compare this to Mar 25 we were 269 WTE over budget and £1.49m) overspent.

Devon Benchmark – DPT: 4.1%, UHP: 4.8%, RDUH: 3.8%

Agency WTE and Spend Analysis by staff group

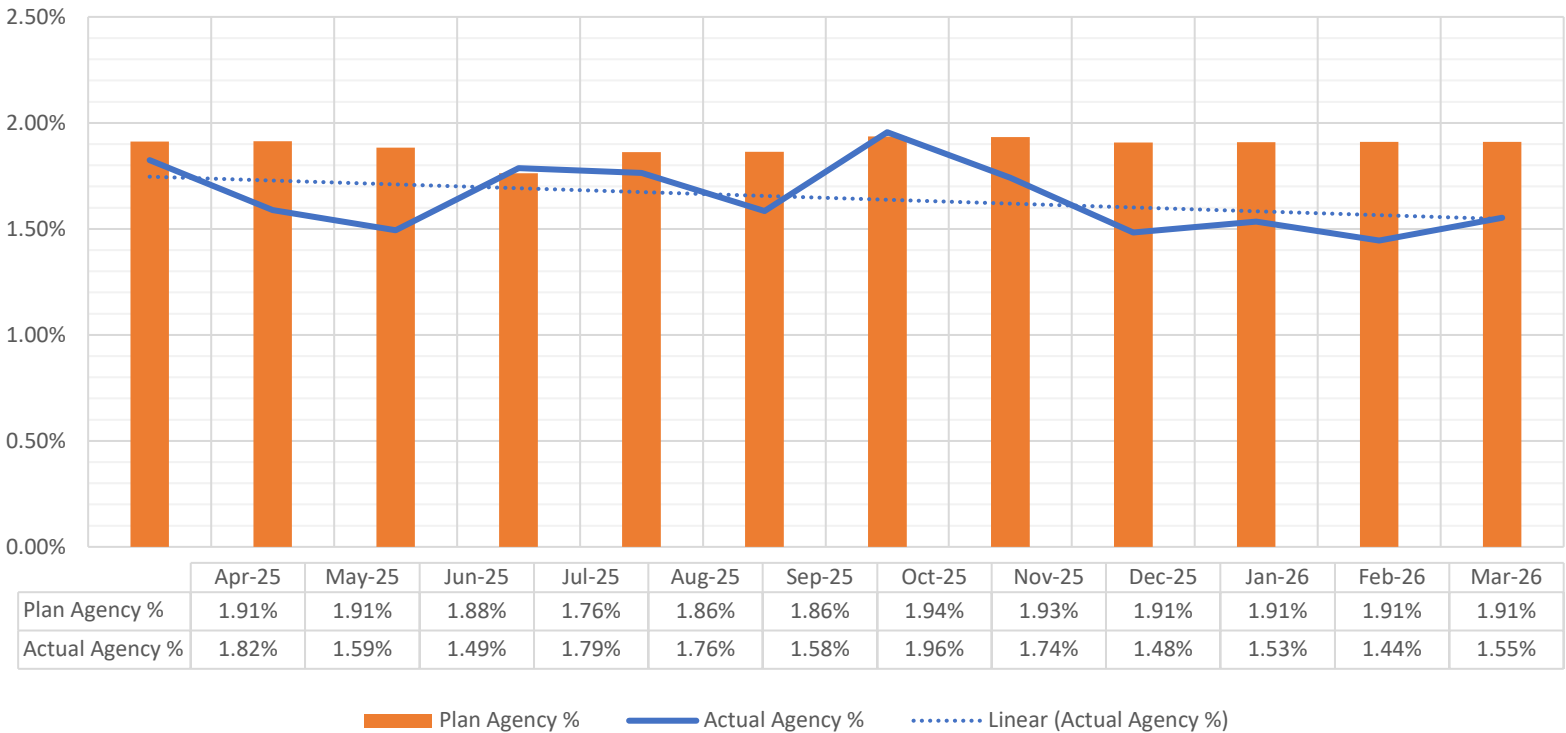
Month 12	M12 Budget WTE	M12 Worked WTE	Variance of worked to budget	M12 Budget £	M12 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Medical and Dental	5.01	7.64	2.63	£122,658.00	£144,265.22	£21,607.22	£1,571,796.00	£1,758,162.83	£186,366.83
NHS Infrastructure support	8.74	2.34	-6.40	£47,347.00	£9,744.00	-£37,603.00	£568,252.00	£9,524.61	-£558,727.39
Registered Nursing, Midwifery and Health Visiting Staff	30.52	58.07	27.55	£274,623.00	£280,116.46	£5,493.46	£3,295,439.00	£3,443,150.14	£147,711.14
Registered/ Qualified Scientific, Therapeutic and Technical staff	9.32	6.94	-2.38	£94,337.00	£40,226.88	-£54,110.12	£1,131,650.00	£692,385.53	-£439,264.47
Support to Clinical Staff	9.19	0.05	-9.14	£44,775.00	£239.89	-£44,535.11	£537,360.00	£287,020.08	-£250,339.92
Grand Total	62.78	75.05	12.27	£583,740.00	£474,592.45	-£109,147.55	£7,104,497.00	£6,190,243.19	-£914,253.81

In Month 12, Agency usage totalled 75.05 WTE, which is 12.27 WTE above the budgeted level of 62.78 WTE. This adverse variance is driven almost entirely by Registered Nursing, Midwifery and Health Visiting staff, which operated 27.55 WTE above plan. These pressures were partially offset by favourable variances within NHS Infrastructure Support (-6.40 WTE), Scientific, Therapeutic and Technical staff (-2.38 WTE) and Support to Clinical Staff (-9.14 WTE).

Despite higher-than-planned WTE usage, the in-month financial position for Agency is favourable, with a £109k underspend. Total Agency expenditure was £474.6k against a budget of £583.7k, reflecting lower average costs and significant underspends within NHS Infrastructure Support (-£37.6k), Scientific and Technical roles (-£54.1k) and Support to Clinical Staff (-£44.5k). These savings more than offset overspends in Registered Nursing (£5.5k) and Medical and Dental staffing (£21.6k).

Year-to-date, Agency expenditure remains £914k underspent, with actual spend of £6.19m against a budget of £7.10m. The favourable position continues to be driven by reduced Agency usage and cost control in Infrastructure Support, Scientific and Technical staff, and Clinical Support roles, partially offset by persistent overspends in Registered Nursing (£148k) and Medical staff (£186k). Overall, while Agency WTE remains above plan, the cost impact continues to be well controlled, providing mitigation against wider workforce and financial pressures.

Agency Spend vs Budget



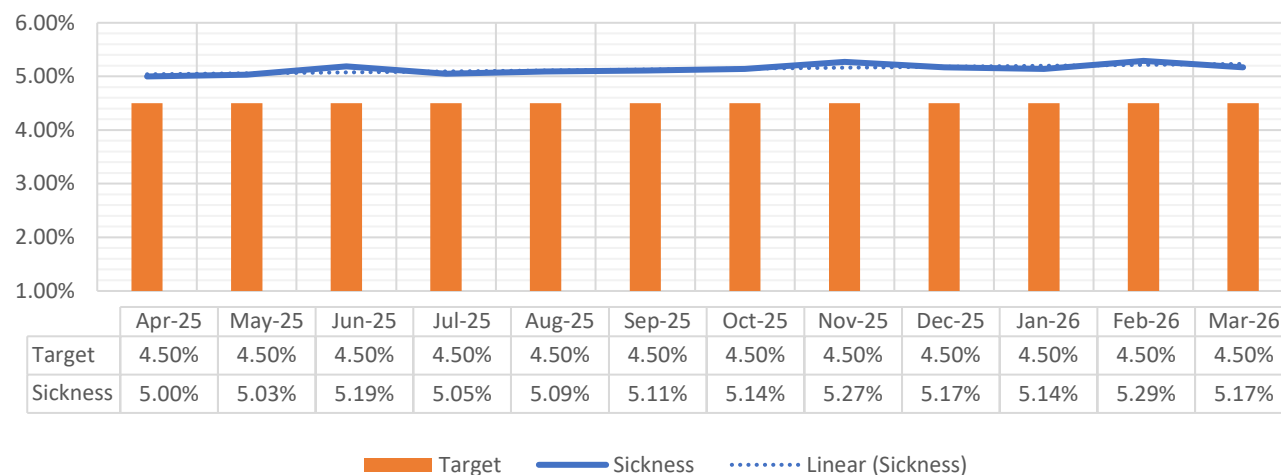
Mar 26 Agency is 12.27 WTE over plan and equates to £109k underspend.

Year to date Mar 26 we are at £914k underspent compared to a £3.4 million overspend in Mar 25.

Devon Benchmark – DPT: 1.8%, RDUH: 1.8%

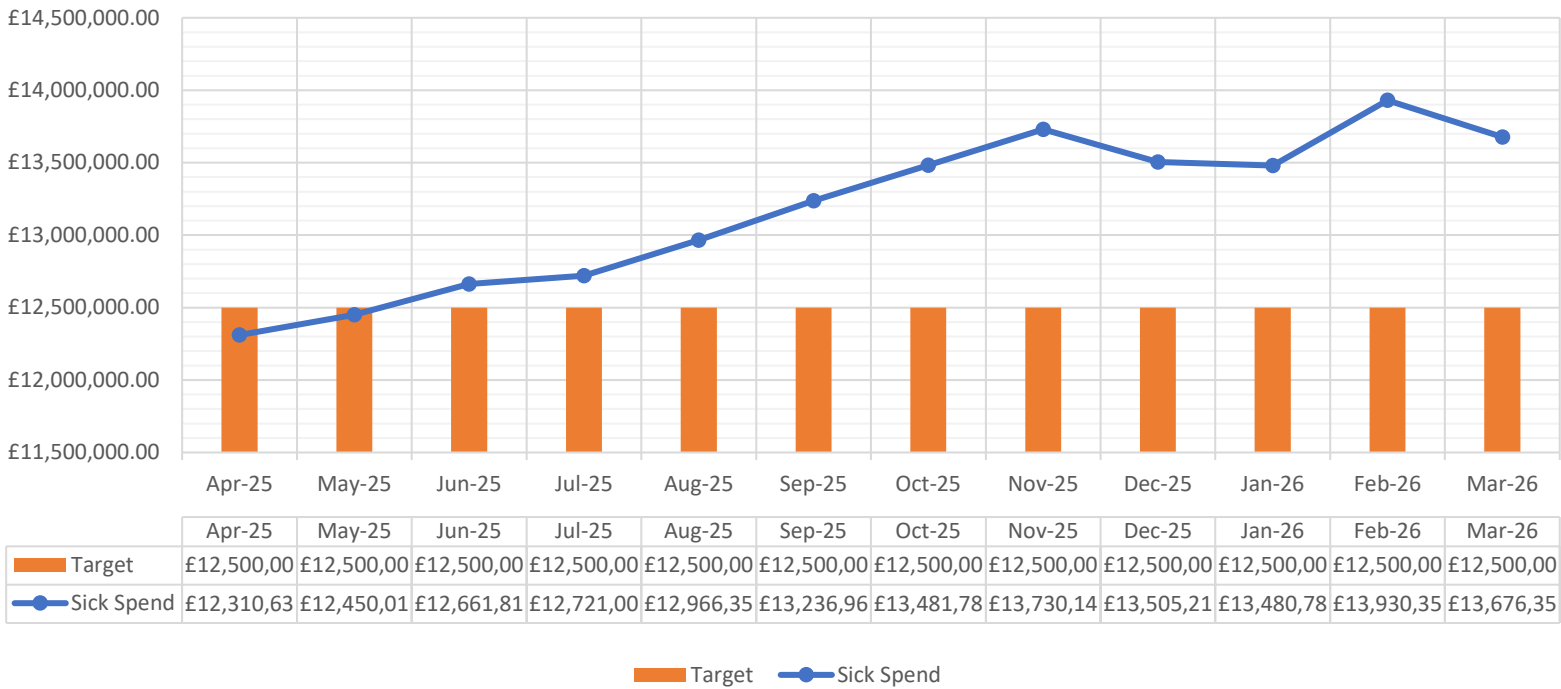
Sickness

Mar 26	Feb 26	Target	Change from previous Month	Performance against target
5.17%	5.29%	<4.50%		



Current Performance	Actions
Sickness absence decreased slightly between February and March, dropping from 5.29% in February to 5.17% in March, continuing the upward trend seen across recent months. Both months remained above the 4.50% target. While the overall pattern shows sickness levels consistently tracking above plan, the March figure indicates renewed pressure on workforce availability and highlights the need for ongoing focus on attendance management and wellbeing support. Devon Benchmark – RDUH: 4.8%, DPT: 6.3%, UHP: 5.6%	- Care group deep dive shows ongoing high rate of mental health related absence with impact on morale and increased leaver risk - Developing a plan to implement a Just and Learning culture and support high risk cases, expected to positively reduce absence - Within the Care Groups all managers (incl team leaders, supervisors) are managing sickness locally supported by ER community. - Health and Well-being business case to support staff with MSK and Mental Health is currently being considered

Sickness Cost

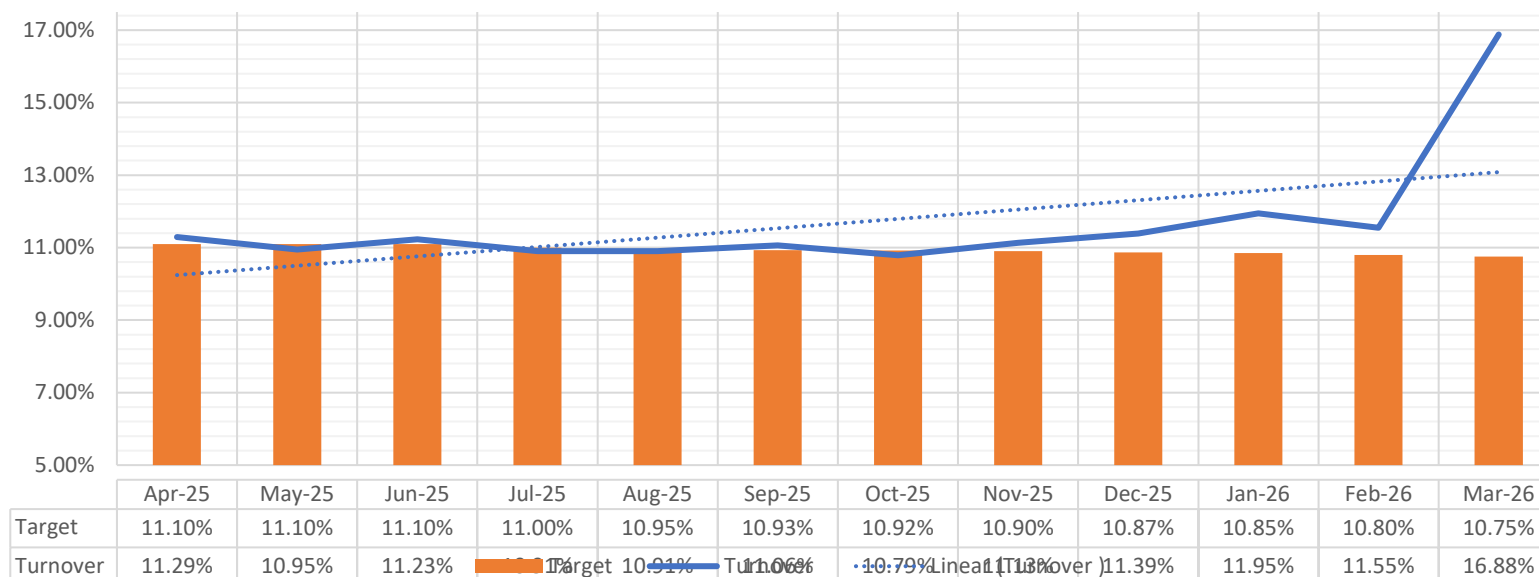


The estimated cost of sickness for the rolling 12 months was £13.6 million until the end of Mar 26. This is up from £13.9 million in Feb 26.

It was £12.2 million at the same point in Mar 25.

Turnover

Mar 26	Feb 26	Target	Change from previous Month	Performance against target
16.88%	11.55%	<12%		



Current Performance	Actions
Turnover – in month is 16.88%, this is due to the planned transfer of all CFHD staff to DPT of 292 WTE. If the transfer was excluded then the turnover rate would be 12.2% which isn't far off our normal rate. Devon Benchmark – DPT: 9.25%, UHP: 7.95%, RDUH: 8.29%	• Ageing work profile with potential vulnerability around unplanned voluntary retirements. Further scoping/development of how we support our older workforce to remain in employment including flexible working opportunities • Access to development and career pathways also flagged as poor in NSS. Action to develop career pathways and access points to further development. • Staff voice routes not sufficient. Plans to include development local staff voice channels, including visibility of leaders and strengthening of staff networks

Appraisal

	Mar 26	Feb 26	Target	Change from previous Month	Performance against target
AfC Appraisal	77.65%	78.52%	>90%		
Medical Appraisal	72.00%	68.98%	>90%		

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
 AfC Appraisal	78.86%	80.02%	79.77%	80.69%	81.21%	80.51%	81.17%	79.10%	79.53%	79.04%	78.52%	77.65%
 Medical Appraisal	76.03%	77.51%	75.00%	71.43%	68.85%	70.89%	69.51%	73.86%	71.48%	71.90%	68.98%	72.00%
 CFHD	81.29%	82.46%	82.46%	83.66%	87.41%	87.97%	84.31%	74.47%	78.90%	74.09%	71.68%	73.52%
 Families & Community	79.79%	80.65%	80.65%	81.81%	81.58%	83.04%	81.80%	87.97%	84.96%	79.91%	77.87%	78.15%
 Medicine & Urgent Care	79.98%	80.51%	80.51%	79.62%	80.02%	79.63%	78.24%	75.46%	77.10%	75.59%	76.55%	77.21%
 Planned Care and Surgery	81.19%	78.32%	78.32%	83.67%	83.28%	82.11%	83.46%	83.24%	82.50%	84.83%	85.16%	83.22%
 Shared Corporate Services	71.42%	79.74%	79.74%	75.09%	76.58%	77.27%	78.69%	75.60%	73.40%	74.62%	71.64%	69.10%
 ASCT	0%	0%	0%	63.44%	66.22%	65.77%	64.73%	62.50%	64.89%	62.56%	66.67%	66.52%

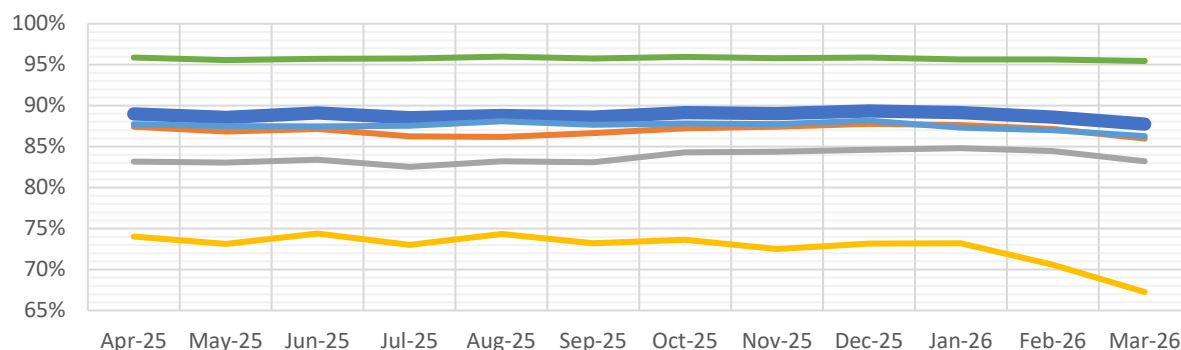
By March, appraisal compliance shows a general downward trend across most care groups compared to earlier in the year, with several areas reaching their lowest or near-lowest levels at year end. AfC appraisal compliance decreased to 77.65%, continuing a gradual decline seen since autumn. Medical appraisal improved slightly month-on-month to 72.00%, but remains below the levels achieved earlier in the year.

At care-group level, Medicine & Urgent Care (77.21%), Families & Community (78.15%), and Shared Corporate Services (69.10%) remain below 80%, indicating ongoing challenges in sustaining appraisal completion. Planned Care & Surgery remains the strongest performer at 83.22%, despite a slight reduction from February. CFHD recovered modestly to 73.52%, while ASCT remained stable at 66.52%, continuing to record the lowest compliance overall.

The March position reflects year-end capacity pressures and highlights the need for renewed focus on appraisal delivery going into the new financial year.

Mandatory Training

	Mar 26	Feb 26	Target	Performance against target	Change from previous Month
Mandatory Training	87.75%	88.60%	>85%		



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Overall Training %	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	88%
Infection Control	87%	87%	87%	86%	86%	87%	87%	87%	88%	88%	87%	86%
Information Governance	83%	83%	83%	83%	83%	83%	84%	84%	85%	85%	84%	83%
Manual Handling	74%	73%	74%	73%	74%	73%	74%	72%	73%	73%	71%	67%
Safeguarding Children	88%	87%	87%	88%	88%	88%	88%	88%	88%	87%	87%	86%
Safeguarding Adults	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	95%

Current Performance	Actions
At 87.75% overall compliance remains largely unchanged and above target. Two topics remain challenged, Manual Handling at 67.25% and Information Governance at 83.20%. However, with the current pause on training to support EPIC we expect this position to change.	- Resuscitation: is now more accessible & in situ options available. - Manual Handling: The Team is identifying, managing and supporting areas regarding DNAs in the training session with the goal of raising compliance. Bespoke face to face sessions are running in department areas. - Care group deep dive review showed risks to retention include career pathways and access to development. Conduct gap analysis to prioritise highest development needs. Develop career pathways and access points to development.

Finance

Dimension	Measure	RAG thresholds	Month	Month	Month
			10	11	12
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	-1.60%	-1.80%	-1.80%
	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	0.00%	0.00%	0.10%
	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	-1.90%	-1.90%	-1.80%
	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	0.10%	0.10%	0.10%
	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	-2.30%	-2.30%	-2.30%
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	0%	0%	0%
	Percentage efficiency delivery against plan year to date	Red rating where less than 95% Green rating where plan value achieved or exceeded	92%	92%	100%
	Percentage forecast recurrent efficiency delivery against plan	Red rating where less than 95% Green rating where plan value achieved or exceeded	65%	65%	64%
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 Red rating where YTD expenditure is less than 70% of forecast straight-line profile	46%	58%	100%
	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	81%	96%	104%
	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%

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 12 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 to plan at M12
- The forecast achievement of recurrent savings at 50% of plan.

Capital plan

- Funding approval status of schemes is at 100% with funding approval with significant (49%) increase to the forecast value of the programme.
- Capital expenditure profile YTD is at 100% of plan, with 47% spent in the final month.

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS Torbay and South Devon NHS NHS Foundation Trust																
RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Operational Plan trajectory Mar 2026
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1981		1268	839	1530	1159	725	943	1823	810	624	559	1283	621	755	1980
Average handover time (mins)	45 mins		47	36	52	45	32	38	60	33	29	27	45	30	31	37
Total average time in ED (hours/minutes)			05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	06:10	06:06	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		615	415	688	494	457	426	655	585	549	520	918	740	734	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.7%	7.4%	13.3%	11.5%	10.1%	6.1%
UEC 4-hour target (RAG against local trajectory to national target)	78%		70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	78.0%
% patient discharges pre-noon	33%		22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	33%
Elective recovery																
RTT 78 week wait incomplete pathway	0		7	4	8	8	9	16	13	16	9	9	13	8	7	0
RTT 65 week wait incomplete pathway	0		141	145	126	95	97	105	110	109	84	94	83	76	47	0
RTT 52 week wait incomplete pathway	268		931	914	805	740	615	618	615	647	607	663	604	607	600	268
RTT % Incomplete pathways <18 wks	66.8%		63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	67.0%	66.8%	66.4%	66.8%
RTT Wait for first appointment <18 weeks	70.3%		70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	69.9%	70.3%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	78.7%	60.6%	79.7%	75.8%	80.5%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	75.2%	67.1%	66.2%	75.1%
Cancer: No of patients waiting >62 days to start treatment	138		111	133	225	223	220	257	176	132	91	119	159	177	177	138
Cancer: % of patients > 62 days to start treatment	tbc		6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	5.9%	7.6%	8.1%	7.2%	tbc
RAG indicator																
Meeting monthly trajectory																
Not meeting monthly trajectory																

Tab 3.1 Integrated Performance and Quality Report (item 4.2.1)

Torbay and South Devon NHS Foundation Trust			INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															Performance Report - March 2026			
RAG rated against year-end position			Setting	Target 2025_26	13 month trend			Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to date
QUALITY LOCAL FRAMEWORK																					
Reported Incidents - Moderate	Trustwide	Trend																			
Reported Incidents - Severe	Trustwide	<6		3	3	5	1	2	5	4	3	3	3	6	0	5	40				
Reported Incidents - Death	Trustwide	<1		3	3	2	1	1	2	0	0	3	4	4	1	3	24				
Medication errors resulting in moderate or more severe harm	Trustwide	<1		0	2	1	0	0	0	0	1	2	3	0	1	2	12				
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)	Trustwide	Trend																			
Never Events	Trustwide	<1		0	1	0	0	0	0	0	0	0	0	1	0	0	2				
Number of Patient Safety Incident Investigations (PSII)	Trustwide	Trend		2	4	2	0	0	1	3	1	0	0	1	0	2					
Formal complaints - Number received	Trustwide	<20		20	20	31	33	45	31	25	27	18	20	16	12	8	286				
Formal complaints - not acknowledged in 3 days	Trustwide	Trend		2	6	25	28	30	20	20	13	15	14	14	7	6					
Formal complaints - closed in 6 months	Trustwide	Trend		8	11	5	10	10	11	18	14	13	15	15	6	10					
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		104.7	104.6	103.7	104	103.6	104.6	105.1	105.4	108									
Standardised Hospital Mortality Rate (SHMI)	Trustwide	100		0.95	0.95	0.95	0.96	0.95	0.95	0.96	0.96										
Safer staffing fill rate - ICO - Day time	Trustwide	90% - 110%		89.6%	93.6%	91.5%	92.4%	93.0%	90.9%	91.2%	90.2%	92.1%	92.0%	91.5%	90.4%	90.6%					
Safer staffing rate - ICO - Night time	Trustwide	90% - 110%		94.1%	93.2%	91.8%	94.0%	94.6%	94.4%	95.1%	95.3%	96.6%	95.6%	94.1%	95.4%	95.6%					
Care Hours Per Patient Per Day: Day	Trustwide	Trend		4.1	4.1	4.2	4.1	4.2	4.2	4.1	4.1	4.2	4.2	4.1	4.1						
Care Hours Per Patient Per Day: Night	Trustwide	Trend		3.4	3.3	3.4	3.4	3.4	3.4	3.3	3.3	3.3	3.3	3.3	3.3						
Number of Healthcare Associated Infection: MRSA	Trustwide	Trend		0	0	0	0	0	0	0	0	0	0	0	0						
Number of Healthcare Associated Infection: E-Coli	Trustwide	Trend		7	2	5	5	7	8	10	2	9	3	8	6						
Number of Healthcare Associated Infection: MSSA	Trustwide	Trend		1	2	4	2	4	1	5	2	3	5	5	2						
Nutrition risk assessment within 24 hours	Trustwide	>95%		93.9%	94.9%	94.4%	94.4%	94.3%	93.7%	92.1%	92.3%	92.3%	92.5%	92.6%	91.3%	92.5%					
Falls for 1000 bed days	Trustwide	<5.5		6.3	6.4	6.1	5.7	5.7	5.6	4.3	6.0	4.9	5.4	7.1	5.5	5.8					
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		73.2%	46.5%	70.7%	61.8%	68.1%	47.4%	55.0%	70.3%	75.8%	51.0%	45.0%	60.9%						
Stroke - % patients admitted to stroke unit within 4 hours	Trustwide	>50%		50.0%	37.0%	37.0%	47.3%	28.0%	46.4%	50.0%	49.1%	34.1%	52.9%	34.0%	38.0%	0.0%					
Mixed Sex Accommodation breaches	Trustwide	Trend		163	208	94	265	200	124	220	190	160	222	186	134	180	2183				
Follow ups 6 weeks past to be seen date	Trustwide	6400		17361	18380	17843	18040	18486	19016	18135	16900	17610	17827	16967	16835	18638					
Maternity 1:1 care in labour (%)	Trustwide	Trend				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	98.6%	0.0%						
Maternity 1:1 % Admission to SCBU (full term)	Trustwide	Trend				8.1%	6.8%	7.4%	8.3%	7.4%	4.0%	7.8%	5.1%	10.9%	0.0%						
Maternity Stillbirths and perinatal deaths	Trustwide	Trend				0	0	1	2	0	0	0	0	1	0						
Maternity Smoking at time of delivery	Trustwide	Trend				9	5	10	9	3	3	5	8	3	0						
Maternity 3rd and 4th degree tears - total (%)	Trustwide	Trend				2.3%	1.4%	3.1%	3.1%	4.5%	7.7%	6.8%	2.5%	3.1%	0.0%						
Maternity PPH>1500mls (%)	Trustwide	Trend				4.2%	7.6%	3.5%	1.4%	4.1%	4.4%	3.6%	0.7%	4.3%	0.0%						
Maternity Birth rate	Trustwide	Trend						173	143	145	136	140	148	141	148	0					

Tab 3.1 Integrated Performance and Quality Report (item 4.2.1)

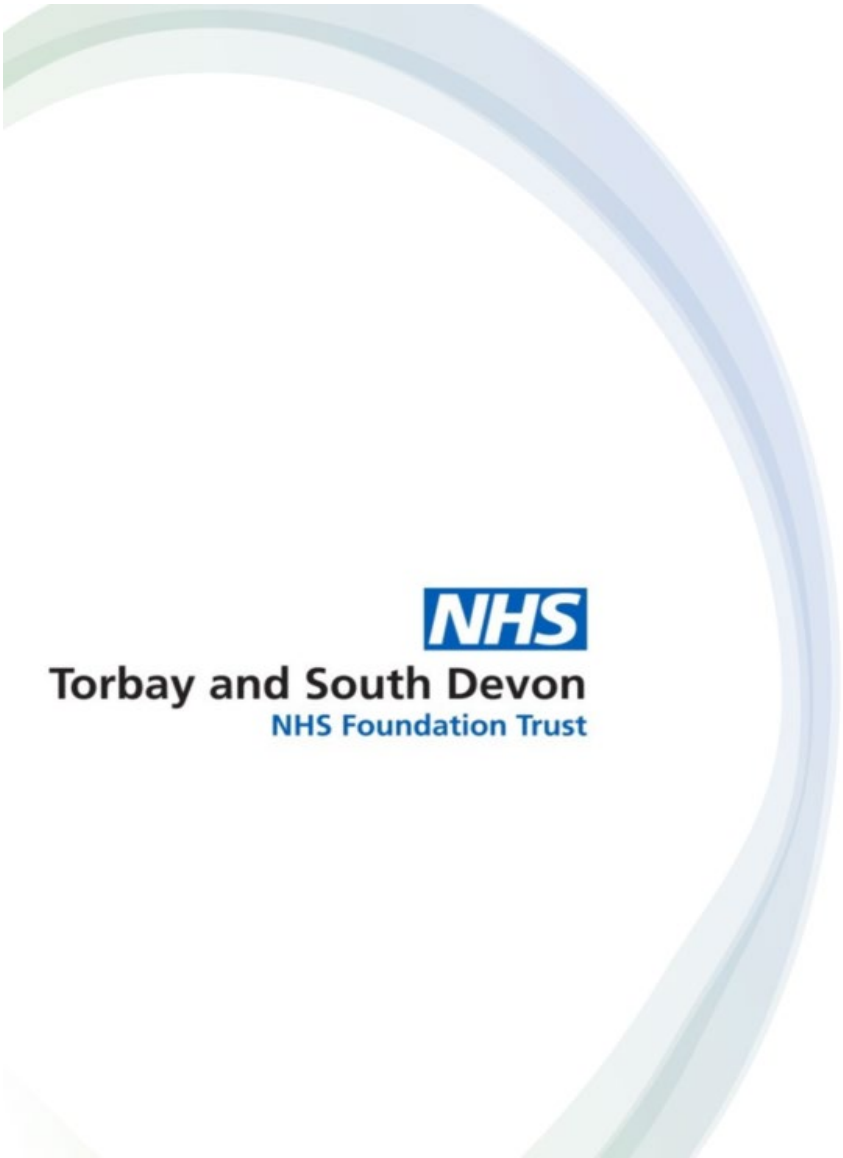
Torbay and South Devon NHS Foundation Trust		INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS														Performance Report - March 2026	
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to date
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.0%	5.0%	5.0%	5.0%	5.1%	5.1%	5.1%	5.2%	5.3%	5.3%	5.3%	0.0%		
Appraisal Completeness	Trustwide	>90%		79.6%	78.9%	79.8%	79.5%	80.2%	80.5%	80.5%	80.5%	78.8%	78.9%	78.7%	78.1%	0.0%	
Mandatory Training Compliance	Trustwide	>85%		89.0%	89.0%	84.7%	85.3%	85.0%	85.4%	85.5%	86.2%	86.2%	87.9%	85.9%	85.0%	0.0%	
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		11.1%	11.3%	11.0%	11.0%	10.9%	10.9%	10.8%	10.8%	11.1%	12.8%	12.9%	10.6%	0.0%	
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.0%	18.1%	18.4%	18.1%	18.1%
Opiate users - % successful completions of treatment (quarterly 1 qtr in arrears)	Trustwide	6.95%					5.7%			6.9%			6.7%			5.7%	
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET							568	526	515	503	506	472	492	479	
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		273	239	240	222	235	199	215	264	229	207	243	191	204	2688
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		221	204	202	204	211	166	190	241	208	211	242	195	204	2478
Community Hospital Length of Stay (days) - (general)	Community Hospital	NONE SET		13.2	13.9	14.2	13.4	14.4	15.7	15.6	13.9	12.8	14.0	14.2	12.9	15.2	14.2
Community Hospital % patient discharges pre-noon	Community Hospital	33%		50.0%	50.0%	47.0%	47.0%	49.0%	50.0%	48.0%	45.0%	47.0%	44.0%	45.0%	48.0%	49.0%	
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	80% ICB target		87.4%	87.7%	88.8%	87.8%	89.9%	85.8%	90.4%	91.3%	94.5%	91.8%	92.6%	93.8%	91.0%	90.5%
Urgent Community Reponse (2 hour) - Number of referrals	Trustwide	157		215	219	197	172	227	232	251	299	220	243	230	194	211	2695
ADULT SOCIAL CARE TORBAY KPIs																	
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		30.0	26.1	23.5	20.9	31.1	24.6	24.6	24.6	24.6	22.1	23.4	24.6	25.9	25.9
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		907.3	772.8	778.1	783.4	750.6	721.9	687.9	737.6	742.8	729.7	753.3	734.9	745.4	745.4
Proportion of clients receiving direct payments	Trustwide	25%		18.2%	17.8%	18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.0%	18.1%	18.4%	18.1%	18.1%
% reablement episodes not followed by long term SC support	Trustwide	83%		86.2%	86.1%	86.9%	88.3%	89.1%	88.8%	88.9%	88.6%	88.9%	89.1%	89.1%	88.9%	94.2%	94.2%
PERFORMANCE FRAMEWORK																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		62.6%	38.5%	33.5%	31.7%	31.7%	24.9%	30.9%	38.0%	38.9%	37.0%	37.9%	41.0%	33.6%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		91.7%	89.9%	93.3%	90.7%	91.4%	88.9%	91.4%	91.1%	93.1%	92.9%	92.7%	95.8%	93.4%	
Cancer - 62-day wait for treatment - national reporting (2024/25 target 70%) (2025/26 target 75%)	Trustwide	75%		74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	75.2%	67.1%	66.2%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		19	26	22	52	24	28	29	21	21	20	27	44	44	
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	67.0%	66.8%	66.4%	
On the day cancellations for elective operations	Trustwide	<0.8%		0.8%	0.9%	0.8%	1.3%	1.3%	1.1%	0.7%	0.8%	0.7%	0.9%	0.9%	0.7%	0.5%	
Cancelled patients not treated within 28 days of cancellation	Trustwide	0		3	3	5	11	21	11	11	17	17	14	11	11	11	
Theatre Utilisation	Trustwide	85%		83.1%	82.7%	83.2%	81.1%	76.7%	82.3%	82.7%	83.2%	81.8%	80.3%	82.8%	81.5%	81.3%	
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		16.3%	17.0%	15.7%	16.2%	15.9%	16.7%	15.9%	14.6%	15.6%	15.5%	16.9%	16.3%	16.1%	
Bed Occupancy	Acute	90%		95.8%	95.2%	95.9%	96.1%	96.0%	95.3%	96.8%	96.7%	96.5%	95.2%	97.5%	97.2%	97.2%	
% patient discharges pre-5pm	Acute	75%		73.0%	71.8%	71.0%	72.6%	75.3%	71.4%	68.3%	66.0%	68.8%	69.5%	68.9%	68.1%	66.8%	

Tab 3.1 Integrated Performance and Quality Report (item 4.2.1)

Torbay and South Devon NHS Foundation Trust			INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS													Performance Report - March 2026	
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to date
Percentage of inpatients with No Criteria to Reside (Torbay GP registered patients)	Acute	<5%		6.9%	7.8%	8.7%	7.6%	8.8%	6.5%	9.3%	11.9%	7.8%	9.0%	10.7%	10.1%	10.3%	
Percentage of inpatients with No Criteria to Reside (South Devon GP registered patients)	Acute	<5%		10.0%	10.4%	8.4%	9.9%	9.7%	8.3%	10.0%	12.8%	10.6%	14.0%	14.4%	15.1%	12.8%	
Average length of stay (days) - discharges from main acute wards	Acute			5.8	6.0	5.9	5.9	5.9	5.9	6.1	5.9	5.6	6.3	7.0	6.9	6.8	
Number of patients >7 days LoS (daily average)	Acute	153		139.2	151.5	144.2	148.0	149.2	149.2	159.6	158.3	161.9	169.6	178.2	168.0	169.5	
Number of extended stay patients >21 days (daily average)	Acute	35		32.3	35.7	32.5	31.5	28.4	38.8	42.5	39.3	43.7	47.7	48.9	38.4	41.2	
Ambulance handover delays > 30 minutes	Acute			966	720	1122	951	716	804	1250	933	957	813	1277	965	1170	11678
Ambulance handover delays > 60 minutes	Acute	0		521	307	601	531	302	390	764	203	121	103	450	135	167	4074
UEC - patients seen within 4 hours (2025/26 plan target 78%)	Trustwide	78%		70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	70.0%
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute			60.0%	63.3%	58.0%	58.7%	60.9%	63.7%	60.4%	65.3%	65.1%	66.4%	62.7%	64.3%	61.5%	
Clinically Ready to Proceed delay over 1 hour - Emergency Department	Acute			24.2%	25.7%	28.3%	23.6%	22.0%	19.7%	25.6%	21.8%	21.3%	22.5%	25.5%	19.8%	18.1%	
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute			04:00	03:52	04:10	03:54	03:48	03:50	04:07	04:10	04:03	03:59	04:14	04:24	04:37	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute			08:25	07:12	08:59	08:04	07:08	07:05	08:58	08:15	08:05	08:16	11:37	10:16	09:37	
Diagnostic tests longer than the 6 week standard	Trustwide	5%		31.8%	32.4%	37.8%	34.0%	37.0%	37.0%	37.0%	29.0%	28.0%	30.0%	36.0%	31.0%	37.0%	
Dementia - Find - monthly report	Trustwide	>90%		97.3%	96.2%	96.5%	96.8%	93.6%	97.7%	95.1%			94.6%	97.2%	95.8%	81.5%	94.9%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		77.5%	83.6%	81.9%	75.7%	80.0%	77.5%	77.8%	77.5%	71.4%	73.8%	75.6%	71.5%	72.0%	76.6%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		65.2%	67.5%	61.0%	64.6%	62.5%	60.8%	58.0%	60.6%	67.2%	63.5%	59.8%	52.5%	61.3%	61.8%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		65.6%	71.9%	68.1%	74.9%	76.0%	79.3%	72.2%	72.1%	74.4%	63.2%	50.3%	63.2%	77.1%	
ERF activity 2025/26 vs 2019/20 baseline																	
Day cases										120%	109%	99%	101%	104%	106%	99%	109%
Elective inpatient admissions										86%	87%	69%	78%	87%	87%	81%	84%
Admitted Patient Care Total										116%	106%	96%	99%	103%	103%	97%	106%
Outpatient - first appointment										114%	108%	110%	105%	103%	105%	109%	105%
Outpatient - first appointment with procedure										131%	130%	132%	143%	146%	133%	135%	145%
Outpatient - follow-up with procedure										117%	126%	148%	125%	124%	124%	112%	133%
Outpatient Appointment Total										117%	117%	126%	117%	116%	115%	113%	119%
ERF Income Grand Total (% above 2019/20)		114%								124%	113%	109%	109%	111%	109%	104%	114%
Non-ERF activity 2025/26 vs 2024/25																	
Non-elective admissions											110%	104%	100%	100%	102%	104%	105%
UEC attendances (Type 1 and 3)											106%	109%	94%	110%	113%	105%	105%

Tab 3.1 Integrated Performance and Quality Report (item 4.2.1)

Torbay and South Devon NHS Foundation Trust		INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS													Performance Report - March 2026		
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to date
NHS I - FINANCE AND USE OF RESOURCES																	
Year-to-date revenue variance to plan	Trustwide													-1.60%	-1.80%	-1.80%	
Year-to-date revenue variance to plan, excluding the impact of loss of DSF	Trustwide													0.00%	0.00%	0.10%	
Forecast revenue variance to plan	Trustwide													-1.90%	-1.90%	-1.80%	
Forecast revenue variance to plan, excluding the impact of loss of DSF	Trustwide													0.10%	0.10%	0.10%	
Recurrent forecast variance to planned underlying position	Trustwide													-2.30%	-2.30%	-2.30%	
Percentage of efficiency schemes assessed as high risk	Trustwide													0.00%	0.00%	0.00%	
Percentage efficiency delivery against plan year to date	Trustwide													92%	92%	100%	
Percentage forecast recurrent efficiency delivery against plan	Trustwide													65%	65%	64%	
Forecast cash support required from the system	Trustwide													None	None	None	
Year-to-date charge against CDEL as a percentage of forecast CDEL expenditure	Trustwide													46%	58%	100%	
Funding approval status of schemes in forecast	Trustwide													81%	96%	104%	
Forecast capital spend as a percentage of allocated system capital	Trustwide													100%	100%	100%	



Organisational CHPPD	Planned Total
	7.45
Total Planned Beds / Day	522
Days in month	28

Safer Staffing Dashboard - February-2026

Report Version: 2
Published: 16/03/2026 11:17

Safer Staffing Dashboard - Inpatient Wards - February-2026

Our priorities for 2025-2026: Triangulation of our workforce metrics and Patient Sensitive Indicators

Report Version: 2 | Published: 16/03/2026 11:17

Ward	Beds		Staffing Fill Rates				Actual Staffing Split					Care Hours Per Patient Day (CHPPD)												HR Metrics			Temporary Staffing		Ward Accred. ¹	PATIENT SENSITIVE INDICATORS											
	Estab. Beds	Bed Occ.	Days		Nights		RN v Care Staff Splits		Day v Night Split		RN / Midwives		Days Care Staff		Overall Day		RN / Midwives		Nights Care Staff		Overall Night		Sickness Rate	Turnover Rate	Vacancy Rate	Prop. Bank Hours	Prop. Agency Hours	Red Flags Raised		Safety		Falls		Medicine Errors	% Obs Taken on Time	Feedback		Number of Reps.			
			% RN / Midwives Hours	% Care Staff Hours	% RN / Midwives Hours	% Care Staff Hours	% Day	% Night	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual						ETOC Red Flags ²		All Red Flags	Mod. Harm Incs and Above	PLS G2+ Acq. in Our Care	No Harm			Harm	Patient Complaints		% Positive Resp.		

Below each RAGed figure are indicators giving the RAG status (where available) for post months with the status for the previous month given by the right-most indicator.
Below the Ward Accreditation statuses are (where available), indicators giving the previous accreditation statuses held by the ward.

¹ Ward Accreditation for Maternity and Paediatrics will begin in 2025; the Intensive Care Unit has no accreditation and there is no intention to begin. Note also that the indicators below the current status represent previous accreditation statuses (regardless of when they were achieved) and not the accreditation statuses for the three months prior to the current month.

² The collection of data for Red Flags concerning the lack of EToC provision began on the 4th of March 2025 so no data for this measure is available prior to that date.

Safer Staffing Dashboard - Inpatient Wards - February-2026 - Assurance

Measure	Assurance Summary ¹	Narrative	Mitigation	Actions

Tab 3.1 Integrated Performance and Quality Report (item 4.2.1)

STAFFING METRICS						
Bed Occupancy		Limited	Our bed occupancy indicates that were are running at an bed occupancy rate of 96% this is a decrease of 1.1% from december 25 this is a reflection of the Trusts operational pressures.This puts many of our inpatient areas at a rag rating of red with the majority of our Adult inpatient areas at full capacity throughout the month of January. Areas that are not at this level are focused to Peadatric units/ areas.	The organisation has escalation areas that are able to support when our bed occupancy is in a red status. Escalation areas are Ella, Level 2 AMU and the cohort bay in ED	To optimise flow with use of operations and flow teams. Areas to plan for discharge from the day of patient admission. SAFER to be an active tool to review discharges and plan for before lunch discharges. To meet the trust wide target of 33% of patients home for midday and 75% home pre 5pm. The discharge lounge to be utilised with all wards sending patients to this area to support flow.	
Staffing Fill Rates	Days	RN / Midwives	Satisfactory	February'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 90.4 % . The average registered fill rate for nights has remained stable at 94.6%. Care staff fill rates on day shifts has decreased by 2.3% to 94.6%. The care staff fill rate for nights is 103.7% this is a decrease of 2.7% from January 26.The increase in fill rates for Care Staff, reflects the increase in demand for the Care staff shifts requested to backfill vacancies, sickness, maternity leave and escalation areas. Lower fill rate is concentrated to our fragile services where recruitment of staff is complex. ED has had a successful RN recruitment event and bespoke Care staff recruitment dates are planned for April 26.	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 support bank fill rate on the HCSW line the Trust is working in partnership with NHSP to build a new trainee HCSW pipeline which involves new recruits employed by NHSP undertaking a 3 month training programme within our clinical areas to upskill so that at the end of the programme candidates will align to AFC band 3. To support fill rates the trainee programme will run with bi monthly to support filling the 3.1 FTE monthly net HCSW vacancies.	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 Enhanced care provision across the trust to support enhanced care and the unfill HCSW hours. Recruitment are working with clinical leads to support fragile services and areas where there are vacancies.
		Care Staff	Satisfactory			
	Nights	RN / Midwives	Satisfactory			
		Care Staff	Satisfactory			
Care Hours Per Patient Day (CHPPD)	Days	RN / Midwives	Satisfactory	The Trust overall actual CHPPD is 7.45 this is slightly over the planned target of 7.37. The actual CHPPD for RN/Midwives in February 2026 is 3.98 this is slightly under the target of 4.14.The overall actual CHPPD for HCSW is 3.35.This is slightly over the planned target of 3.28.	Review of CHPPD on a monthly basis. This data is shared nationally and inputted on Model hospital for transparency. Where the fill rate is less then 90% and greater than 110% our senior nurse leaders are asked for narrative to account for the clinical need. To seek weekly narrative and assurance from senior nursing leaders where compliance falls outside of these target ranges.	To continue to report data to Model Hospital. Compare CHPPD data with our peer hospitals. To continue to work with NHS P to meet our shift fill rate targets. To continue to ask our senior leaders for narrative to support reasons for non compliance. To use the data to report trends and themes where compliance is outside of these metrics.
		Care Staff	Satisfactory			
		Overall	Satisfactory			
	Nights	RN / Midwives	Satisfactory			
		Care Staff	Satisfactory			
		Overall	Satisfactory			
HR Metrics	Sickness Rate		Limited	Organisational absence this currently resides at 6.4% this is a decrease of 0.5%. Turnover rate has increased to 9.6% this is an increase of 0.3% from January 26.Vacancy rate has increased to 2.3% a rise of 0.2% from January 26.Focused recruitment campaigns and reduction in the onboarding timeline have supported this decrease within the Nursing workforce. On boarding days reside at an average of 50 days for HCSW and 60 days for RNs. The reduction in the onboarding timeline will support our fill rates whilst reducing our reliance on the use of temporary workforce currently being used to back fill the on-boarding timeline.	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 council governance process. To continue to report on clinical areas unavailabilities as part of our weekly senior leaders bank and agency meetings.	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 council governance process. To continue to report on clinical areas unavailabilities as part of our weekly senior leaders bank and agency meetings.
	Turnover Rate		Satisfactory			
	Vacancy Rate		Satisfactory			
Temporary Staffing	Prop. Bank Hours		Limited	The current proportion of temporary workforce hours supporting pipelines currently resides at: bank proportion 14% this is an increase of 1.6% from January 26.Agency proportion has also increased to 5.4% this is an increas of 2.2% from last month. Focused work is being undertaken to support the migration of agency staff onto NHSP. Currently 10 long standing agency workers have been migrated over to NHSP in the last 2 months. Requesting of agency shifts has also been reduced to 4 days, with prohibiting of direct booking of agency staff to to areas that are currently high users. Substantive recruitment is also now a permanent fixture on the weekly bank and agency meeting with check and challenge. Exception reporting for use of temporary staffing remains a priority with the bank and agency meeting.	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. Agency Hours		Limited			
Ward Accreditation			Satisfactory	Many of the inpatient areas are now consistently achieving silver in their accreditation. This ensure that wards are working toward COC compliance, and making improvements within their service to maintain quality and safety for our patients.	The Professional standards lead nurse will continue to carry out ward/unit assessments. Wards will continue to improve their outcomes, by working with the lead nurse on their action plans. For peer learning where ward outcomes are bronze and below.	For the Professional Standards lead nurse to continue to review the accreditation document to ensure it remains current. To report outcomes and trends to the trust wide safety and quality group.
PATIENT SENSITIVE INDICATORS						
Safety	Red Flags	ETOC Red Flags	Limited	Areas are using the red flag within safecare to indicate when there are risks and shortfall within staffing. There are key areas that are using this as a form of recognition to highlight risks to staff and patients. This month has seen a good reporting of the use of red flags this provides assurance that risks are being highlighted at the daily staffing meeting and then appropriate mitigations are being put in place to safeguard staff and patients. Focused work will begin around the use of the red flags to indicate the ETOC provision, as this month has once again seen that the ETOC red flag is not being optimised to highlight risk.	To ensure staff are raising ETOC 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 ICO. For the ETOC lead nurse to work with senior leaders to ensure that ETOC red flags are being used to highlight risks across the organisation. There will be an updated learning package for staff to complete and be assessed as competent to use safe care alongside understanding the importance of using red flags.
		All Red Flags	Satisfactory			
	Mod. Harm Incns and Above		Limited	Moderate harm incidents has seen a further decline in the month of February 26. It can be noted that there is a correlation between areas with increased moderate harm and low compliance with HR metrics. These areas have complex patient groups, high ETOC usage and elevated turnover rates.	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.
	Pressure Ulcers G2+ Acq. in Our Care		Satisfactory	Hospital acquired pressure ulcer reporting is maintaining a positive reporting trend, indicating that our workforce are being pro active in assessing patients skin, initiating preventative care and acknowledging professional accountability . Where G2 incidences have been recorded it is worth noting that red flags have also been raised to indicate that intentional rounding has also been missed or shortfall in RN time.	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 pressre 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 responses. Where harm has been caused AARs are completed. Trends across the directorate are reported to the Quality and Safety group.
	Falls	No Harm	Limited	February has seen a decrease in the incidents of falls; with falls no harm increasing from 59 to 42 and falls with harm decreasing from 42 to 31.Areas at risk of higher falls incidents are within medicine where patients require high levels of nursing care and support. Staffing fill rate in these areas are below 90%.	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.
		Harm	Satisfactory			
	Medicine Errors		Limited	Medicine errors has seen a decrease from January 26 from 44 to 30. When triangulated with workforce metrics it is evident to see that there is a trend with increased errors in areas where there are elevated use of temporary workforce. There is a robust governance process in place with NHSP and agencies that supports learning for the temporary workforce when errors are made.	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 spread 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 NHS P to monitor complaints, themes and trends with temporary staffing.
	% Obs Completed on Time		Satisfactory	Trust compliance for this metric has increased to 90.8% this is an increase of 0.8% for February 26. The average for this metric has remained consistent for the last 7 months across the Trust.	Data is reported monthly and sent to clinical leads for actions. Where compliance is below 85% this is managed within care directorates by the ADNPPs.	Monthly compliance reort to be sent to ADNPP and trends to be escalated via care groups.
Feedback	Patient Complaints		Satisfactory	These are being managed within care groups , with themes and trends being shared in care group meetings with leads.	Where harm is caused a full investigation is completed and reported on using the Datix platform. Timelines for complaint responses 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.
	% Pos. Resp.		Satisfactory	Patient feedback in captured responses is 265. 98.9% of these were positive.	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	Report monthly on patient responses themes and trends. To ensure areas who are not met

Tab 3.1 Integrated Performance and Quality Report (item 4.2.1)

FFT	No. of Resp.	Satisfactory	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.	reports monitoring and patients responses shared with senior. To ensure data is collected collecting data are supported by their ADNPP to begin the data collection process.

¹ Definitions for the Assurance Summary categories are given in the 'Notes and Definitions' section of this document.

Safer Staffing Dashboard - Emergency Care (ED Only) - February-2026

Torbay and South Devon 
NHS Foundation Trust

STAFFING METRICS		Emerg. Dept
Number of Attendances		6,443
Staffing Fill Rates	Days RN / Midwives	91.7%
	Care Staff	88.3%
	Nights RN / Midwives	94.4%
	Care Staff	80.5%
Actual Staffing Split	Days % RN / Midwives Hours	63.0%
	% Care Staff Hours	37.0%
	Nights % RN / Midwives Hours	65.7%
	% Care Staff Hours	34.3%
	Day / Night Split % Day	50.4%
	% Night	49.6%
HR Metrics	Sickness Rate (Jan-26)	9.6%
	Turnover Rate	12.4%
	Vacancy Rate	-3.5%
Temporary Staffing	Prop. Bank Hours	17.7%
	Prop. Bank Hours	16.7%
Accreditation		

PATIENT SENSITIVE INDICATORS		Emerg. Dept
Number of Unplanned Reattendances		220
Service Delivery Times	% Waiting > 4 Hrs	49.3%
	% Waiting > 12 Hrs	11.5%
	Avg. Triage Time (mins)	15
	Ambulance Handovers < 30 mins	58.8%
Safety	All Red Flags	0
	Mod. Harm Incs and Above	3
	Medicine Errors	4
	PUs G2+ Acquired in Our Care	0
	Falls No Harm	3
	Harm	7
	Sepsis % Overall Sepsis 6 Compliance	82%
	% Antibiotics within 1 Hour	100%
	Patient Complaints	2
	Feedback % Positive Resp. (Jul-25)	100.0%
FFT Number of Resp. (Jul-25)		28

Safer Staffing Dashboard - Emergency Care (ED Only) - February-2026 - Assurance

Torbay and South Devon 
NHS Foundation Trust

Measure	Assurance Summary ¹	Narrative	Mitigation	Actions
STAFFING METRICS				

Tab 3.1 Integrated Performance and Quality Report (item 4.2.1)

Staffing Fill Rates	Days	RN / Midwives				
		Care Staff				
	Nights	RN / Midwives				
		Care Staff				
HR Metrics	Sickness Rate					
	Turnover Rate					
	Vacancy Rate					
Temporary Staffing	Prop. Bank Hours					
	Prop. Bank Hours					
Accreditation						
PATIENT SENSITIVE INDICATORS						
Number of Unplanned Reattendances						
Service Delivery Times	% Waiting > 4 Hrs					
	% Waiting > 12 Hrs					
	Avg. Triage Time (mins)					
	Ambulance Handovers < 30 mins					
Safety	All Red Flags					
	Mod. Harm Incs and Above					
	Medicine Errors					
	PUs G2+ Acquired in Our Care					
	Falls	Falls - No Harm				
		Falls - Harm				
	Sepsis	% Overall Sepsis 6 Compliance				
		% Antibiotics within 1 Hour				
Feedback	Patient Complaints					
	FFT	% Positive Resp.				
		Number of Resp.				

¹ Definitions for the Assurance Summary categories are given in the 'Notes and Definitions' section of this document.

Safer Staffing Dashboard - February-2026 - Notes and Definitions

STAFFING METRICS

Measure	Applicability	RAG Criteria			Notes and Definitions
		Red	Amber	Green	
Beds	Established Beds	N/A	N/A	N/A	Figures represent the established Bed Stock along with the percentage of available beds that were occupied throughout the month.
	Bed Occupancy	>=93% or <77%	(>=77% and <80%) or (>90% and <93%)	>=80% and <=90%	Please note that the Bed Occupancy RAG status is not applied to John Macpherson, Louisa Cary, SCBU or ICU due to the specialty of the areas.
Number of Attendances	Emergency Only	N/A	N/A	N/A	The total number of ED attendances.
Staffing Fill Rates	Days RN/Midwives Care Staff	<80%	>=80% and <90%	>=90%	Staffing Fill Rates represent the proportion of the planned staffing level that was met. A figure below 100% indicates that the actual staffing level was below the planned level; a figure above 100% indicates that the actual staffing level exceeded the planned.
	Nights RN/Midwives Care Staff				
Actual Staffing Split	Days % RN / Midw. % Care Staff Hours	N/A	N/A	N/A	Figures represent the actual (rather than planned) split between Registered Nurses and Care Staff on day shifts and night shifts.
	Nights % RN / Midw. % Care Staff Hours				Figures represent the actual (rather than planned) split between Day and Night for Registered Nurses and Care Staff combined.
	Day / Night Split				
	Day Night				
Care Hours Per Patient Day (CHPPD)	RN / Midwives	Actual CHPPD is <80% of the Planned CHPPD	Actual CHPPD is (>=80% and <90%) of the Planned CHPPD	Actual CHPPD is >=90% of the Planned CHPPD	Figures indicate the number of Care Hours per Patient resident on the ward at 23:59 each day. Figures for each staff category (and 'Overall') are split between the CHPPD provided by the Planned staffing level and the CHPPD provided by the Actual staffing level. The bracketed figures in the Actual column represent the difference between the Planned and the Actual figures with a positive difference indicating that the Actual CHPPD <i>exceeds</i> the Planned CHPPD. The RAG status is only applied to the Actual CHPPD column and is based on the relative difference between the Actual CHPPD and the Planned CHPPD. A Green RAG status is assigned where there was no Planned staffing but Actual staffing was present.
	Days Care Staff				
	Overall Day				
	RN / Midwives				
	Nights Care Staff				
	Overall Night				
HR Metrics	Sickness Rate	>4%	>=3.65% and <=4%	<3.65%	Please note that the Vacancy Rate represents the difference between the Staff in Post FTE and the Establishment FTE - this means that if the Staff in Post FTE <i>exceeds</i> the Establishment FTE for a ward then a <i>negative</i> Vacancy Rate is reported. The Vacancy Rate is based on a weekly average within the month.
	Turnover Rate	>=14%	N/A	<14%	
	Vacancy Rate	>20%	>=10% and <=20%	<10%	Please note that the 'All Wards' figures for the Sickness Rate and Turnover Rate measures are averages (mean) figures.
Temporary Staffing	Prop. Bank Hours	<5%	>=5 and <=10%	>10%	Figures represent the Bank and Agency FTE as a proportion of the Establishment FTE based on weekly averages within the month.
	Prop. Agency Hours	<3%	>=3% and <=10%	>10%	

Safer Staffing Dashboard - February-2026 - Notes and Definitions (cont.)

STAFFING METRICS (cont.)

Measure	Applicability	RAG Criteria			Notes and Definitions
		Red	Amber	Green	
					Ward accreditation indicates national recognition of the general standard of care provided by a ward. There are five levels of accreditation:

Accreditation	Inpatient and Emergency	N/A	N/A	N/A	○ White: Below basic standards of care ● Bronze: Meets the basic standards expected for that area ● Silver: Meets all the standards expected for that area with a clear plan and evidence of improvement ● Gold: Meets all standards and is deemed excellent ● Platinum: Sustains Gold for a year

Maternity and Paediatrics assessments will begin in 2025 and there is no intention to begin assessments for the Intensive Care Unit.

Please note that the indicators below the current status give the previous accreditation statuses held by the ward and *not* the accreditation statuses for the months prior to the current reporting month.

Safer Staffing Dashboard - February-2026 - Notes and Definitions (cont.)

PATIENT SENSITIVE INDICATORS

(Measures that are potentially impacted by staffing issues)

Measure		Applicability	RAG Criteria			Notes and Definitions
			Red	Amber	Green	
Number of Unplanned Reattendances		Emergency Only	N/A	N/A	N/A	
Service Delivery Times	% Waiting > 4 Hrs	Emergency Only	>5%	N/A	<=5%	The percentage of ED attendances that exceeded 4 hours.
	% Waiting > 12 Hrs		>0%	N/A	0%	The percentage of ED attendances that exceeded 12 hours.
	Avg. Triage Time (mins)		>=15	N/A	<15	The average time to triage (minutes).
	Amb. Handovers < 30 mins		<95%	N/A	>=95%	The percentage of Ambulance handovers completed within 30 minutes.
Safety	Red Flags Raised	Inpatient and Emergency (EToC Red Flags: Inpatient Only)	>=2	1	0	A Red Flag is a concern raised by a member of staff regarding staffing levels.
	EToC Red Flags					The collection of data for 'Lack of EToC Provision' Red Flags begun in March 2025.
	All Red Flags		>=5	>=3 and <5	<3	The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	Moderate Harm Incidents and Above	Inpatient and Emergency	>=3	>=1 and <3	=0	The number of incidents resulting in Moderate Harm where the ward / area was recorded as the location of the incident. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	Grade 2+ Pressure Ulcers Acquired in Our Care	Inpatient and Emergency	>=4	>=2 and <4	<2	A Pressure Ulcer 'Acquired in Our Care' is a Pressure Ulcer that has developed subsequent to the Patient coming under our care. (This includes both those that are newly acquired and those that have resulted from a deterioration) The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	No Harm	Inpatient and Emergency	>=3	>=1 and <3	=0	Figures represent the number of Patient falls where the location was recorded as the relevant ward. Figures are grouped by the month the incidents was recorded on Datix
	Harm		>=4	>=2 and <4	<2	The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	% Overall Sepsis 6 Compliance	Emergency Only	<70%	>=70% and <90%	>=90%	The percentage of Patients meeting all six of the Sepsis 6 criteria. (They are: Sepsis proforma, Senior Review within an hour, Oxygen appropriately administered, IV access and bloods taken, Antibiotics administered appropriately, IV Fluids administered appropriately and Ongoing monitoring)

% Antibiotics within 1 Hour		<70%	>=70% and <90%	>=90%	The percentage of appropriate Patients receiving antibiotics within one hour.
Medicine Errors	Inpatient and Emergency	>=2	=1	=0	Figures represent the number of Patient medicine-related incidents where the location was recorded as the relevant ward. Figures are grouped by the month the incidents was recorded on Datix. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
% Obs Taken on Time	Inpatient Only	<80%	>=80% and <85%	>=85%	Figures represent observations taken on time as a percentage of those expected.

All measures sourced from Datix CloudIQ are grouped by the month that they were reported on the system which may not necessarily be the month that the incident occurred

Safer Staffing Dashboard - February-2026 - Notes and Definitions (cont.)

PATIENT SENSITIVE INDICATORS (cont.)

Measure	Applicability	RAG Criteria			Notes and Definitions
		Red	Amber	Green	
Patient Complaints	Inpatient and Emergency	>0	N/A	=0	The number of formal complaints received by the Trust where the primary area of complaint is the relevant ward location. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
Feedback	% Positive Responses	<90%	>=90% and <95%	>=95%	The Friends and Family Test is a nationally mandated Patient feedback opportunity given to inpatients upon discharge. A 'Positive Response' is a response of either 'Very Good' or 'Good' to the core question of 'Thinking about the service we provide, overall, how was your experience of our service?'. Please note that figures for the maternity and neo-natal wards are taken from the Maternity Friends and Family Test and not the Inpatient Friends and Family Test. Please also note that responses may relate to Hospital Stays in earlier months due to the time it takes to receive and process them. All figures exclude 'Don't Know' responses and responses where the core question has not been answered.
	FFT				
	Number of Responses	N/A	N/A	N/A	

ASSURANCE SUMMARY CATEGORIES

Category	Definition
Significant	Delivery of care 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 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 risk 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.

Safer Staffing Dashboard - February-2026 - Notes and Definitions (cont)

DATA SOURCES AND TIMINGS - STAFFING METRICS

Measure	From	When	Data Source Details
Beds Established Beds Bed Occupancy	PAS / Rostering Team	2nd or 3rd working day of each month (PAS); by 15th of each month (Rostering Team)	Bed Occupancy figures are taken from PAS and correspond to those submitted in the daily UEC sitrep. The exceptions to this are John McPherson ward, SCBU and ICU - occupancy figures for these areas are taken from information provided by the Rostering Team when they provide the information for the national CHPPD submission.
Number of Attendances	Tableau	2nd or 3rd working day of each month	Figures are taken from the 'UEC & System Flow Dashboard (E1110) - A&E Type 1 and 3 Summary' Tableau dashboard, filtered to display a monthly view.
Staffing Fill Rates Days: RN/Midwives, Care Staff Nights: RN/Midwives, Care Staff	HealthRoster	Received by email from Rostering Team by the 15th of each month	Dashboard figures are sourced from those provided by the Rostering Team for the national CHPPD submission.
Actual Staffing Split Days: % RN / Midw., % Care Staff Hours Nights: % RN / Midw., % Care Staff Hours			
Care Hours Per Patient Day (CHPPD) Days: RN / Midwives, Care Staff, Overall Day Nights: RN / Midwives, Care Staff, Overall Night			
HR Metrics Sickness Rate Turnover Rate Vacancy Rate	HealthRoster	10th - 15th of each month (Sickness and Turnover Rates); by 7th of each month (Vacancy Rate)	Figures for the Sickness and Turnover Rates are taken from the Caregroup End of Month Workforce reports produced and distributed by the Workforce Information Team. Figures for the Vacancy Rate are taken from the month end columns of the weekly Bank and Agency Report produced and distributed by the Workforce Information Team.
Temporary Staffing Prop. Bank Hours Prop. Agency Hours	HealthRoster	By the 7th of each month	Figures are taken from the month end columns of the weekly Bank and Agency Report produced and distributed by the Workforce Information Team.
Accreditation	Professional Standards Lead Nurse		Each month the Professional Standards Lead Nurse sends an email to notify of any changes to the accreditation status of any wards

Safer Staffing Dashboard - February-2026 - Notes and Definitions (cont.)

DATA SOURCES AND TIMINGS - PATIENT SENSITIVE INDICATORS*(Measures that are potentially impacted by staffing issues)*

Measure		From	When	Data Source Details
Number of Unplanned Reattendances		Symphony	2nd or 3rd working day of each month	Figures for this measure are obtained by running a query against warehoused Symphony data.
Service Delivery Times	% Waiting > 4 Hrs	Tableau and Symphony	2nd or 3rd working day of each month	Figures for the 4 hour breaches are taken from the 'UEC & System Flow Dashboard (E1110) - A&E Type 1 and 3 Summary' Tableau dashboard, filtered to display a monthly view.
	% Waiting > 12 Hrs			Figures for the 12 hour breaches and Average Triage Time are taken from the 'UEC & System Flow Dashboard (E1110) - A&E Type 1 Waiting Times' Tableau dashboard, filtered to display a monthly view.
	Avg. Triage Time (mins)			
	Amb. Handovers < 30 mins			Figures for the Ambulance Handovers measure are taken from querying warehoused Symphony data.
Safety	Red Flags Raised	HealthRoster	5th day of each month	Figures are sourced from HealthRoster. In Allocate Optima, perform a SafeCare search for Red Flags for the reporting month and for any Flag State. It is then necessary to remove those with a Flag State of 'Raised in Error'. The 'ETOC Red Flags' measure represents the count of Red Flags with a 'Red Flag Tyoe' of 'Lack of ETOC Provision'; the 'All Red Flags' measure represents the total count of all Red Flags.
	ETOC Red Flags All Red Flags			
	Mod. Harm Incs & Above	Datix CloudIQ Incident Module	2nd or 3rd working day of each month	Figures are taken from Datix CloudIQ and represent Unrejected incidents involving Patients. This is taken from the same incident data that is used by the QIG Dashboard. The 'Moderate Harm Incidents and Above' measure additionally filters for incidents with a Severity of Moderate, Severe or Death harms. The 'Grade 2+ Pressure Ulcers' measure additionally filters for incidents with a Category of Pressure Ulcer' along with a Subcategory indicating Grade 2, 3 or 4. The 'Falls' measures additionally filter for incidents with a Subcategory containing 'Slip, Trip or Fall' and split by Severity to distinguish between No Harm and Harm.
	Grade 2+ Pressure Ulcers Acquired in Our Care			
	Falls			
	% Overall Sepsis 6 Compliance	Monthly Audit via a Formic Dashboard	5th day of each month	Figures are taken from the Sepsis Formic Dashboard with filters applied to only include figures applicable to ED for the reporting month.
	% Antibiotics within 1 Hour			
Feedback	Medicine Errors	Datix CloudIQ Incident Module	2nd or 3rd working day of each month	Figures are taken from Datix CloudIQ and represent the number of Unrejected incidents involving Patients with a Category of 'Medication'. This is taken from the same incident data that is used by the QIG Dashboard.
	% Obs Taken on Time	VitalPac VOR Report	5th day of each month	Figures are taken from the Standard Observations VitalPac Report. The report is filtered to only include data for the reporting month. This is the same VitalPac data used by the QIG Dashboard.
	Patient Complaints	Datix CloudIQ Feedback Module	5th day of each month	Figures are taken from Datix CloudIQ and represent the number of Unrejected Complaints. This is taken from the same incident data that is used by the QIG Dashboard.
	% Positive Responses	Scanned Paper Responses emailed from the Feedback and Engagement Team	Typically between the 5th and 10th of each month	Figures are taken from data emailed through by the Feedback and Engagement Team. This data is the result of scanning paper forms.
Feedback	FFT			
	Number of Responses			



NHS England
Wellington House
133-155 Waterloo Road
London SE1 8UG

To: Joe Teape, Chief Executive, Torbay and South Devon NHS FT

Adel Jones, Deputy Chief Executive and Chief Operating Officer,
Torbay and South Devon NHS FT

Sue Doheny, Regional Director, South West Region

Thomas Kearney, Director of Performance, South West Region

Martin Wilkinson, Director of Performance & Delivery, South
West Region

31 March 2026

Re: EPR Go Live

Dear Joe, Adel and Sue,

Thank you for your letter and subsequent emails setting out the plans for the go-live of the EPIC EPR at Torbay and South Devon NHS FT on 3 April 2026.

With respect to performance:

- We understand you have adjusted your plan to achieve 4 hour performance of 71% in April with current performance standing at c.68% and recovery to 77% expected by August 2029.
- We note the impact that you set out on your elective performance and specifically that you will aim to mitigate a 4% reduction in performance by the end of the year and increase in waiting list size of c.2.4k pathways by the beginning of October.
- Additionally we note the temporary decrease to the Faster Diagnosis Standard you expect to see in April and May, which will be recovered by June.

We can approve this go-live on the condition that the region ensures that the performance impact of this go-live as stated above is mitigated entirely at the regional level by the end of June for elective, and in-month for UEC and cancer. We also suggest the region reviews the performance of the Perfect Week currently taking place closely to ensure that the reductions in occupancy levels needed have been achieved prior to go-live.

Based on the information provided and the period of stabilisation required in June, we can confirm that whilst you should continue to submit WLMDS information through the usual route, we will impute your pre-go-live figures from w/e 29 March until the w/e 5 July. We would seek to reintroduce into both internal and external reporting for data relating to w/e 12 July (submitted by 15 July).

For the monthly RTT return, you would be excluded from reporting and publication for data relating to the months of April, May and June and be reintroduced into reporting and publication for data relating to July (to be submitted by 19 August). The RTT data for April, May and June should NOT be submitted to SDCS and should instead be emailed to england.rtt@nhs.net.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'James Mackey', with a stylized flourish at the end.

Sir James Mackey
Chief Executive
NHS England

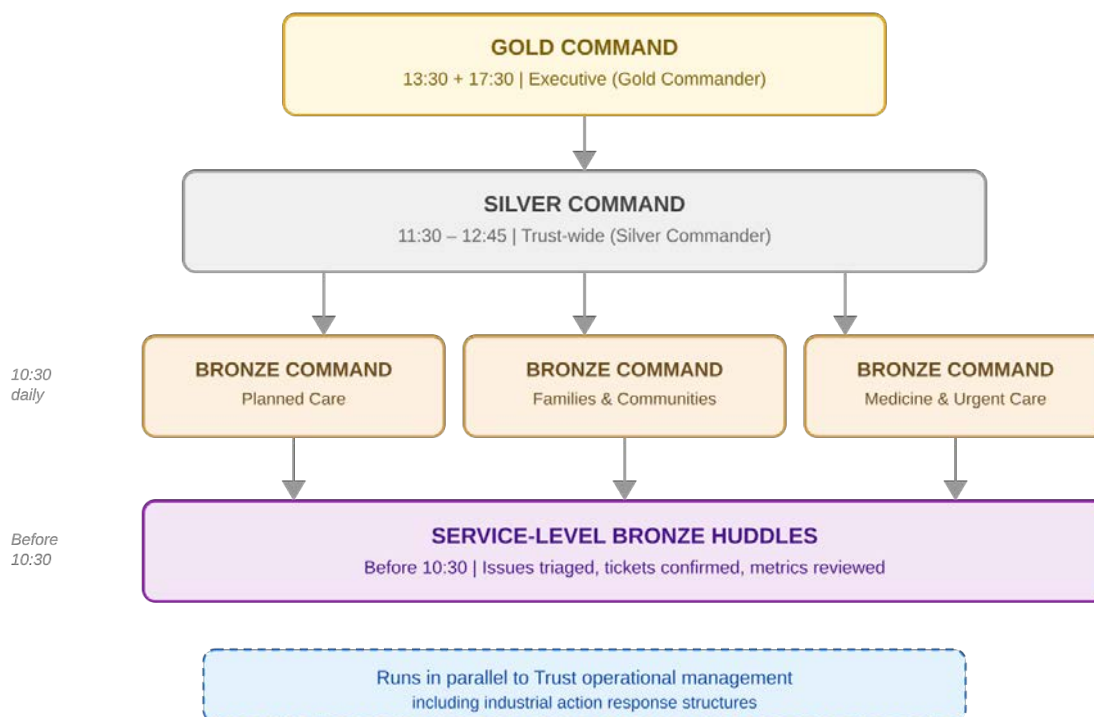
Appendix 2 One Devon EPR Programme TSD First Week	
	One Devon EPR Programme Board membership
Meeting Date	13 th April 2026
Document Name:	TSD First Week Summary
Author:	Richard Collins, Elias Stewart (Epic), Tara Kneller (Epic)
Action required:	For information
Summary	
Background Torbay and South Devon NHS Foundation Trust (TSD) went fully live with the Epic EPR system at 2am on Friday 3rd April. Additional systems (full integration with the Haemonetics Safe Trace (blood transfusion LIMS), ISCV (Echo reporting and Cardiology PACS), and OverSee (casenote tracking)) went live on Tuesday 7th April. Royal Devon successfully went live with the Epic Beacon Oncology module on 3rd April. Cutover Summary The Trust completed core programmatic data migration activity and PAS migration over the weekend of 28th / 29th of March. This included the successful migration of outpatient and day case appointments, referrals, waiting lists and future orders (231,222 records migrated with 0 recorded errors). From 29th March, clinical and administrative cutover teams completed the admission and clinical documentation for inpatients across our community and main hospital wards. This activity completed to plan and with the full scope of data, ensuring that when staff started to use Epic immediately post cutover there was a comprehensive clinical narrative supporting continuity of care. During the evening of 2nd April, teams completed the cutover of maternity and ED patients, ensuring that at the point of cutover, Epic mirrored legacy systems. In the days prior to final cutover, integration teams converted interfaces for retained third-party systems to Epic. This was completed for all systems which were capable of sending messages to both Epic and legacy systems. At approximately 12am on 3rd April, final cutover of remaining systems commenced. A number of legacy systems remained available to staff to enable continued documentation (e.g. SystmOne maternity, Symphony ED and ICCA critical care). The integration team successfully completed remaining go-live dependent integrations between midnight and 2:00am, enabling the Trust to go live as planned at 2:00am on the 3 April across all clinical areas. Final go-no go management A final go/no-go meeting was convened in the Gold Command hub at 01:45 on 2 April. During this session, clinical leads from Inpatient, Pharmacy, and the Emergency Department confirmed that all required cutover activities for patients in their areas had been successfully completed. Technical and interface teams provided assurance that all necessary steps had been executed, including the decommissioning of relevant legacy systems, redirection of interfaces, and enabling	

TSD First Week
10th April 2026

clinical staff access to Epic. Based on these confirmations, a final “go” recommendation was made. The decision to proceed with the planned 02:00 go-live was formally approved by Adel Jones, Senior Responsible Owner.

Command structures

A dedicated Command Centre structure was established to run in parallel to the Trust’s existing operational management arrangements, including the response to concurrent resident doctor industrial action. The structure follows a Bronze, Silver, Gold escalation model. Service-level Bronze Huddles take place each morning before 10:30, where issues are triaged, helpdesk tickets confirmed, and relevant metrics reviewed. These feed into three Bronze Command meetings at 10:30 — one for each care group (Planned Care, Families & Communities, and Medicine & Urgent Care) — where the top issues are prioritised for escalation. Bronze Commanders then present their care group’s top three issues at the daily Silver Command meeting, chaired by the Silver Commander, before the most significant items are escalated to Gold Command. This tiered approach has worked well in practice, ensuring that issues from across the Trust are surfaced, prioritised and resolved efficiently, with clear ownership at every level.



Activity management

The programme is monitoring activity stabilisation through a set of lead indicators that track key workflow completion steps in Epic. These provide an early signal of whether services are on track to recover pre-Epic activity levels, well before meaningful volumes of actual attendance data are available. As of 9th April, five of the eight indicators are on target, with the un-outcome visit rate

the primary area of focus. Individual Bronze leaders own recovery of their indicators, reviewing them in daily huddles and escalating to Silver where necessary.

Lead indicator	Current	Target	Status	Key note
Appointment resolution (check-in) rate	93.7%	95%+	Amber	Focus for improvement: ENT, General Surgery, Respiratory, Rheum, Podiatry, Medical Oncology, Midwifery
Un-Outcomed visits (% of total)	27%	<10%	Red	Despite status, daily trend has been positive with day over day improvements.
Encounter close rate	74%	80%+	Amber	Largest barrier to encounter closure is encounters with un outcomes visits.
“Refer to validator” outcomes (% of total)	<1%	<10%	Green	6 total Route To Validator Outcomes (Urology – 2, Clinical Haematology, Colorectal Surgery, Breast Surgery, Ophthalmology – 1 each).
Missing EDD (% of total)	1%	<10%	Green	Strong compliance maintained throughout go-live period.
Overdue EDD – not updated within 36 hours (% of total)	10%	<15%	Green	Strong compliance maintained throughout go-live period.

Clinical Safety

The programme has maintained a strong focus on clinical safety throughout the first week. The Clinical Safety Dashboard has been reviewed daily, with targeted actions taken to support areas falling below expected thresholds. Themes identified through the dashboard have been communicated to staff via the daily super user briefings, and support teams have been directed to specific wards and clinical areas requiring additional assistance. Staff have performed well against key clinical safety metrics, including timely medication administration, laboratory specimen collection, vital signs documentation, barcode medication administration (BCMA) compliance, and VTE assessment completion. All of these indicators are trending positively as staff become more familiar with Epic workflows. Targeted focus during the first week has centred on ensuring that users are signing orders rather than leaving them in a pending state, avoiding order overwrites, reconciling medications prior to administration, and maintaining on-time medication delivery. These areas are being actively monitored and reinforced through floor support and the Bronze Huddle structure. No serious patient safety events have been escalated to Gold Command since go-live.

Super User Support

Super Users provide invaluable ‘at elbow’ support for staff as they gain familiarity with the new system. The Trust developed a comprehensive plan for this support including supernumerary Trust staff, members of the programme team, Epic staff and colleagues from across the Epic community. Where there are urgent or highly complex issues which our super users have been unable to resolve, floor support has been supplemented by our analyst teams.

As at 10th April 2026 approximately 1,200 shifts have been provided across hospital and community sites. The programme has used dedicated Teams channels to coordinate support

between super user teams which has worked well. These channels are also monitored by change and analyst teams and additional support has been directed to support areas / staff where required.

The Trust has received significant additional support from UHP colleagues who responded to the resident doctor industrial action and redirected their IOs to TSD.

As of 11th April 2026, 190 responses have been received through the Go-Live Support Check-In survey completed by super users across Torbay and South Devon. On a scale of 1 (Terrified) to 5 (Excited and ready to go), super users rated their own confidence at an average of 4.1 out of 5, with 82% selecting either "Mostly good" or "Excited and ready to go." When asked how staff in their area are coping, 94% of respondents reported that their teams are either doing ok or thriving, with 6% identifying areas where staff are struggling. These results indicate a strong and stable position one week into go-live, with the initial enthusiasm settling into steady operational confidence. The small number of areas flagged as struggling are being actively followed up through the Command Centre support structure.

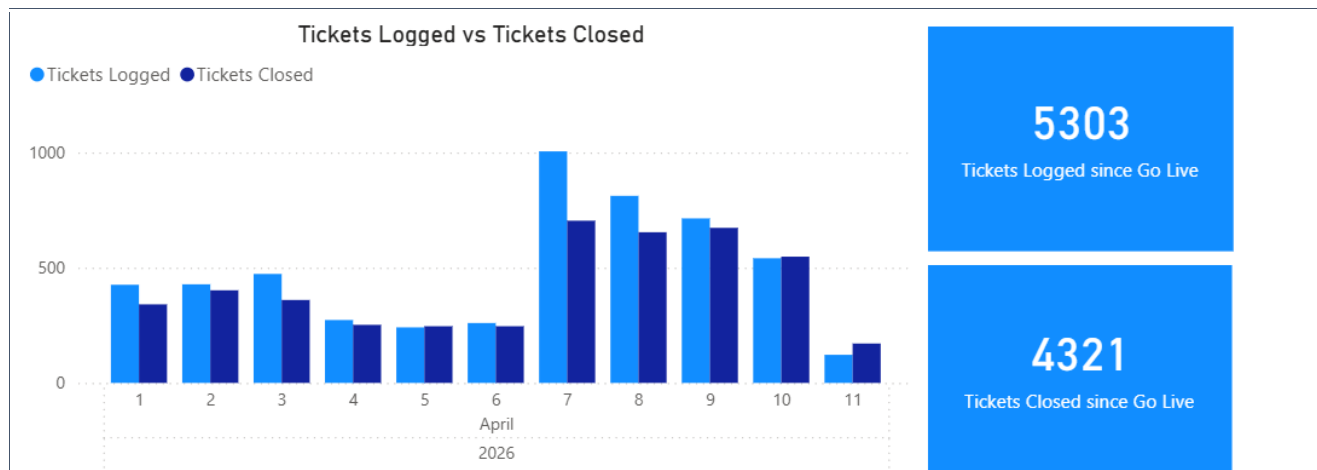
System Issues (Snagging list)

There have been no serious issues (Priority 1) logged since go-live. Typically, we would expect to see a small number in early days post go-live.

The Trust has logged fewer helpdesk calls than is typically seen during an Epic go-live. There are two key factors: we are adopting an existing live system and significant effort was put into addressing risk areas ahead of go-live. This has enabled teams to resolve a larger % of issues more quickly, reducing the impact for our staff. Additionally, strong super users support at the elbow has resulted in a number of issues addressed in real time which reduces the number of tickets logged.

Staff are already starting to log 'optimisation' requests, indicating that they are comfortable with core workflows and are identifying opportunities to make improvements for their local services.

The graph below shows the call volumes received in the days prior to go-live (i.e. issues experienced during cutover activities) and then over the initial Bank Holiday weekend where we were primarily supporting inpatient and UEC areas. The steady reduction in issues over the first few days is a positive indicator of early stabilisation across those areas. The increase in issues from 7th April coincides with commencement of elective activity and aligns with our expected trajectory.



Key issues – Reported through Bronze, Silver and Gold command structure

The following areas have seen the highest number of issues and / or have been most impacted:

- Issues with Safetrace recognising the Epic wristbands required extension of paper processes for transfusion. This was supported by a dedicated support team for staff prescribing or administering blood. The lab teams provided excellent additional support through this period. This issue has been resolved for adult wristbands but SafeTrace cannot read paediatric wrist bands (there is a clinically suitable alternative workflow which aligns with the BAU process in Royal Devon).
- There were multiple issues with automatic filling of observation data from some of our medical devices. There were a number of contributory factors, including staff becoming fully familiar with workflow and issues with specific devices. This persisted for a number of days, with staff manually addressing this issue. It is largely resolved noting that familiarisation and individual device issues may continue (as per BAU).
- Workflows for generating automatic notification for completing observations as a nursing task (supporting NEWS2) required reconfiguration, including alignment with Royal Devon (as this was a change in practice for their staff). The changes have been adopted by both Trusts and the system is now working as designed.
- There were technical issues with Solventum (3rd party system used for voice recognition). This only persisted for a few days and did not materially impact system users.
- Ophthalmology as a service has a number of build issues which may start to impact recovery to full activity. There are no material issues but the team will work actively with the service to ensure that we resolve as many issues as possible over the coming few days.
- Community staff were unable to access the Devon & Cornwall Care Record (DCCR). Approximately 350 users have requested DCCR access to view information on patients seen across county lines. DCCR contains centralised views of Cornwall and Devon acute, community, and social care information. DCCR are prioritising access for the most impacted users and have committed to completing the full list by 14 April.

Challenges / Lessons learned

Whilst there have at times been challenges releasing all of the supernumerary staff, the enhanced training provided to a much larger group of super users (>13% of substantive staff vs an expected 10%) has clearly had a significant benefit as the underlying capability of staff has been much better than seen at previous go-lives.

One area of challenge has been the volume of just-in-time training required for bank and agency staff. Approximately 150 staff required training on the day or night of their shift, rendering them unavailable for the first two hours while they completed their learning and had system access provisioned. While the programme was able to accommodate this, it highlighted a dependency on timely access setup that was not always seamless and placed additional pressure on ward teams absorbing the temporary reduction in capacity. This is a lesson the programme will carry forward into the UHP go-live planning, with a view to identifying bank and agency staff earlier in the process and completing training and access provisioning ahead of their first rostered shift on the live system.

Successes / Reception

The reception from staff across Torbay and South Devon has been very positive. From day one, clinical teams reported that the transition felt smoother than anticipated, with several comparing it favourably to previous system implementations. Staff consistently praised the calm, supportive presence of super users and floor walkers, and as the week progressed managers reported visible growth in confidence, with staff who had completed a couple of shifts already stepping up to support their peers.

The operational benefits of Epic are already being felt. Community therapy teams reported that tasks which previously took 30 minutes can now be completed in seconds using the Storyboard, and community nurses have embraced Rover with 97% of scheduled visits touched by the end of the first week. Laboratory teams noted they are starting to see the benefits of an integrated system, oncology day units have managed well despite pre-go-live concerns, and radiotherapy staff described receiving electronic referrals for the first time in six years. The culture of support across the Trust has been a defining feature, with external stakeholders also reflecting that the go-live has gone well. Colleagues from both Royal Devon and University Hospitals Plymouth provided additional on-the-ground support throughout.

GO-LIVE ACTIVITY STABILISATION

Executive Update – 17 April 2026



OVERVIEW



This report provides a read-out on the Trust-wide position for Activity Stabilisation as of 17 April 2026 and the top off-track services requiring intervention for recovery.

Activity Stabilisation remains at *watch* as service engagement continues to strengthen and lead indicators approach green across most areas; however, tight timelines on service-level data validation, increasing validation queries from services, growing focus required on workqueue reporting, and admin staff still building confidence in their new data quality responsibilities all warrant close monitoring as we move into activity volume statusing next week.

Key Messages:

- Lead Indicators, including Appointment Resolution, Visit Closure, and Outcoming, have stabilised in most areas of the trust. Services of continued focus are outlined below.
- Workqueue reporting will commence from w/c 20 April. Anthony Gregorio is working to refine reports ahead of this to ensure focus on the most meaningful metrics, including missing supervisors and stagnant workqueues. In the meantime, managers are reminded to ensure their admin staff are actively working workqueues daily.
- We are shifting focus from the initial go-live lead indicators, which indicate whether services are completing the basic visit workflows in Epic, toward indicators that measure the operational management of services. As a result, we have added Untriaged Referrals, Unposted Surgeon Logs, and Outstanding GP Discharge Letters to the Activity Stabilisation Lead Indicators Dashboard.
- Next week we will begin statusing service-level activity volumes in our twice-weekly Activity Stabilisation meetings as we move beyond the Lead Indicators.
- Operations managers continue to validate their service-level activity volumes. They have identified community activity being reported as outpatient activity, as well as some inpatient spells appearing twice when patients have multiple lead consultants during a spell. Both issues have fixes in testing and will be resolved before the next Activity Stabilisation meeting on Tuesday 21st April.

LEAD INDICATORS

Lead indicator reports monitor key system adoption which will introduce negative impacts to activity stabilisation if these workflow steps are not performed correctly and timely. In the initial days of Go-Live, which Trust staff are focused on care delivery with the new system and the Planning, Performance, & Informatics teams are validating the Activity Tracker metrics, these lead indicator reports allow the Trust to understand if they are on track for activity stabilisation well before we have a meaningful sample dataset of actual attendances.

For visit outcoming, we continue to find cohorts of visits that do not require outcoming and refine the report logic to exclude these, narrowing the work to be actioned by clinicians. We encourage services to continue monitoring unoutcomed visits on this lead indicator and feedback any exclusions.

Workqueue reporting has not yet been included in this week's Lead Indicators reporting due to some refinement identified to surface the most important areas of concern such as missing supervisors & stagnant workqueues. Anthony Gregorio is working to refine these ahead of next week to ensure reporting is focused on the most meaningful metrics. Alongside this, early review has surfaced two concerns we are getting ahead of proactively: several workqueues do not appear to be actioned by their named supervisors, and there are gaps where supervisors have not been assigned at all. Anthony Gregorio will begin working with IOs next week to address both. We will begin reporting on this in earnest

GO-LIVE ACTIVITY STABILISATION

Executive Update – 17 April 2026



from the week commencing 20 April. In the meantime, managers are reminded to ensure their admin staff are actively working workqueues daily.

Lead Indicator	Current Position (Through 9 April)	Target	Current RAG Status	Comments & Next Steps
Appointment Resolution (Check-in) Rate	94.9%	95%+		3% increase over last week, approaching green.
Encounter Close Rate	95.35%	80%+		3% increase over last week. Top services for improvement: Ophthalmology, Cardiology, Dietetics – Paediatrics
Un-Outcomed Visits - % of TOTAL	12%	<10%		17% increase over last week, approaching green. <i>Note: we updated inclusion logic to exclude visits that have not yet occurred which reduced the dataset.</i> Top services for improvement: Ophthalmology, Gynaecology Oncology, Gastroenterology, Medical Oncology, Haematology
“Refer to Validator” Outcomes - % of TOTAL	2	<10		<i>Strong push by ops managers to clean these up and educate staff and proper outcoming – thank you!</i>
Day Cases not Discharged Same Day - TOTAL	0	<5		
Day Case Appointments Checked-in, but not Admitted - TOTAL	2	<5		Conversion issue the EPR team is working to resolve this week, do not anticipate end-user clean-up required.
Missing EDD - % of TOTAL	1%	<10%		<i>Excellent job sticking to good habits on EDD compliance!</i>
Overdue EDD (Not updated within the last 36 hours)- % of TOTAL	5%	<15%		<i>Excellent job sticking to good habits on EDD compliance!</i>

ACTIVITY METRICS: TRUST-WIDE POSITION

CURRENT FOCUS

We will begin statusing activity volumes the week commencing 20th April. Operational Managers have identified two common issues in their activity data to date that have prevented them from signing off on their metric volumes:

- Community activity performance in an outpatient setting is classified as an outpatient attendance, not a community one.
- Inpatient spells with multiple consultant episodes appear as multiple inpatient spells.

GO-LIVE ACTIVITY STABILISATION

Executive Update – 17 April 2026



Both issues have been fixed and tested and will be in Production ahead of Tuesday's Activity Stabilisation meeting. Therefore we are on track to begin reviewing and statusing activity volumes.

OUTPATIENT ACTIVITY

As the Activity Stabilisation Dashboard currently categorises community outpatient activity as outpatient attendances, outpatient activity is higher than expected. This will be resolved ahead of Tuesday's Activity Stabilisation meeting.

Below are the volumes of outpatient attendances for the week commencing 6 April, the last full week of data. The expected amounts are the average weekly amounts outlined in the 26/27 Annual Plan, with no adjustments for the Easter bank holiday, go-live activity reductions, or last week's industrial action:

- Outpatient First Attendances: 1591/2290 expected
- Outpatient Follow-up Attendances: 4763/6062 expected
- Outpatient Procedure Visits: 354/2199 expected

THEATRE ACTIVITY

Theatre volumes were significantly reduced the week of 6 April due to the Easter bank holiday, go-live activity reductions, and last week's industrial action. Trust-wide, there were 31 theatre cases vs an expected 319.

An additional 31 cases were performed that week but have not yet been counted as the surgeon has not yet posted their log. Operational Managers are encouraged to review the Lead Indicators Dashboard and follow up with their surgeons to ensure they are posting all outstanding logs.

ACTIVITY METRICS: PRIORITY OFF-TRACK SERVICES

While four services are cited for improvement this week, outside of ophthalmology their lead indicators remain strong for week two of go-live and have all improved since last week. The focus is on moving these services from just below our green threshold to fully green before we shift attention to activity volumes from next week.

OPHTHALMOLOGY

SERVICE LEAD: CHARLIE HARDING

EPR LEAD: HANNAH HALL & SALLY MAGEE

EPIC LEAD: VISHAL PATEL

Key Metrics:

- Appointment Resolution Rate: 92% (retinal laser & glaucoma screening are the lowest)
- Appointment Close Encounter Rate: 80.9% (macular injections & glaucoma are the lowest)
- Un-Outcome Visit Rate: 69% (macular injections & glaucoma are the lowest)

Key blockers from the service recovering lead indicators:

- Ophthalmology is transitioning to a new scheduling workflow for procedure visits with virtual follow ups, which can impact documentation completeness as users adjust to the change.

Key recommendations to support service recovery:

- ✓ The Ambulatory, Cadence, and Springboard teams are collaborating to identify and convert legacy encounters to the new workflow, ensuring encounters requiring outcomes are correctly identified moving forward.

GO-LIVE ACTIVITY STABILISATION

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MEDICAL ONCOLOGY

SERVICE LEAD: ALEX ATKINS

EPR LEAD: SARAH REED

EPIC LEAD: DOROTHY OLDACH

Key Metrics:

- Appointment Resolution Rate: 93%
- Appointment Close Encounter Rate: 92%
- Un-Outcomed Visit Rate: 78%

Key blockers from the service recovering lead indicators:

- 42 visits are missing an outcome. These are a mix of telephone and face-to-face visits. Many have been signed and completed, meaning we need to identify whether outcomes are required here and possibly adjust report criteria.

Key recommendations to support service recovery:

- ✓ Service to confirm whether outcomes are required for these encounters and, if so, provide the appropriate RTT outcomes for Medical Oncology patients.

GASTROENTEROLOGY

SERVICE LEAD: EMMA BROOKS

EPR LEAD: HANNAH HALL & SALLY MAGEE

EPIC LEAD: VISHAL PATEL

Key Metrics:

- Appointment Resolution Rate: 96%
- Appointment Close Encounter Rate: 95%
- Un-Outcomed Visit Rate: 69%

Key blockers from the service recovering lead indicators:

- 18 Gastroenterology visits currently do not have an outcome documented. These are all follow up visits. All visits have been signed and completed, meaning we need to identify whether outcomes are required here and possibly adjust report criteria.

Key recommendations to support service recovery:

- ✓ Service to confirm whether outcomes are required for these encounters and, if so, provide the appropriate RTT outcomes for Gastroenterology patients.

HAEMATOLOGY

SERVICE LEAD: AMY MCBRIDE

EPR LEAD: HANNAH HALL & SALLY MAGEE

EPIC LEAD: VISHAL PATEL

Key Metrics:

- Appointment Resolution Rate: 95%
- Appointment Close Encounter Rate: 97%
- Un-Outcomed Visit Rate: 74%

Key blockers from the service recovering lead indicators:

- 26 Haematology visits do not have an outcome. These are all follow up visits. All visits have been signed and completed, meaning we need to identify whether outcomes are required here and possibly adjust report criteria.

GO-LIVE ACTIVITY STABILISATION

Executive Update – 17 April 2026



Key recommendations to support service activity recovery:

- ✓ Service to confirm whether outcomes are required for these encounters and, if so, provide the appropriate RTT outcomes for Haematology patients.

Appendix 4

Review and Rationalisation of EPIC Risks – Proposal to Consolidate into a Single Overarching Risk

Author – Zohaib Paracha (Risk Consultant) 17th April 2026

1. Purpose

To present a review of EPIC-related risks and seek agreement from the Risk Group to:

- Consolidate multiple EPIC risks into a single overarching risk
- Improve clarity through structured Controls, Gaps, and Actions
- Align with DCIQ standards and Cause–Event–Impact (CEI) framework

Safeguarding risks are excluded from this proposal and will remain separate.

2. Background

EPIC is a Trust-wide Electronic Patient Record (EPR) system supporting:

- Clinical documentation
- Prescribing
- Diagnostics
- Patient flow and operational processes

As an integrated system, risks associated with EPIC are interdependent and impact multiple areas simultaneously.

Current risks relate to:

- Clinical safety
- System usability and workflow
- Training and adoption
- Data quality
- Operational disruption

These represent components of a single system-level risk rather than independent risks.

3. Key Issue Identified

The current approach results in:

- Duplication of risks
- Fragmented oversight
- Limited system-wide visibility
- Actions not aligned to underlying system issues

This reduces effective governance and risk management.

4. Proposal

It is proposed that EPIC-related risks are consolidated into one overarching risk reflecting:

- System implementation and stabilisation
- Clinical safety impacts
- Operational disruption and workflow challenges
- Data quality and usability

Safeguarding risks will remain separate due to statutory and governance requirements.

5. Proposed Overarching Risk (DCIQ Format)

Initial Score: 20 (4×5) | **Current Score:** 16 (4×4) | **Target Score:** 8 (2×4)

Cause

Insufficient system optimisation, training, and operational readiness following EPIC implementation, combined with system complexity and workflow change.

Event

The Trust is unable to safely and effectively deliver clinical and operational services using EPIC.

Impact

This could result in:

- Patient Safety and Clinical Outcomes: Increased risk of errors in prescribing, documentation, and clinical decision-making
- Service Delivery: Delays in care and disruption to patient flow
- Performance: Failure to meet operational and clinical targets
- Workforce: Increased pressure on staff and reduced productivity
- Financial: Loss of income or increased costs due to inefficiencies
- Reputational and Regulatory: Increased scrutiny and reduced confidence in digital transformation

6. Controls, Gaps and Actions

6.1 Controls (Current Mitigations in Place)

- EPIC implementation governance and programme structure
- Staff training programmes
- Clinical safety processes and system controls (alerts, checks)
- Helpdesk and user support arrangements
- System monitoring and incident escalation

6.2 Gaps in Control

- Inconsistent user training and competency
- System usability issues impacting workflow

- Data quality and documentation inconsistencies
- Limited optimisation of system configuration
- Misalignment between system design and clinical workflows
- Ongoing operational disruption post go-live

6.3 Actions

- Deliver targeted training and competency validation across all staff groups
- Implement structured EPIC optimisation programme aligned to clinical workflows
- Strengthen data quality governance and audit processes
- Enhance clinical safety monitoring and incident review
- Improve support model during stabilisation phase
- Establish regular EPIC governance and performance oversight

All actions to be specific, time-bound and assigned to a named owner.

7. Governance and Reporting

- Risk to be managed at Care Group or Corporate level depending on if the risk is operational or strategic.
- Escalated to Corporate Risk Register where thresholds are met
- Escalated to Board Assurance Framework if impacting strategic objectives

8. Recommendation

The Risk Group is asked to:

1. Approve consolidation of EPIC risks into a single overarching risk
2. Support the revised structure using Controls, Gaps and Actions
3. Endorse ongoing review to strengthen actions and quality

Quality and People Committee

72 hour standards report and 7 day working report

Date of meeting	Date report produced
17 th March 2026	12 th March 2026

Author(s)		Report approved by	
Name and title:	Sam Wardham-Sharpe, Deputy COO Mark Roberts Deputy MD Carly Renaud, Improvement team	Name and title:	Catherine Lissett, CMO.

Date: 17th March 2026

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

Not applicable

Executive summary

The 72 hour standards set out by NHS England focus our organisation's attention on ensuring we ensure this critical 72 hour phase of secondary care, from the moment contact is made with our acute service entry points, supports the best possible quality, safety and experience and makes the use of our healthcare resources as productive as possible.

We will move towards iterative improvements in this domain by focusing on early senior decision making, maximising continuity and coordination whenever possible, delivering care in the most appropriate place and at the right time. To achieve these outcomes for our population we need to build on existing elements of 7 day working and seek opportunities to expand these through pathway redesign, focused investment and harnessing the digital care opportunities EPIC enables.

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

Section	Assurance (Limited/Satisfactory/	Trend from previous report

	Significant)	
Early clinical decision-making	Limited	Unchanged
Early clinical decision-making Frailty	Limited	Unchanged
Care navigation Operational policies, pathways and escalation	Satisfactory	Improved
Care navigation Clinically led flow	Limited	Unchanged
Care navigation Specialty decision maker availability	Satisfactory	Unchanged
Care on the acute receiving area and continuity of care Continuity and minimising handover	Limited	New
Care on the acute receiving area Boardrooms and outlying patients	Limited	Unchanged
Care on the acute receiving area Senior-led standardised handovers/huddles with MDT participation	Satisfactory	New
Care on the acute receiving area Timeliness of urgent specialty opinion delivery	Limited	New
Care on the acute receiving area Transfer targets and flow direction	Limited	New
Care on the acute receiving area Low length of stay targets	Limited	Unchanged
Support services and 7-day working Diagnostic and support service availability	Limited	Unchanged
Data recording and metrics 13 , Accurate attribution/coding (e.g.,	Limited	Unchanged

TFC 326 for acute medicine first episode)		
Our patients, families and carers Patient and family involvement and goal setting	Limited	New
Board assurance Internal Professional Standards and performance progress	Limited.	

Appendices

Appendix 1 – 72 Hour Standards

Appendix 2 – UEC Driver Diagram

included in the Quality and People Committee Items for Information Pack

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

This report builds on UEC regional and national reports to improve UEC, and local opportunities as supported by the ECIST (Emergency Care and Improvement Support Team) in late 2025

Key recommendations and actions requested

Maximising utilisation of EPIC capabilities both for individual patient care and for performance management and improvement opportunities.

How does this report further our Trust strategy?

This report supports our trust strategy for safe and effective clinical services in Urgent and Emergency Care pathways, improving quality and minimising inconsistencies.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Improved emergency and urgent care
Quality of services provided	More consistent right care, right place, right time
Sustainable and efficient use of resources	Optimising use of limited capacity and capability by improving efficiency and effectiveness

Impact on BAF Objectives

BAF Objective	Impact

Quality, Safety and Patient Experience	Improved
Leadership and Governance	
Performance	Improved
People and Culture	More sustainable working patterns
Strategy and Business Intelligence	
Finance	Optimising best use of financial resources
Risk	

Not applicable

Risks lodged on Datix:

ED congestion - 1095

External Standards affected by this report and associated risks

Not applicable

1. Introduction and background

NHSE published its guidance and standards for care of acutely unwell patients on 16th December 2025. This guidance was created following 1.7 million patients spending greater than 12 hours in emergency departments in 2024. It is also widely understood that length of stay in hospitals is 10% greater than it was pre pandemic.

The guidance and standards published by NHSE outlines the approach for each acute provider to take during the first 72 hours of a patients stay within acute hospitals and when implemented these standards aim to

- reduce the time patients are spending in emergency departments
- reduce 12-hour waits and corridor care
- improve quality, safety and patient experience
 - reduce anxiety and stress for carers and family members by improving information sharing and involvement in care planning
 - ensure greater clarity, ownership and oversight of care
 - help reduce unnecessary long stays in hospital and help people return to their homes more quickly

2. Purpose of report

This report is designed to inform QPC and Exec Co on the Trusts current performance in relation to these standards, and how we plan as an organisation to respond to meeting the standards set out nationally in relation to the first 72 hour period and the 7 day working approaches. For each of the standards, the key requirement is listed in *italics*, with a position statement from the Trust detailed directly below.

A further iteration of this report will be circulated once the ability to outline the data associated with compliance is able to be presented, post EPIC go live.

To support an understanding on the work in place currently, two appendices have been provided to accompany this paper. Appendix one is a current assessment on the standards, the required change ideas and an alignment to current improvement work. Appendix 2 is a driver diagram identifying the key drivers for this work.

3. Commentary on Standards 1-13

Standard 1: initial and expert assessment

All patients should have a full assessment by a competent clinical decision-maker within 1 hour of referral from the emergency department (ED) or of arrival on the acute receiving area.

TSDFT position – we have built rotas with this grade of decision maker in our receiving and assessment areas but we do not consistently meet this standard within 1 hour. Further data presenting current position, historic trend will be presented in next iteration of the paper, alongside any interventions required to achieve the standard.

Any time-critical medications should be identified and prescribed with a plan for a pharmacy review within 24 hours of admission. This should complement, not duplicate, any previous assessment.

TSDFT position – our ED and assessment unit teams have an enhanced focus on prescribing time critical medications at the point time of first assessment.

EDs and acute receiving teams should work together to deliver and document a streamlined assessment that builds on a shared clinical narrative.

TSDFT position - our ED and acute assessment teams share the same documentation software in ED but this switches to paper-based models outside of ED. EPIC will replace this model effectively and build a more joined up, shared clinical narrative.

All admitted patients should be assessed by an expert clinical decision-maker, normally a consultant, within a maximum of 6 hours during the day and 14 hours overnight.

TSDFT position – we current fail to meet this standard consistently. The change to the admitting pathway, ensuring all medically admitted patients (except for cardiology and stroke) are admitted through the acute assessment areas was designed to support this, unfortunately ongoing issues with flow and demand through winter have meant that we have not achieved this standard as expected. Further data presenting current position, historic trend will be presented in next iteration of the paper, alongside any interventions required to achieve the standard.

Acute trusts should resource and plan the expert decision-maker workforce to maximise the day's work by modelling cover for peak times

TSDFT position – we continually review whether evening and weekend arrangements, with predictable peak times, can be better resources with expert decision makers.

Standard 2: additional requirements for specific patient cohorts

Older people with frailty

Patients aged over 65 presenting to hospital as an emergency should be assessed by a competent clinical decision-maker within 30 minutes of arrival using the Clinical Frailty Scale (CFS) and the 4AT tool for delirium.

TSDFT position – we are not meeting this standard consistently at present. Further data presenting current position, historic trend will be presented in next iteration of the paper, alongside any interventions required to achieve the standard.

Acute trusts should ensure that older people with frailty (CFS 5+) have access to a senior clinical decision-maker with skills in managing frailty and multiple long-term conditions within 1 hour of referral during the day, or before 10am the next day if overnight.

TSDFT position – we have made significant improvements and investment in this area particularly with the Harbour Frailty team set up but workforce capacity constraints limit the extent to which we can aspire to this clinical standard.

All older people with frailty (CFS 5+) should be assessed by an expert clinical decision-maker in managing frailty, normally a consultant, within a maximum of 6 hours during the day and 14 hours overnight.

TSDFT position – our focus on 'Post Take Ward Round' by expert clinical decision makers skilled in frailty identification and management works towards meeting this standard but we are not yet consistently meeting this standard.

Specialty and/or specialist palliative care teams should be consulted when known patients present to ED with an exacerbation of a long-term condition, where appropriate.

TSDFT position – this model is delivered episodically and not consistently as we do not have the workforce capacity to respond consistently. Further data presenting current position, historic trend will be presented in next iteration of the paper, alongside any interventions required to achieve the standard.

Acute trusts should ensure patients who are receiving palliative care and end-of-life care or who have advance care plans can be identified to ensure their preferences and wishes are supported.

TSDFT position – increased roll out of electronic Treatment Escalation Plans, and advanced care plans, will improve our position and EPIC will enable this more consistently. Work is ongoing to ensure that these treatment plans are visible to other services such as SWASFT when patients are in the community.

Standard 3: operational policies

All acute admissions by default, move from ED or community care to an acute receiving area. Exceptions: direct specialty admission where there is clear patient benefit (e.g. stroke, STEMI).

Clear pathways: agreed admission criteria for common presentations, regularly reviewed with specialties.

Shared care: defined processes with one clinician responsible for overall care.

In line with national expectations, our pathways at TSDFT is all patients by default move to our medical, surgical and paediatric assessment areas unless clear exceptions eg Acute Stroke, Cardiac Thrombolysis.

We have co-produced with specialties clear admission criteria and pathways for all commonly presenting clinical problems.

We have co-produced and published clear escalation and dispute resolution processes 24/7 as part of 2026 Internal Professional Standards work.

At times of increased escalation and lack of flow, this requirement can be breached in an attempt to provide flow to the emergency department.

Standard 4: clinical leadership of patient flow

Flow into and out of acute receiving areas should be clinically led to promote the right patient moving to the right specialty bed.

In line with national expectations, outside ED, our assessment and ward areas have regular MDT meetings to update Swiftplus boards to promote the right patient moving to the right specialty bed.

Acute trusts should have a designated consultant in charge who is responsible for the acute take, mirroring the EPIC role in ED and working with the nurse in charge and/or allocated navigation team to prioritise and co-ordinate patient care.

TSDFT position - we have this in most specialties, not all, notably Medicine.

We consistently seek to access alternatives to admission, utilising our same day emergency care (SDEC) and virtual wards/hospital at home offers.

The consultant in charge should not cover additional clinical duties such as downstream wards or outpatient care.

TSDFT position – we currently lack the workforce capacity to enable a leadership role like this in any specialty which does not also have additional direct care clinical duties attached.

Standard 5: senior clinical decision-maker availability

A senior clinical decision-maker or above in specialties with highest non-elective admission numbers/rates should be job planned/rostered to receive referrals and provide advice to primary and community care and hospitals 24/7.

TSDFT position – we have senior decision makers (tier 2 group) onsite and available 24/7.

Job planning/rostering may be networked across acute trusts where appropriate or required and should not negatively impact on the general internal medicine rota.

TSDFT position – we are actively seeking to align to this expectation esp in certain specialties like hyperacute stroke care.

If a senior clinical decision-maker or above performs this role, they should have immediate access to an expert clinical decision-maker.

TSDFT position – we have 24/7 access to expert decision makers via on-call rotas.

Standard 6: continuity of care

Expert clinical decision-makers in acute receiving areas with accountability for individual patients should be job planned and rostered to ensure continuity of care across the first 72 hours and reduce multiple consultant episodes.

TSDFT position – many of our key receiving specialities run a Consultant of the week model which meets this standard. Larger volume specialties like Medicine require a shift model approach which makes meeting this standard for continuity more challenging.

Standard 7: ward rounds and board rounds

All our inpatient and assessment units have a targeted, consultant-led and multidisciplinary team (MDT)-supported ward round during weekdays and weekends.

TSDFT position – we meet this standard during weekdays but capacity constraints at present we do not deliver a consistent model at weekends.

Standard 8: clinical huddles and handovers

Clinical huddles and shift handovers must be led by an appropriate senior clinical decision-maker and take place at a designated time and place, with MDT participation from the relevant incoming and outgoing shifts. Handovers should be consistent and standardised and include the identification of high risk/priority patients and assessment of operational conditions.

Clinical huddles and shift handovers are led by an appropriate senior clinical decision-maker and take place at a designated time and place, with MDT participation from the relevant incoming and outgoing shifts in our ED, Assessment unit and inpatient wards.

In line with national expectations, we have a morning and night standardised handover for the Trust on-call resident teams that Consultants are invited to as needed. We use existing electronic handover tools for out of hours and weekend tasks.

Standard 9: specialty response times

Where a patient requires urgent specialty opinion for acuity, clinical decision-making or discharge planning, the specialty senior clinical decision-maker should respond within a maximum of 2 hours of the request.

TSDFT position – we do not currently measure how often senior clinical decision makers in this setting meet this standard. EPIC metrics which are time stamped will assist in this process.

Patients referred to another specialty by the admitting team should be assessed by a senior clinical decision-maker (with access to an expert clinical decision-maker) within 4 hours during the extended day (as determined by demand and capacity modelling) or before 10am the next day if overnight.

TSDFT position – we do not currently measure how often senior clinical decision makers in this setting meet this standard. EPIC metrics which are time stamped will assist in this process

Standard 10: bed transfers

Patients requiring downstream specialty beds should be transferred within 12 hours of a bed request. If no bed is available, the specialty team should ensure daily review on the acute receiving area.

TSDFT position – most downstream specialty teams have very limited capacity at present to attend acute receiving areas consistently.

Specialty teams should know how many patients are waiting for a base ward bed at all times and work to deliver transfer within 12 hours of referral.

TSDFT position - we currently do not routinely describe this to teams to help them queue manage, but we expect EPIC will assist in this function.

At TSDFT we are aligned to the principle that patients should not usually move from downstream wards or ICU/ITU to acute receiving areas (reverse flow).

Standard 11: Length of Stay on Acute Receiving Areas

Any individual patient's length of stay on an acute receiving area should not exceed 72 hours unless sanctioned by the responsible consultant and senior nurse in charge.

TSDFT position – we aspire to this standard but typically LoS stay in our acute receiving unit consistently exceeds this.

Acute receiving area length of stay is expected to be 24–48 hours and should be routinely measured, split by those who are discharged and those who are transferred to downstream wards.

TSDFT position – we measure this routinely, but need to reinvigorate the distribution group and method of sharing this data and how we can improve on it.

Standard 12: availability of support services

To ensure equity of provision of care and maximise discharge opportunities, all support services, including therapies, pharmacy and social services, should be available to acute receiving areas during extended-day working hours (for example, 8am to 8pm), 7 days a week.

TSDFT position – Some key Allied Health services, including our discharging facilitating JETS team and Pharmacy, currently can not match this standard due to capacity constraints.

All areas providing acute and emergency non-elective care in the first 72 hours must have the same access to diagnostics, including imaging, in terms of availability and turnaround times, to support decision-making and prevent unnecessary admission.

TSDFT position – we have good access to plain, ultrasound and CT diagnostics to support this. MR services and cardiac imaging is more variable due to fluctuations in the extent of diagnostic backlog on site.

Standard 13: accurate recording of patient care

Patients' care should be accurately attributed and recorded to the team delivering it.

For example, patients who are referred for care under acute medicine should have Treatment Function Code (TFC) 326 applied regardless of where they are physically located.

If a patient is transferred from an acute receiving area to a specialty ward, the TFC should be changed to reflect the patient's responsible consultant.

This standard will be met through the implementation of EPIC and our ability to better manage patient records which is currently not possible robustly through our legacy systems.

Standard 14: patient and carer experience

All patients and carers must be:

- *treated with dignity, have their basic needs met – in terms of hydration, access to toilet facilities and food – and be offered adequate pain control when needed*
- *fully involved in decisions about their care*
- *kept regularly informed about waiting times and delays to their care*

- *clear about what they need to achieve to get home, when they should expect to go home and who to contact when they are at home*

We meet this standard with a focus on 'four patient questions' daily to track the patient experience, a focus on home-first and get up and dressed culture to counter deconditioning and improve independence and dignity.

Standard 15: compliance and governance

The site-level detail of all standards should be reflected in a written internal professional standards document, developed following discussion and agreement between hospital teams and owned at executive level.

Our Emergency care pathways Internal Professional Standards is going live 30 days after EPIC implementation with clear standards, conditions list and escalation processes to resolve disputes.

4. Assurance recommendations and summary

Based on the level of detail provided in the paper and the current lack of data to align to the standards it is recommended that the committee only take limited assurance on current adherence to this guidance.

It is recommended that a further iteration of this paper is provided in May, post the EPIC go live with a fuller data pack and accompanying action plan, building on the work in Appendix 1.

DRAFTING NOTE: PLEASE DELETE PAGE

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

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

First 72 Hours Standards – Combined Matrix: Compliance, UEC Implementation, IPS Behaviour, and Right Care Alignment

This matrix combines the First-72h standards, the UEC driver diagram's recommended implementation actions, the IPS behaviors required, and alignment to Torbay & South Devon Right Care Phase 2 initiatives.

72 hr Standard	UEC – Nationally Recommended change ideas	IPS – Behaviour required	Right Care Phase 2 – Alignment
Early clinical decision-making 1a, All patients should be fully assessed by a competent clinician within 1 hour of ED referral or arrival in the acute receiving area. 1b, Any time critical meds should be identified and prescribed with a plan for a pharmacy review within 24 hours of admission. 1c, All admitted patients should be assessed by a consultant or expert clinician within 6 hours by day and 14 hours overnight. 1,d Resource and plan the expert decision-maker workforce to maximise the day's work by modelling cover for peak times.	Run CTA as a live tool at attendance Job plans enabling early senior reviews Establish a virtual hub to manage referrals and outreach to specialist teams Scale Virtual Wards capacity	Publish referral pathways Set response SLAs (urgent ≤2h, standard ≤4h) Default acceptance from ED Rapid phone access Clear escalation	ED triage redirection Internal pathways projects such as: AMU single coordinator, SRU ENT IPC pathway, Direct SWAST pathway UEC IPS development
Early clinical decision-making Frailty 2a, Emergency patients aged ≥65 should be assessed within 30 minutes by a competent clinical decision-maker using the Clinical Frailty Scale (CFS) and 4AT. 2b, Acute trusts should ensure that frail older patients (CFS ≥5) have access to a senior clinician skilled in frailty care	Scale Frailty/General Virtual Wards (VW) Strengthen alternatives to admission and Home-First approach	Trigger specialty/palliative advice on presentation	Frailty project "The Harbour" at Newton Abbott

within 1 hour of referral by day, or before 10am the next day if overnight. 2c, All frail older patients (CFS ≥ 5) should be assessed by an expert frailty clinician, usually a consultant, within 6 hours by day and 14 hours overnight Patients with long-term conditions: 2d, Specialty and/or palliative care teams should be consulted for known patients presenting to ED with long-term condition exacerbations, with advice on alternatives to admission and community support Patients receiving palliative care and end of life care: 2e, Acute trusts should identify patients receiving palliative or end-of-life care, or with advance care plans, to support their wishes, and have systems to identify those likely in the last phase of life and refer them to specialty or palliative care.			
Care navigation Operational policies: 3a, All acute admissions by default, move from ED or community care to an acute receiving area. 3b, Exceptions: direct specialty admission where there is clear patient benefit (e.g. stroke, STEMI). 3c, Clear pathways: agreed admission criteria for common presentations, regularly reviewed with specialties. 3d, Shared care: defined processes with one clinician responsible for overall care.	Publish admission criteria and common pathways; default acute take unless clear specialty exception (stroke/STEMI)	Clarity of 'who owns the patient' at all times. standardised navigation; Resolve disputes via senior escalation	Streaming/redirection pathways; such as SSPAU direct routes, SWAST – SRU UEC IPS development

3e, Escalation: clear process for resolving disagreements			
Care navigation 4, Clinically-led flow with consultant in charge of acute take, working with the nurse in charge or navigation team to prioritise care, They should not have other clinical duties such as wards or outpatient care.	Designate consultant in charge of acute take with no conflicting duties Proactive use of SDEC/VW to avoid admission	Collective leadership at the front door; daily visible presence;	None
Care navigation 5, Senior specialty decision-maker available to receive referrals/advice 24/7	Networked rotas for low-volume specialties Ensure 7d access to advice; Phone-first conversations (not pager-only)	Response SLAs; default acceptance; Responsibility transfer on acceptance; shared documentation; escalation chain	UEC IPS Development
Care on the acute receiving area and continuity of care 6, Expert decision-maker continuity across first 72h (consecutive days) and reduce multiple consultant episodes	Annualised job planning for acute receiving areas; consecutive-day consultant cover; Reduce multiple consultant episodes	Rostering norms for continuity; Standard handover content across shifts; Proactive review of all in-patients	None
Care on the acute receiving area 7a, Daily consultant-led ward round + action-focused MDT huddle (incl. weekends) 7b, 2 nd board round / consultant review of high risk patients 7c, Outlying patients from acute receiving areas, including in ED have same principles applied	Codify twice-daily rhythm (incl. weekends/Bank Holidays); second board round for high-risk patients Embed flow principles	Standardised huddles/handovers MDT participation every day	None

Care on the acute receiving area 8, Senior-led standardised handovers/huddles with MDT participation	Implement standard handover templates/times/locations; test IPS under crowding; minimise ward moves	SBAR protocol; defined times/places; identification of high-risk patients;	None
Care on the acute receiving area 9, Urgent specialty opinion ≤2h; other referrals ≤4h/day or ≤10am next day	Networked rotas; phone-first referral; track referral response clocks; executive oversight of breaches	Response SLAs; Default acceptance; senior decision-maker availability; responsibility transfer rules	UEC IPS Development Internal streaming pathways referral pathways
Care on the acute receiving area 10, Transfer to downstream specialty bed ≤12h; avoid reverse flow	Bed-transfer clock in ops huddles; proactive escalation; use SDEC/VW to reduce pressure; minimize ward moves	Clear ownership while awaiting bed; daily review on acute area; Escalation protocol for delays	Flow work; UEC IPS development Internal streaming work
Care on the acute receiving area 11, Acute receiving area LoS 24–48h; cap ≤72h; measure routinely	Re-run CTA at 24h for admitted patients; expand alternatives to discharge; criteria-led discharge (incl. weekends)	Daily review rhythm; target discharge progression; avoid deconditioning	LOS meetings; CLD (Paeds); discharge-before-noon focus (emerging)
Support services and 7-day working 12, 7-day diagnostics & support services aligned to demand	Agree 7-day availability and turnaround SLAs for imaging, pathology, therapies, pharmacy; Prioritise discharge-dependent cases	IPS for access parity; agreed prioritisation rules	None

Data recording and metrics 13, Accurate attribution/coding (e.g., TFC 326 for acute medicine first episode)	Fix TFC 326 attribution and change on transfer; data quality dashboard; link to Model Hospital/BI	Shared documentation; coding rules embedded in IPS; transparency of activity	None
Our patients, families and carers 14, Patients involved, informed; dignity/pain control; clear 'get home' goals	Implement 'four patient questions' daily; Home-First; Deconditioning/get up-get dressed; weekend discharges	Shared decision-making norms; patient-centred discharge planning; communication standards	Paeds CLD & Green Pathway; strengthening Home-First in adult pathways Ward improvement work
Board assurance 15a, Internal Professional Standards document; 15b. board assurance	Write, publish and monitor IPS; include in induction; 6-monthly board assurance with SPC pack	Agreed IPS 'top 10'; role-model behaviours; measurement & accountability	UEC IPS development

Overall Aim	Primary Drivers	Secondary Drivers	Change Ideas
Increase the timeliness, quality and productivity of urgent and emergency care resources by improving patient outcomes, flow and reducing variation and waste	Right Care (in the Right Place) Ensure patients are cared for in the most appropriate setting for their needs	Ambulance Navigation	Navigate patient to the right place the first time
		Single Point of Access	Patients referred to the right place the first time
		Urgent Community Response	Urgent Community Response - Framework
		Streaming and Direct Access	Established models for streaming and initial assessment
		Criteria to Admit	Criteria to admit decision support tool
	Right pathway: Ensuring attendance and admission alternatives are available so only those patients requiring admission are admitted	Urgent Treatment Centres	Urgent Treatment Centre – Framework
		Same Day Emergency Care	Same Day Emergency Care – right sizing
		Virtual Wards	Avoid unnecessary admissions
		Acute Patient Flow	Inter-specialty working across acute care
	Right process: For our patients receiving inpatient care ensuring timely, effective care to optimise time spent in hospital	Ward Processes	Standardise care processes / Inter Professional standards
		Care Planning	Care plans acting upon every day, by everyone
		Discharge Planning	Planning discharge from point of admission

NHS IMPACT

Improvement Guides

Urgent and Emergency Care Improvement – [NHS England » Urgent and emergency care acute patient flow](#)

Overall Aim	Primary Drivers	Secondary Drivers	Change Ideas	
Increase the quality and productivity of urgent and emergency care resources by improving flow and reducing variation and waste	Right Place: Ensure patients are cared for in the most appropriate setting for their needs	Optimising admissions: Adopt criteria driven approach regarding decision to admit	Run Criteria To Admit as a live tool for confirming patient admissions	Team job plans that support early review of patients by senior clinicians
			Extend CTA to residents and other HCPs with senior oversight	Ensure use of CTA by senior decision maker at the point of attendance
			User CTA audits to confirm capacity required in alternatives to admission	Run CTA for admitted patients at 24hr to determine fitness for discharge
		Alternatives to admission: Reduce reliance on admitted care by increasing the use and impact of alternative care models	Implement 10 core components of the Virtual Wards Operational Framework	Ensure virtual wards link with SPoAs / ICC, SDEC, UCR, 999/111, care homes
			Scale virtual wards capacity to deliver efficiencies and meet UEC demand	Establish a virtual hub to manage referrals & outreach to specialist teams
			Local profiling of SDEC demand to ensure core services meet demand	Establish acceptance criteria & include SDEC and VW on DoS
	Right Process: Optimise process, making best use of resources & minimising waste	Standardised Process Increase the use and optimise the impact of Internal Professional Standards (IPS) 7 days a week, across all services and specialities	Ensure job plans and resource support SDEC delivery	Co-locate SDECs with the emergency department
			Use self-assessment tools to benchmark & address gaps in SDEC	
			Establish, measure and hold to account IPS delivery	Test IPSs during times of crowding and increased pressures in ED
			Implement changes to rostering and job planning to ensure the right resource	Use telephone to refer allowing conversations rather than electronic referrals
			Ensure consistent access to diagnostics 7 days a week	Minimise ward moves
			Deliver networked rotas to access speciality advice in low volume specialities	

Quality and People Committee

Cultural Insights Review Group – update for information

Date of meeting	Date report produced
28 April 2026	21 April 2026

Author(s)		Report approved by	
Name and title:	Laura Fuller, Deputy Director of People and Education (acting)	Name and title:	Jess Piper, CPO
		Date:	21 April 2026

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

N/A

Executive summary

The Cultural Insights Review Group (CIRG) is the Trust's formal mechanism for reviewing, triangulating and providing assurance on cultural intelligence derived from both qualitative and quantitative sources. Its role is to ensure that insight relating to staff experience, leadership behaviours, psychological safety and wellbeing is systematically analysed, translated into proportionate improvement action and escalated appropriately through established governance routes.

Since the previous update, CIRG has continued to mature its role in coordinating cultural oversight across the organisation, with particular focus on strengthening assurance, clarity of ownership and alignment between multiple intelligence streams. These include the National Staff Survey (NSS), Pulse Survey, Freedom to Speak Up (FTSU) themes, listening activity, workforce metrics and learning from incidents and employee relations processes.

Key developments during the period include continued progress on listening and support activity in high-fragility teams, refinement of the Enhanced Care for Staff offer, identification of recurring leadership behaviour themes, and prioritisation of organisational development capacity through CIRG.

Work is also commencing to strengthen RJLC embedding, with CIRG agreed as the formal forum for reviewing learning, alignment with behavioural expectations and consistency of application.

Further work includes thematic cultural analysis of information governance breaches through a learning lens, and a staff wellbeing impact review following EPIC go-live once post-implementation data is available. These strands will be brought back to CIRG for oversight as data becomes available.

Overall assurance from CIRG remains satisfactory. The Group continues to provide the Trust with a structured, risk-based mechanism for understanding cultural conditions, integrating staff experience intelligence and ensuring that improvement actions are owned, tracked and escalated appropriately.

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

Appendices

N/A

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

N/A

Key recommendations and actions requested

The committee is asked

- To support progress with CIRG dashboard creation so insights can be proactive
- To note the plan to use CIRG as the formal route to review RJLC implementation
- To support using CIRG to oversee and support action plans from staff survey, Pulse and FTSU thematic data

How does this report further our Trust strategy?

This report provides assurance of systematic cultural insight that helps identify risks, behaviours, and workforce needs that influence strategic delivery. It also strengthens governance and improvement planning, ensuring cultural conditions enable the Trust to achieve its strategic priorities.

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- morale & engagement of staff directly impacts quality of care & experience
Leadership and Governance	YES- associated reduction in ER cases. improved compassionate leadership demonstration.
Performance	YES- staff morale & engagement , and ability to fulfil their role developed
People and Culture	YES- improved morale & culture
Strategy and Business Intelligence	
Finance	YES- potential to impact sickness absence
Risk	
N/A	
Risks lodged on Datix:	
None	
External Standards affected by this report and associated risks	
N/A	

1. Introduction and background

The Cultural Insights Review Group (CIRG) was established as part of the organisation's commitment to strengthening cultural governance, enhancing organisational learning, and ensuring that staff experience and behavioural insights are systematically understood and acted upon. As culture is a critical determinant of organisational performance, workforce wellbeing, and the ability to deliver high-quality care, the Trust recognised the need for a dedicated mechanism to review, triangulate, and escalate cultural intelligence at scale

CIRG serves as the organisation's formal structure for consolidating cultural insights from a wide variety of qualitative and quantitative sources. These include listening activities, diagnostic work, thematic reviews, workforce intelligence, and learning drawn from staff experience of organisational processes. By bringing these insight streams together, CIRG ensures that cultural issues are not reviewed in isolation but instead assessed through a holistic, system-wide lens.

The purpose of CIRG is to ensure that cultural insights are rigorously examined, translated into coherent improvement actions, and escalated appropriately through established governance structures. This role includes identifying recurring behavioural patterns, monitoring risks related to leadership, psychological safety, and workforce wellbeing, and ensuring that organisational learning is embedded in practice. CIRG provides monthly assurance to the People & Education Governance Group (PEGG), enabling senior leaders to maintain oversight of emerging cultural risks and the effectiveness of associated interventions.

Formally established in November 2025, CIRG has already demonstrated substantial progress in building a structured, repeatable, and transparent approach to cultural oversight. Since its inception, the Group has strengthened the organisation's capacity to understand cultural dynamics through systematic insight gathering, active follow-up on emerging concerns, and maturing action-tracking processes. This early activity has been instrumental in identifying cross-cutting themes, highlighting capacity and wellbeing pressures, and establishing a clearer framework for how cultural issues are escalated, governed, and addressed.

As the organisation continues to face operational pressures and workforce challenges, CIRG provides an essential mechanism for ensuring cultural intelligence is embedded within decision-making and improvement planning. Its work forms a foundational component of strengthening organisational culture, supporting workforce wellbeing, and ultimately improving the quality of services provided.

2. Purpose of report

The report provides governance assurance on the work of the Cultural Insights Review Group (CIRG) for the reporting period. It summarises the cultural insights reviewed, the level of organisational assurance, key risks, and progress against actions. It also highlights issues requiring escalation to the People & Education Governance Group (PEGG).

3. Risks

A review of the action log highlights several emerging cultural risks that require continued oversight:

1. Psychological Safety & Wellbeing Risk

Multiple teams have raised concerns about speaking up, emotional fatigue, workload pressure and team tensions.

This reflects a wider organisational risk linked to staff experience, wellbeing and workforce sustainability.

2. Capacity Constraints Impacting Cultural Follow-Up

OD and other supporting functions continue to experience capacity pressures, potentially delaying listening sessions, improvements work and embedding of learning.

3. Inconsistent Leadership Behaviours

Thematic issues have been raised across several CIRG reviews relating to senior leadership tone, communication and responsiveness, presenting a behavioural and cultural risk.

4. Process-related Cultural Friction

Staff continue to report concerns around clarity and fairness in organisational processes (e.g., ER pathways), indicating ongoing risk to psychological safety and trust.

5. Multi-Team Support Demand

Sustained demand for Enhanced Care for Staff interventions across multiple teams indicates broader organisational pressures that may require system-level support and prioritisation.

Key Updates

RJLC Policy and Framework Development

Work to strengthen and embed a Restorative, Just and Learning Culture (RJLC) across the Trust is now commencing in a more structured and coordinated way. Initial activity has focused on clarifying the Trust's intent for RJLC, reviewing current practice, and identifying governance routes for oversight and assurance.

RJLC is being positioned as a core cultural framework, aligning leadership behaviours, organisational processes and staff experience with the principles of fairness, learning and psychological safety. This reflects learning from recent incidents, staff experience themes, and wider national direction relating to just culture and compassionate leadership.

CIRG has agreed to act as the primary forum for reviewing RJLC implementation, ensuring alignment with cultural insights, workforce intelligence and behavioural themes arising across the organisation.

The RJLC policy review group is currently reviewing TSDFT policy to align to RJLC and associated actions required.

National Staff Survey (NSS): Alignment and Gap Analysis

The 2025 National Staff Survey (NSS) is being used as a key but not standalone source of cultural intelligence, alongside insight from the Quarterly Pulse Survey, Freedom to Speak Up (FTSU), listening activity, workforce metrics and employee relations themes.

Rather than treating NSS outcomes in isolation, the Trust is undertaking a structured alignment and gap analysis to understand how staff-reported experience compares with existing qualitative and quantitative insights already reviewed through the Cultural Insights Review Group (CIRG). This approach reflects the recognition that

NSS provides a broad, periodic snapshot, which requires triangulation to inform targeted and meaningful improvement action.

Initial review indicates strong consistency between NSS findings and themes already identified through CIRG, including:

- sustained workload and capacity pressure
- variability in psychological safety and leadership behaviours
- mixed wellbeing outcomes
- persistent inequity of experience for some staff groups

Further detailed work is now underway to:

- analyse NSS findings at Care Group and service level
- identify gaps where survey results indicate unmet need or insufficient local action
- ensure that existing Culture Plan interventions are appropriately targeted
- avoid duplication or over-reliance on survey-driven actions where intelligence already exists

Action Planning, Governance and Accountability

- To ensure coherent governance and delivery, CIRG will act as the formal oversight mechanism for all NSS-related action planning.

Care Groups are required to:

- develop local, insight-led action plans informed by NSS results and triangulated cultural intelligence
- submit plans by the end of June 2026
- demonstrate clear ownership, prioritisation and measurable actions

CIRG will:

- review and challenge Care Group action plans
- assess alignment with Trust-wide cultural priorities and RJLC principles
- track delivery and impact through its monthly assurance cycle
- escalate where risks, gaps or delays are identified

This approach ensures that NSS insights are translated into owned, proportionate and sustainable actions, rather than generating parallel or disconnected improvement plans.

Information Governance (IG) Breaches: Thematic Cultural Analysis

Current work is underway to review recurring themes and contributing factors
Consider cultural and system drivers, rather than focusing solely on individual error
Identify opportunities for preventative, learning-focused interventions

Findings from this thematic review will be brought back to CIRG and linked into RJLC development, reinforcing a learning-rather-than-blaming approach.

EPIC Go-Live: Staff Wellbeing Impact Review (Awaiting Data)

CIRG has agreed that a staff wellbeing impact review following EPIC go-live is required to ensure that workforce experience, pressure points and unintended consequences are understood and addressed.

This review will be informed by:

- Workforce metrics (absence, turnover, roster impact)
- Qualitative feedback and listening activity
- EPIC-related incident themes and process friction points

At present, this work is awaiting the availability of post-implementation data. Once data is available, CIRG will:

- Undertake a structured review of wellbeing and cultural impact
- Identify any teams requiring targeted support
- Ensure learning is fed into both operational and cultural governance forums

5.Assurance and Recommendations

Overall assurance remains satisfactory.

CIRG continues to provide a systematic, risk-based mechanism for identifying cultural issues, triangulating insight from multiple sources, and ensuring that actions are owned, tracked and escalated appropriately.

The committee is asked to note the actions:

Over the coming reporting period, CIRG will:

- Formalise RJLC oversight within its agenda and reporting structure
- Complete NSS alignment and Care Group gap analysis (June 2026 start)
- Establish routine assurance on Care Group staff experience action plans
- Receive and review the IG breach thematic analysis
- Initiate EPIC wellbeing review once data is available

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

Quality and People Committee

Freedom to Speak up Bi-annual Report

Date of meeting	Date report produced
28 th April 2026	7 th April 2026

Author(s)		Report approved by	
Name and title:	Laura Fuller, Deputy Director of People and Education (acting) Fahida Rehman-Manby FTSU Guardian (interim)	Name and title:	Jess Piper, CPO
		Date:	21 April 2026

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

N/A

Executive summary

Freedom to Speak Up (FTSU) is a critical component of the Trust's quality, safety and governance framework, providing an essential early warning system for risks affecting patient safety, workforce wellbeing and organisational culture. When staff feel psychologically safe to speak up and have confidence that concerns will be heard and acted upon, the Trust is better able to intervene early, learn effectively and prevent harm.

During this reporting period, the Trust has continued to operate under interim Freedom to Speak Up arrangements following the departure of the substantive FTSU Guardian and in the context of anticipated national changes to the Freedom to Speak Up landscape., with 53 concerns raised through the Freedom to Speak Up route. As in previous reporting periods, the dominant themes continue to relate to organisational culture, inappropriate behaviours, lack of psychological safety, inconsistent leadership response, and patient safety concerns

While these interim arrangements have maintained access for staff wishing to raise concerns, they introduce recognised limitations relating to independence, capacity, visibility and governance, particularly given the volume and seriousness of concerns being raised.

This bi-annual report confirms that staff continue to engage with Freedom to Speak Up routes, demonstrating awareness and willingness to raise issues. However, analysis of FTSU intelligence highlights persistent and recurring themes relating to culture, leadership behaviour, psychological safety, patient safety escalation and governance processes. These themes are systemic rather than isolated, and present ongoing risks to patient safety, staff confidence and organisational effectiveness.

When triangulated with NHS Staff Survey results, Cultural Insights Review Group (CIRG) analysis and priorities within the Trust Culture Plan and Restorative Just and Learning Culture (RJLC) framework, FTSU intelligence provides consistent and reinforcing evidence of cultural and leadership challenges impacting staff experience and safety. Taken together, these data sources demonstrate that while concerns are being raised, they are not yet consistently translating into timely action, robust escalation, visible learning or sustained improvement.

As a result, limited assurance can currently be taken from the interim Freedom to Speak Up framework. The interim nature of current provision further constrains assurance, particularly in relation to the handling and escalation of higher-risk concerns, and reduces confidence in the Trust's ability to systematically identify, monitor and respond to emerging risks.

Executive-level review has therefore identified the need for strengthened Freedom to Speak Up governance arrangements. These arrangements are intended to restore independence, improve capacity and accessibility, strengthen escalation and accountability, and enable more effective triangulation of FTSU intelligence with patient safety, workforce and cultural data. Together with CIRG oversight and RJLC principles, they will strengthen the Trust's approach to learning from staff voice and improve assurance to the Board and its Committees.

This report provides further assurance case evidence in support of that direction of travel and reinforces the necessity of sustained investment in a robust, independent and well-governed Freedom to Speak Up function as a core enabler of safer care, workforce wellbeing and cultural improvement.

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

Appendices

N/A

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

N/A

Key recommendations and actions requested

The Quality & People Committee is asked to:

- Receive and note the bi-annual Freedom to Speak Up report, including the volume, themes and systemic issues identified.
- Recognise and consider the quality, patient safety and cultural risks highlighted, alongside the current limited assurance position arising from persistent themes and interim Freedom to Speak Up arrangements.
- Endorse and support the implementation of strengthened Freedom to Speak Up governance arrangements and associated actions, aimed at improving psychological safety, escalation, organisational learning and assurance.
- Receive ongoing, triangulated assurance through future reporting, including evidence of:
 - ✓ the effectiveness and impact of strengthened governance;
 - ✓ improved escalation, action and learning from concerns raised; and
 - ✓ measurable improvement in staff confidence, psychological safety and patient safety outcomes.

How does this report further our Trust strategy?

Staff voice, including the Freedom to Speak Up process, is fundamental to creating an environment where people feel safe, supported and able to raise concerns without fear. A psychologically safe workforce supports improved patient experience, safer care delivery and healthier communities.

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- morale & engagement of staff directly impacts quality of care & experience
Leadership and Governance	YES- associated reduction in ER cases. improved compassionate leadership demonstration.
Performance	YES- staff morale & engagement , and ability to fulfil their role developed
People and Culture	YES- improved morale & culture

Strategy and Business Intelligence

Finance	YES- potential to impact sickness absence

Risk

Risks lodged on Datix:

None

External Standards affected by this report and associated risks

NHSE CQC – well led National Guardian Office

1. Introduction and background

People are the eyes and ears of the organisation. Their views, concerns and lived experience provide a vital early warning system for risks relating to quality, safety, culture and workforce wellbeing. When staff feel confident and supported to speak up, concerns can be identified and addressed earlier, reducing harm, strengthening learning and preventing escalation into more formal processes. However, speaking up remains challenging where psychological safety is limited, trust in leadership is fragile, or past experiences have led to perceptions that concerns are not acted upon.

Freedom to Speak Up (FTSU) arrangements therefore remain a key component of the Trust's quality, governance and patient safety framework, supporting staff voice and contributing to compliance with national NHS guidance and the CQC Well-Led domain.

Current Interim Provision

During the reporting period, the Trust has been operating under interim Freedom to Speak Up arrangements following the departure of the substantive Freedom to Speak Up Guardian and in advance of national changes associated with the planned closure of the National Guardian's Office. Under these arrangements, the strategic oversight of FTSU sits within the People function, with day-to-day access maintained via the generic FTSU email inbox and the Work in Confidence anonymous reporting platform.

Concerns raised through these routes are triaged and signposted by the Wellbeing Development Facilitator, and the People Promise Manager and escalated to the Executive Lead for Speaking Up where required, particularly in relation to urgent patient safety or safeguarding matters.

In addition, Wellbeing Buddies and People Promise Ambassadors continue to provide informal listening routes, with clear escalation pathways where issues require formal consideration.

While these interim arrangements have ensured continuity of access for staff wishing to speak up, they introduce known limitations relating to perceived independence, capacity alongside substantive roles, visibility and sustainability, particularly given the volume and seriousness of concerns being raised. These limitations have a direct bearing on the level of assurance that can currently be taken from FTSU data and its ability to drive timely organisational learning and improvement.

2. Purpose of report

This bi-annual report provides QPC with:

- An overview of concerns raised during the period
- Insight into the quality and safety implications of recurring themes
- An assessment of the risks associated with the current interim model
- Assurance on actions flowing from FTSU intelligence

3. Volume and Nature of Concerns Raised

Between October 2025 and March 2026 53 concerns were raised through Freedom to Speak Up. Concerns were raised across a broad range of staff groups, with nursing, administrative and allied health professionals most represented. No single hotspot has been identified, indicating that challenges are systemic rather than isolated.

4. Key Themes and Quality Implications

Culture and Behaviour

- Reports of bullying, harassment, misogyny, sexism and racism
- Harmful or inappropriate limited behaviours perceived as unchallenged by senior leadership

Speaking Up and Psychological Safety

- Fear of speaking up where concerns involve senior leaders
- Lack of confidence in follow-through and outcomes

Patient Safety

- Concerns raised regarding Datix reports being closed inappropriately
- Staff reporting fear or futility in escalating patient safety risks

HR and Governance

- Inconsistent application of ER processes
- Perceived inequity and lack of transparency
-

These themes present ongoing risk to patient safety, workforce confidence and organisational effectiveness.

6. Strengthened Governance

Executive-level review has identified that interim provision does not fully meet mandated national requirements for Freedom to Speak Up and presents material

risks to patient safety, workforce confidence, regulatory compliance and organisational resilience.

Key gaps identified include:

- limited independence,
- restricted availability,
- variable capacity, and
- inconsistent governance and reporting

All of which negatively impact staff confidence in raising concerns and the Trust's ability to identify, escalate and address emerging risks in a timely and systematic way. The absence of an independent and sustainable FTSU model reduces assurance to the Board and its Committees and weakens compliance against CQC Well-Led expectations and NHS England Freedom to Speak Up guidance.

Strengthened governance arrangements are therefore required to:

- Provide robust independence and impartiality, increasing staff confidence to speak up
- Ensure 24/7 accessibility and sufficient capacity to manage the volume and seriousness of concerns
- Establish clear governance, escalation and reporting routes aligned to Board and Committee oversight
- Enable effective triangulation of FTSU intelligence with patient safety, workforce and cultural data
- Support compliance with national policy and regulatory expectations
- Reduce quality, workforce, financial and reputational risk to the Trust

The strengthened Freedom to Speak Up governance arrangement is to be presented and approved at Executive level represents a strategic response to these risks, enabling the Trust to meet statutory and regulatory obligations while strengthening psychological safety, improving learning from staff voice and supporting safer care delivery.

This bi-annual report provides further assurance case evidence to support this direction of travel and reinforces the necessity of sustained investment in a robust, independent and well-governed Freedom to Speak Up function

7.Alignment of FTSU Thematic Data with NSS, CIRG, the Trust Culture Plan and RJLC

The themes emerging from Freedom to Speak Up (FTSU) reporting are consistent with the findings of the most recent NHS Staff Survey (NSS), the Cultural Insights Review Group (CIRG) analysis, and the priorities set out in the Trust Culture Plan to address these.

When considered together, these sources provide strong triangulated evidence of systemic cultural and leadership challenges impacting psychological safety, staff wellbeing and patient safety.

The Trust Culture Plan sets the strategic intent for cultural improvement, while CIRG and the Restorative Just and Learning Culture (RJLC) framework provide the

mechanisms through which insight, action and assurance are delivered. FTSU data forms a critical qualitative component within this system.

Culture, Behaviour and Leadership

FTSU concerns relating to bullying, harassment, inappropriate behaviours and hierarchical leadership closely align with NSS outcomes indicating:

- reduced staff confidence in senior leadership,
- low scores relating to respectful treatment at work, and
- variable experience of compassionate and inclusive leadership.

CIRG analysis similarly identifies leadership behaviours, local management culture and inconsistency in management response as key drivers of negative staff experience. The recurrence of these themes across FTSU, NSS and CIRG confirms that these are entrenched cultural issues rather than isolated incidents, requiring coordinated organisational action.

Alignment with the Culture Plan and RJLC

- The Trust Culture Plan sets clear expectations for compassionate, inclusive and accountable leadership.
- CIRG provides the insight and governance mechanism to identify where leadership behaviours fall short of these expectations.
- RJLC provides the behavioural and decision-making framework that supports fair, consistent and learning-focused responses to concerns, reinforcing trust and reducing fear of blame.

Psychological Safety and Speaking Up

FTSU intelligence consistently highlights fear of speaking up where concerns involve senior leaders, lack of confidence in outcomes, and anxiety about detriment. This mirrors NSS findings showing:

- lower scores for psychological safety,
- concerns about speaking up safely, and
- staff perceptions that feedback does not always lead to meaningful change.

CIRG has identified psychological safety as a critical enabler for improvement, recognising that staff are less likely to raise concerns where they believe speaking up is unsafe or futile.

Alignment with the Culture Plan and RJLC

- Psychological safety is a core pillar of the Trust Culture Plan.
- CIRG uses NSS and FTSU intelligence to identify where psychological safety is weakest.
- RJLC supports psychologically safe responses to concerns, helping shift organisational behaviour away from blame and towards learning and improvement.

Patient Safety and Quality

Concerns raised through FTSU regarding patient safety escalation, Datix closure and lack of response are consistent with NSS responses indicating that staff do not always feel confident that patient safety concerns will be addressed. CIRG has similarly identified the strong link between culture, psychological safety and under-reporting of risk.

The alignment of these data sources reinforces evidence that patient safety risk increases where staff voice is suppressed or concerns are not addressed in a transparent and supportive way.

Alignment with the Culture Plan and RJLC

- The Culture Plan explicitly recognises culture and psychological safety as enablers of patient safety.
- CIRG aligns cultural insight with patient safety intelligence to identify emerging risk.
- RJLC supports a learning-focused approach to safety concerns, encouraging earlier reporting and meaningful learning rather than fear-driven silence.

Governance, Consistency and Trust

FTSU themes highlighting inconsistent application of HR and governance processes align with NSS-reported perceptions of unfairness, lack of transparency and unequal treatment. CIRG findings reinforce that inconsistency undermines trust, engagement and confidence in leadership.

Alignment with the Culture Plan and RJLC

- The Trust Culture Plan emphasises fairness, consistency and transparency.
- CIRG provides oversight of where inconsistency is occurring.
- RJLC strengthens trust by promoting consistent, proportionate and principles-based responses to concerns and incidents.

Overall Alignment and Assurance

Taken together, the alignment between:

- FTSU thematic intelligence,
- NSS results reviewed through CIRG,
- the Trust Culture Plan, and
- RJLC principles

provides a coherent, mutually reinforcing evidence base demonstrating that current cultural and leadership challenges are systemic rather than episodic. It also strengthens assurance that actions being progressed through CIRG and strengthened FTSU governance are responding to the same underlying risks.

The strengthened Freedom to Speak Up governance model, operating alongside CIRG and underpinned by RJLC, will further enhance assurance by:

- providing richer qualitative insight behind NSS scores,
- enabling earlier identification of emerging cultural and safety risks,
- supporting targeted, learning-focused interventions, and
- enabling QPC to receive more reliable, triangulated assurance on culture, quality and patient safety.

8. Assurance and Recommendations

Based on the volume, nature and recurrence of concerns raised through Freedom to Speak Up, triangulated with NHS Staff Survey outcomes, CIRG analysis and staff feedback the level of assurance available is currently limited.

The continued use of the Freedom to Speak Up route demonstrates that staff are aware of speaking up mechanisms and remain willing to raise concerns. However, the persistent and consistent themes relating to culture, leadership behaviours, psychological safety, patient safety escalation and governance indicate that concerns are not yet reliably translating into timely resolution, organisational learning or sustained improvement.

The evidence suggests that risks raised through FTSU are often symptomatic of broader systemic issues rather than isolated events. Where staff perceive that concerns are not escalated appropriately, acted upon consistently or result in meaningful change, confidence in the effectiveness of speaking up is undermined. This in turn presents an increased risk of delayed escalation of patient safety issues, deterioration in workforce wellbeing and erosion of trust in leadership and governance processes.

The interim nature of current Freedom to Speak Up provision further constrains the level of assurance available, particularly in relation to higher-risk concerns. Known limitations around independence, capacity, visibility and governance reduce the Trust's ability to:

- provide robust, impartial handling of concerns;
- assure timely and proportionate escalation;
- demonstrate consistent follow-through and accountability; and
- evidence organisational learning arising from staff voice.

As a result, the current control environment does not yet provide sufficient assurance that FTSU intelligence is being maximally utilised as an early warning system for quality, safety and cultural risk.

The proposed strengthened governance arrangements are therefore a necessary response to close these gaps, and to improve the level of assurance available to the Board and its Committees in future reporting cycles.

Recommendations to the Quality & People Committee

The Quality and People Committee is asked to:

- Receive and note the Freedom to Speak Up Bi-Annual Report, including the volume, themes and trends identified.
- Note the limited assurance position, reflecting persistent cultural, quality and patient safety risks, and the constraints associated with interim FTSU arrangements.
- Recognise the quality, patient safety and workforce risks associated with the current position, particularly those relating to escalation, follow-through, organisational learning and staff confidence.
- Support the implementation of strengthened Freedom to Speak Up governance arrangements, as approved through Executive-level processes.
- Seek ongoing assurance through future reporting, including evidence of:
 - ✓ the effectiveness and impact of strengthened governance arrangements;
 - ✓ improved escalation, action, feedback and organisational learning; and
 - ✓ improved staff confidence, psychological safety and patient safety outcomes.
- In addition, the Committee is asked to request continued triangulation of Freedom to Speak Up intelligence with patient safety, workforce, culture and performance data to support QPC oversight, risk recognition and assurance.

10. Conclusion

Freedom to Speak Up remains a critical mechanism for surfacing risks that directly affect patient safety, workforce wellbeing and organisational culture. This bi-annual report demonstrates that staff continue to raise concerns and engage with speaking up routes. However, it also highlights persistent systemic challenges that currently limit the level of assurance available to the Trust.

Recurring themes relating to behaviour, leadership response, psychological safety, patient safety escalation and governance—when considered alongside NSS outcomes and CIRG analysis—indicate that existing arrangements are not yet sufficient to consistently ensure early resolution, effective learning or sustainable improvement. The interim nature of current provision further reduces confidence in independence, capacity and governance, particularly for higher-risk concerns. As such, the level of assurance that can be taken from the Freedom to Speak Up framework at this point remains limited.

The strengthened Freedom to Speak Up governance arrangements represent a proportionate, necessary and strategic response to these risks. They are intended to:

- restore confidence and independence in speaking up;
- improve accessibility, capacity and resilience;
- strengthen escalation, accountability and oversight; and
- enable more effective organisational learning from staff voice.

Successful implementation of these arrangements, alongside CIRG thematic monitoring and underpinned by the Restorative Just and Learning Culture framework, will be critical to improving assurance, strengthening compliance with national expectations, enhancing psychological safety, and ultimately supporting safer care delivery and a culture where staff feel safe, heard and supported to speak up.

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.

Quality and People Committee

2025 National Staff Survey Results Report

Date of meeting	Date report produced
28 th April 2026	7 th April 2026

Author(s)		Report approved by	
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Date: 21st April 2026

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

Not applicable

Executive summary

This paper provides an update to the Quality and People Committee on the Trust's 2025 National Staff Survey (NSS) results, the key themes emerging from the feedback, and the arrangements in place to ensure a coordinated and effective organisational response through strengthened oversight by the Cultural Insights Review Group (CIRG).

The 2025 NSS results reinforce themes already well understood through ongoing cultural intelligence, including variable staff experience, sustained workload pressure, inconsistent psychological safety, and continued disparities for some marginalised groups. While colleagues consistently report pride in the care they deliver, the results confirm that pressures relating to wellbeing, compassionate culture and advocacy continue to constrain overall improvement.

These findings validate the focus and direction of the Trust's Culture Plan, approved in August 2025, which was deliberately designed to address these known challenges and is already delivering targeted action. Key initiatives include

- strengthening staff voice and inclusion through six Executive-sponsored staff networks and the RCN Cultural Ambassador programme;
- planned investment in a preventative, support-focused wellbeing offer in response to mental health and musculoskeletal absence trends;

- and embedding greater behavioural consistency and learning through the Restorative Just and Learning Culture (RJLC) programme.

Overall, the Trust’s NSS results reflect a largely stable but fragile position, in line with the national picture. While there are small improvements in engagement, morale and aspects of inclusion and staff voice, there has been no material shift in overall staff experience. Workforce experience remains mixed and inconsistent across roles and services. Work pressure continues to be the most persistent and significant challenge, alongside concerns relating to wellbeing, behavioural consistency, psychological safety, and experiences of violence, bullying and discrimination.

Cultural indicators are similarly mixed, with some improvement in speaking up and organisational responsiveness offset by small declines in compassionate culture and continued reports of negative experiences. Advocacy scores remain below comparator organisations, reflecting reduced confidence in recommending the Trust as a place to work, despite sustained confidence in patient care. The response rate fell to 35.55%, limiting the breadth of staff voice captured and highlighting the need for more targeted engagement, particularly among underrepresented groups.

To ensure strong governance, alignment and accountability, CIRG will now act as the central oversight mechanism for all NSS-related action planning. Care Groups will develop insight-led local action plans, due by the end of June 2026, with CIRG responsible for reviewing, challenging and tracking delivery. These plans will be consolidated into a coherent Trust-wide response, ensuring a clear line of sight from staff feedback to improvement, with progress monitored through CIRG’s monthly assurance cycle.

A consistent “You Said – We Did – We Will” communications approach will support transparency and confidence in staff voice processes.

A defined set of early priority actions including:

- targeted work on discrimination,
- wellbeing in high-pressure areas,
- strengthening incident feedback loops,
- improving recognition and appreciation,
- and Executive Listening Rounds

will be monitored through CIRG to maintain momentum ahead of full plan implementation. Through this strengthened governance model, the Trust will ensure that NSS feedback is systematically translated into visible, meaningful and sustained cultural improvement, with clear accountability at both Care Group and Executive level.

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
National Staff Survey	Satisfactory	Declining/Satisfactory

Appendices

Appendix 1: TSD 2025 National Staff Survey Results and Analysis PPT
 Appendix 2: Narrative to support Appendix 1
 Appendix 3: NSS Question by Question Review
Included in the Quality and People Committee Items for Information Pack

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

NA

Key recommendations and actions requested

The Committee is asked to:

1. NOTE the outcomes and insights the National Staff Survey provide to the Trust
2. Endorse the action planning process stated (Section 8) and the early actions stated therein.

How does this report further our Trust strategy?

The National Staff Survey provides us with the opportunity to hear from our staff on their experience of working at the Trust and develop plans to address the findings. Improving staff experience and engagement contributes to better patient experience and staff retention.

It is our intention to continue to improve our level of returns and ensure improved feedback to employees to build our overall engagement.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Yes (engaged staff deliver better services that impact health care delivery)
Quality of services provided	Yes (engaged staff deliver better services that impact health care delivery)
Sustainable and efficient use of resources	Yes staff are the most vital resource

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Yes (engaged staff deliver better services that impact health care delivery)
Leadership and Governance	Yes (provides feedback on leadership and governance in the organisation)

Performance	Yes (engaged staff deliver better services that impact health care delivery)
People and Culture	Yes (engaged staff deliver better services that impact health care delivery and better working environments)
Strategy and Business Intelligence	Yes (employee engagement impacts across the Trust)
Finance	Yes (indirect impact)
Risk	
Not applicable	

Risks lodged on Datix:

External Standards affected by this report and associated risks
Care Quality Commission
1. Terms of authorisation, NHS England licence and regulations
2. National policy, guidance

2025 National Staff Survey Results Report

1. Introduction and background

The NHS National Staff Survey (NSS) is the annual survey of staff experience across all NHS organisations and provides a nationally consistent measure of colleague engagement, wellbeing, inclusion and culture, aligned to the NHS People Promise. The National Quarterly Pulse Survey (NQPS) complements this by providing more regular, in-year insight using a subset of nationally defined questions, supporting real-time monitoring of staff experience.

This paper presents the Trust’s 2025 NSS results and summarises the key themes emerging from colleague feedback. It provides an overview of workforce experience at Torbay and South Devon NHS Foundation Trust, highlighting areas of relative strength, ongoing challenge and organisational risk, and situates the Trust’s results within both the national and comparator context.

The NSS is one component of a broader suite of people and culture intelligence used by the Trust, alongside data from the Pulse Survey, Freedom to Speak Up (FTSU), workforce metrics, employee relations trends, sickness absence, and qualitative insight from staff engagement activity. Taken together, these sources provide a more comprehensive and nuanced understanding of staff experience than any single dataset in isolation.

This report therefore sets out how NSS findings should be interpreted alongside existing cultural intelligence and describes how they align with the priorities and delivery of the Trust’s Culture Plan. It also outlines how insights from the NSS will inform ongoing and future action, ensuring that cultural improvement activity remains responsive to staff feedback and focused on areas of greatest impact.

Governance and oversight of this work will be provided through the Cultural Insights Review Group (CIRG), which brings together multiple sources of people and culture data to support triangulation, prioritisation and assurance, and to ensure that staff survey feedback is translated into meaningful, visible and sustained improvement across the organisation.

2. Purpose of report

The purpose of this report is to provide the Quality and People Committee with assurance on the Trust's 2025 National Staff Survey results and their implications for organisational culture, staff experience and workforce sustainability. It summarises the key themes emerging from the survey, highlights areas of risk and opportunity, and sets out how these findings align with the Trust's Culture Plan and wider people strategy. The report also describes the governance arrangements for responding to NSS feedback, including the role of the Cultural Insights Review Group (CIRG) in overseeing action planning, triangulating insights with other people metrics, and ensuring that staff feedback is translated into coherent, visible and measurable improvement at both Care Group and Trust-wide level.

3. 2025 National Staff Survey

3.1 The National Picture

Over 1.5 million NHS employees were invited to participate in the 2025 National Staff Survey, with 766,285 responses received, representing a 49% response rate (down from 51% in 2024).

Overall, the results showed broad stability across most measures, with modest but consistent declines in key indicators, particularly those relating to advocacy and experience.

Key findings included:

- 87.78% of staff reported that their role made a difference to patients or service users (2024: 87.81%)
- 71.78% said patient care was their organisation's top priority (2024: 74.37%)
- 69.18% felt their organisation acted on patient concerns (2024: 70.90%)
- 58.05% would recommend their organisation as a place to work (2024: 60.79%)
- 62.84% said they would be happy with the standard of care if a friend or relative required treatment (2024: 64.26%)
- Staff Engagement score was 6.75 (2024: 6.85)

National People Promise themes remained largely unchanged, with all nine theme scores stable year-on-year. However, none of the 21 sub-scores improved, and two areas (development and advocacy) declined. Advocacy remained a key barometer, with recommendation as a place to work falling by over two percentage points. Measures relating to line management and compassionate leadership remained relatively stable.

Staff experience indicators highlighted persistent pressures. While overall health and wellbeing scores were unchanged, perceptions of employer action on wellbeing declined (57.5% to 54.8%). Work-related stress increased slightly (41.65% to 42.3%), with nearly one in three staff reporting burnout. Satisfaction with flexible working remained static at 57%.

Bullying, harassment and violence remained at concerning levels, although reporting rates improved, suggesting greater confidence in speaking up.

In summary, the national picture was one of stability without improvement, with emerging signs of erosion in staff advocacy and wellbeing, set against a backdrop of sustained workforce pressure.

[NHS Staff Survey results 2025 | NHS Employers](#)

4. TSD NHSFT: NSS Overview

4.1 Methodology

The Trust contracted an independent external provider, IQVIA, to deliver the 2025 NHS National Staff Survey (NSS). IQVIA provides the infrastructure and end-to-end process to administer the survey and ensures the confidentiality of responses. Individual responses are not shared with the Trust. The NSS uses nationally defined questions which are closely aligned to the NHS People Promise and support measurement of staff experience.

The 2025 NSS ran from 26 September 2025 to midnight on 28 November 2025. The Trust's target response rate for the NSS 2025 was 45%.

Initial high-level feedback was received at the end of January 2026, with more detailed and full reporting released nationally on 12 March 2026. A suite of four reports were published on the TSD ICO network: [Staff Survey 2025 Results](#) with supporting documentation.

4.2 TSD Staff Survey at a Glance

- Response rate: 35.55%; down from 39.15% in 2024
- Highest score: Diversity & Equality (8.15)
- Lowest score: Appraisals (4.33)
- Results remain below comparator trusts
- Overall message: Workforce experience stable but fragile

Workforce Experience

- Engagement and morale slightly improved
- Health & wellbeing results mixed
- Musculoskeletal concerns increasing
- Frontline staff report greatest pressure

Culture Signals

- Flexible working viewed positively
- Violence and discrimination remain concerns
- Compassionate culture declined slightly
- Staff experience uneven across roles
- Culture remains key influence on engagement

Advocacy

- 68% consider care of patients / service users to be top priority
- 55% recommend Trust as place to work
- 60% happy for relatives to receive care here
- Advocacy remains stable despite pressures

Work Pressure

- Only 41% report they can meet work demands on time
- Around half report insufficient staffing
- Materials generally available
- Frontline workload remains very high

5. TSD Results in more Detail

5.1 Response Rate

A total of 7,370 staff were in post on 1 September 2025 and were invited to participate. The survey was supported by a CEO letter and regular internal communications. Care Groups were provided with response rate updates on a fortnightly basis and asked to promote participation locally. The project team also undertook site visits and attended team meetings to encourage completion. Two local companies donated prizes for prize draws, with one prize allocated to the NSS and one to the National Quarterly Pulse Survey (NQPS).

2,609 surveys were returned yielding a response rate of 35.55% down from 39.15% in 2024. The response rate was poor and the Trust needs to hear from more colleagues in the 2026 survey. Therefore, we will set a further ambitious target for Care Groups to achieve a 51% response rate in 2026. This will be influenced through showing colleagues that they have been listened to in the action planning process on the 2025 results

Response patterns indicate a slight reduction in diversity, with increased representation from White British staff and small but notable declines across several minority ethnic groups, including Mixed, Asian and some Black groups. Underrepresentation compared to national benchmarks remains a key issue, particularly for Asian groups (notably Indian, Pakistani and Filipino staff) and Black African staff. These gaps are significant and appear persistent rather than reflecting normal year-on-year variation.

5.2 Employee Engagement and Morale

TSD results were 'stable' that is to say they did not improve but did not decline. That is similar to national NHS level responses. The results do tell us that: TSD colleagues feel:

- under pressure
- at risk
- that they are proud of what they do
- want support
- and feel that times continue to be challenging.

TSD's employee engagement score is 6.68 which is 0.02 percentage points (pp) increase on 2024 but remains below comparators by 7pp. Morale was 1pp up on 2024 at 5.80% but again is below comparators (5.88%).

5.3 Advocacy Scores

This question group looks at how well colleagues would recommend TSD as a place for patient care. These scores are a key measure and thus of importance to the Trust.

- Care of patients advocacy score 67.7% declined by 0.01% and is below comparators.
- If a relative needed treatment score increased 0.01% to 60.4% but again is below the comparator score.

These need to be areas for attention in action planning.

5.4 Work pressures

TSD is below comparators for recommendation as a place to work. Colleagues do report having adequate materials but show concern over time demands and levels of staffing.

- Recommendation of TSD as a place to work (55%) declined by 2%

5.5 People Promise Scores

Six People promise scores show a slight increase, 1 shows a decline. The highest score was on Diversity & Equality (8.15); the lowest score on Appraisals (4.33). The biggest improvement was for flexible working (+0.13) and the biggest decline was on Compassionate Culture and negative experiences (-0.07).

5.6 Top 10 / Bottom 10 scores

The Top 10 results highlight areas where staff experience remains comparatively strong. These are typically linked to teamworking, elements of local leadership, and aspects of the People Promise such as flexibility and inclusion. These strengths indicate that, even within a pressured system, positive day-to-day experiences are being sustained in parts of the organisation. However, it is important to recognise that “top” results are relative and not always high in absolute terms. They represent areas of comparative strength within a mixed overall picture rather than consistently high-performing domains.

The Bottom 10 results provide a clearer indication of organisational risk. These scores are concentrated around workload, staffing levels, work-life balance, recognition, and aspects of compassionate culture. This reinforces a consistent message across the survey: staff continue to experience pressure in delivering their roles and do not always feel sufficiently supported. The persistence of these themes year-on-year suggests structural challenges rather than isolated issues, requiring sustained and targeted intervention.

5.7 Most Improved / Declined

The most improved scores demonstrate that targeted actions may be beginning to have an impact. Improvements are particularly evident in areas linked to involvement, voice, and aspects of learning and development. This suggests that where focused effort has been applied—particularly around engagement and communication—staff are beginning to perceive positive change.

The most declined scores are concentrated in areas already identified as concerns, including compassionate culture, workload, recognition, and aspects of work-life balance. While the scale of decline is generally small, the direction of travel is important. These areas represent early warning indicators of cultural and operational strain. The contrast between improving and declining areas reinforces a widening gap in experience across the organisation, highlighting the need for consistent delivery and leadership focus.

5.8 Significant results compared to 2024

Year-on-year comparison shows a largely stable position, with a small number of statistically significant improvements and no significant declines at question level where comparisons are available. Improvements are seen in areas such as staff involvement in decision-making, confidence that concerns will be addressed, and aspects of learning from incidents. These gains indicate that progress is being made in strengthening voice, reporting culture, and organisational responsiveness.

Despite this, several indicators show small but consistent declines in experience, particularly relating to workload, work-life balance, recognition, and aspects of management support. While not statistically significant, the cumulative effect of these movements reinforces the narrative of a workforce under pressure. Overall, the results suggest incremental progress in some areas, but no material shift in the underlying challenges affecting staff experience.

5.9 Significant results compared to comparator organisations

Comparison with peer organisations presents a mixed position. The Trust performs comparatively well in a number of areas, including teamworking, elements of leadership, speaking up, and

aspects of learning and development. These areas provide assurance that there are strong foundations within the organisation.

Several key domains remain consistently below comparator organisations. These include workload and staffing, work pressure, appraisal and development experience, and elements of health and wellbeing. In addition, some culture-related measures, including compassionate culture and negative experiences, also lag behind comparators. This indicates a relative performance gap in areas that have a direct impact on staff experience and retention.

Overall, the comparator position reinforces that while the Trust has strengths, there are key areas where performance is not keeping pace with similar organisations, presenting both organisational and competitive risk.

5.10 Equality, Diversity and Inclusion (EDI)

Reports of discrimination, bullying and harassment remain a concern, particularly for clinical staff and those from minority ethnic backgrounds. While some improvements are noted in reporting and organisational response, the persistence of these experiences indicates that psychological safety is not yet consistent across the organisation.

Response rate analysis also shows that minority ethnic groups remain underrepresented in survey responses, with small numbers in some categories limiting visibility of lived experience. This reinforces the need for targeted engagement, safe spaces for dialogue, and continued focus on addressing inequalities in experience. Strengthening inclusive leadership behaviours and ensuring visible action on concerns will be critical to improving trust and equity.

5.11 Wellbeing

Health and wellbeing results present a mixed and at times contradictory picture. While some indicators show slight improvement, others highlight increasing pressure on staff. In particular, there has been a notable rise in musculoskeletal (MSK) issues linked to work, alongside persistently high levels of stress, fatigue, and presenteeism.

Workload remains a central driver of wellbeing challenges. A significant proportion of staff report difficulty managing competing demands, and only a minority feel there are sufficient staffing levels to do their job effectively. Emotional exhaustion, frustration, and end-of-day fatigue remain common experiences for many colleagues.

Variation across services suggests that wellbeing is not experienced consistently, with some teams better supported than others. Overall, the findings indicate that while support mechanisms are in place, they are not yet sufficient to offset the operational pressures faced by staff. A more preventative, consistent and system-wide approach to wellbeing—linked to workload, leadership and work design—will be required to deliver meaningful improvement.

6. What the Staff Survey Tells Us

The 2025 National Staff Survey presents a largely stable but fragile position for the Trust. While there are small improvements in some areas, there is no overall shift in staff experience. This reflects the national picture and indicates that underlying workforce pressures remain unresolved.

There is a clear and consistent message from the data: staff are committed, but under sustained pressure. Colleagues continue to report pride in their work and confidence in patient care, but this sits alongside ongoing challenges relating to workload, staffing, and day-to-day experience.

Performance across themes is mixed and uneven. Areas such as flexible working, elements of inclusion, and aspects of teamworking provide a positive foundation. However, these strengths are not consistently experienced across the organisation. Variation by role, service and staff group indicates that culture and experience are not uniform.

Work pressure remains the most significant and persistent issue. Measures relating to staffing levels, ability to manage competing demands, and work-life balance are consistently low and below comparator organisations. This continues to impact morale, engagement, and overall wellbeing.

Cultural indicators present a mixed but concerning picture. While there are signs of improvement in areas such as speaking up and organisational response to concerns, there are small declines in compassionate culture and continued reports of negative experiences, including violence, bullying and discrimination. This suggests that psychological safety and behavioural consistency are not yet embedded across all areas.

Engagement and morale show slight improvement but remain below comparator organisations and are sensitive to pressures within the system. Advocacy measures reinforce this position: staff continue to express confidence in the quality of care provided but are less positive about the organisation as a place to work.

Health and wellbeing data further reinforces this narrative. There are contradictory signals, with some improvements alongside clear areas of deterioration, including a rise in musculoskeletal issues and ongoing high levels of stress, fatigue and presenteeism. This indicates that current support mechanisms are not fully offsetting operational pressures.

Equality, diversity and inclusion results highlight a positive overall perception of inclusion, but also ongoing disparities in experience and underrepresentation of some staff groups within the survey. This limits visibility of lived experience and indicates the need for continued focus on equity and psychological safety.

Overall, the results point to an organisation that is functioning under pressure but maintaining core strengths. There is evidence of progress in targeted areas, but no material change in the underlying drivers of staff experience. **The key challenge is not identifying issues, but achieving consistent, organisation-wide improvement in the context of sustained operational demand.**

7. Alignment and actions identified as part of Culture Plan & CIRG

NSS finding	Alignment to Culture Plan Actions	Alignment to CIRG Actions	Focus Area Identified
1. Workload, Work Pressure & Wellbeing	Wellbeing is a core Culture Plan priority with investment in emotional wellbeing support, physiotherapy and prevention programmes.	CIRG has escalated psychological safety concerns and is coordinating enhanced wellbeing interventions in hotspot areas.	System level action on core workload drivers (staffing models, workload redesign, operational pressure mitigation). Wellbeing actions support symptoms, not causes.
2. Variation in Staff Experience,	Creation of six Staff Networks, RCN Cultural	CIRG integrates FTSU themes,	Plan to increase participation or

Inclusion & Speaking Up	Ambassador programme to address inequity in recruitment and disciplinary outcomes.	addressing hierarchy, psychological safety and inconsistent processes.	representation in NSS, especially underrepresented minority groups. continue to build strengthened psychological safety framework beyond process level actions.
3. Leadership, Compassionate Culture & Behavioural Consistency	RJLC implementation underway to support learning culture and behavioural consistency; OD and compassion	CIRG reviewing ER process experience and strengthening guidance and reconciliation mechanisms.	Targeted bullying/harassment and violence reduction strategy Leadership capability uplift to be system-wide and mandatory.
4. Staff Voice, Engagement & Advocacy Engagement/m	Strengthening of staff voice through listening events, networks and planned “You Said – We Did – We Will” feedback.	CIRG triangulates NSS, Pulse, FTSU and HR data to drive real-time insights.	Staff to see visibility of action — feedback loops across the organisation. Cultural interventions linking staff experience to patient-care advocacy.
5. Cultural Insight, Real-Time Intelligence & Actionability Improved responsiveness but inconsistent; need for	Culture Plan/Workstream 5.3 developing live cultural insight dashboard.	CIRG already provides triangulation mechanism and is progressing dashboard development.	Action tracking is internal; staff need to see impact. Dashboard to be deployed — real-time insight to be available.
6. Appraisals & Development (Lowest Scoring Area) Appraisals	OD support and leadership development described but no explicit appraisal improvement plan.	CIRG does not reference appraisal or development themes in its workstreams.	Trustwide appraisal reform, capability development strategy, or quality assurance mechanism for appraisal outcomes.
7. Recognition & Appreciation	Culture Plan does not reference recognition as a priority; only small-scale pilots exist.	CIRG does not monitor recognition as a cultural indicator.	No structured recognition framework or Trust-wide approach. Not embedded within leadership expectations or People Promise delivery.

8. Sharing the Results and Acting

The 2025 Staff Survey results have now been released to colleagues and were launched with communication from the CEO and Chief People Officer. The Trust is moving into the listening and action-planning phase, ensuring a clear line of sight from staff feedback to improvement. While the immediate visibility of change will be affected by the EPIC launch, substantive action planning will progress, with impact expected to become visible from late April into May.

A structured, organisation-wide approach will be used to engage colleagues and develop targeted, meaningful actions. CIRG will now act as the central oversight mechanism for all NSS-related

action planning The Cultural Insights Review Group (CIRG) will act as the central governance mechanism for this work, providing oversight, scrutiny and accountability for the development, quality and timely delivery of all Care Group action plans.

At Trust level, the CEO and Executive Team will host 'listening and dialogue' events that share the results and focus on key organisational actions. Our Staff Networks will be a particular focus but open events will also be held.

Care Groups will develop local action plans informed directly by their survey insights, with the expectation that these reflect local cultural drivers, strengths and risks. Completed Care Group action plans will be submitted by the end of June 2026, after which CIRG will hold responsibility for reviewing, challenging and tracking these plans, ensuring alignment with Trust-wide cultural priorities.

CIRG will consolidate the outputs into a single, coherent Trust-wide plan, monitor delivery through its monthly assurance cycle, and ensure a consistent "You Said – We Did – We Will" communication approach.

To maintain momentum ahead of wider delivery, the Executive Team has identified a focused set of early priority actions, which will also be monitored through CIRG governance. These include:

1. We will set a further ambitious target for Care Groups to achieve a 51% response rate in the 2026 National Staff Survey.
2. A targeted discrimination action sprint focusing on age and disability, reinforcing zero tolerance and improving reporting confidence.
3. Deep-dive analysis into key questions, including perceptions of patient care priority and improvements in race-related experience.
4. Strengthening the incident feedback loop, with regular, visible updates on learning and action.
5. A targeted wellbeing intervention in high-pressure areas, combining rapid assessment with practical local actions.
6. A pilot of recognition and appreciation practices to strengthen everyday culture.
7. Introduction of Executive "Listening Rounds" to increase visibility, role-model compassionate leadership and ensure follow-up on issues raised.

Alongside these early actions, ongoing programmes related to learning, development and appraisal improvement will continue, and CIRG will ensure these are aligned with survey insights and tracked for impact.

Through CIRG's oversight, the Trust will ensure that Staff Survey feedback is systematically translated into visible, meaningful change, with strong governance, clear accountability at Care Group and Executive levels and assurance that actions are progressing at the required pace

Communications

The project team will work closely with the Communications Team to coordinate and deliver this programme.

9. Assurance recommendations and summary

It is recommended that the Trust proceeds with the planned NSS and NQPS actions to demonstrate clear "you said, we did" follow-through and strengthen confidence in the staff voice process.

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
National Staff Survey	Satisfactory	Declining/ Satisfactory
Pulse Survey	Limited	Declining (lower response) Limited

Quality and People Committee

Working Lives of Resident Doctors – Integrated Executive Summary

Date of meeting	Date report produced
28 April 2026	22 April 2026

Author(s)	Report approved by
Dr Kate Lissett, Chief Medical Officer (Executive summary and integrated assurance) Contributing authors (via appendices): Joshua Tulley, Resident Doctor Representative Committee Chair & Peer Lead Sophia Bickle, Medical Workforce Human Resources Advisor Sam Meyer, Head of Medical Education Dr Claire Blandford, Guardian of Safe Working Hours Mr Jeremy White, Medical Education Manager	Dr Kate Lissett, Chief Medical Officer

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

N/A

Executive summary

This paper provides a single, integrated executive summary for the **QPC**, drawing together three related but distinct sources of assurance:

The **April 2026 Ten Point Plan Programme Update** to improve resident doctors' working lives
 The **Guardian of Safe Working Hours (GoSWH)** response on **exception reporting** (Point 7 of the Ten Point Plan)
 The **General Medical Council (GMC) National Training Survey (NTS) 2025**, focusing on the working lives of resident doctors

The combined evidence shows that national reforms to exception reporting (implemented from 4 February 2026) have been implemented locally and are functioning as intended. No unresolved system access issues have been identified,

and resident doctors have reported no evidence of detriment. Reporting volumes have increased substantially, providing improved visibility of working patterns and safety concerns. However, the volume, consistency and clustering of reports indicate persistent operational pressure and mismatch between workload and rotas, particularly within acute medical services.

The **Ten Point Plan Programme Update** describes a well-established local governance and engagement framework in place to deliver the national requirements. This includes the appointment of a resident doctor peer lead, a designated senior board-level lead, and a multidisciplinary working group meeting monthly, supported by an action-tracking approach to monitor progress across all ten points.

The update highlights the current national areas of focus for Trusts, including:

- Fair and equitable annual leave arrangements for resident doctors
- Strengthened board-level leadership and oversight of resident doctor experience
- Implementation and embedding of the reformed exception reporting system
- Ongoing support for resident doctor peer lead engagement at the local, regional and national level

The progress described in the update indicates that the Trust has met or is meeting these expectations, supported by established resident doctor representative structures and escalation routes through education and negotiation forums. However, the update also explicitly identifies a continuity risk. At the time of writing, the tenure of the Guardian of Safe Working Hours was due to conclude in early May 2026, with no successor identified. This represents a short-term governance risk requiring active oversight to ensure continuity of safe working arrangements.

Guardian of Safe Working Hours (GoSWH)

Appendix 2 contains the independent GOSW report. This demonstrates Exception reporting has increased substantially following national reforms (Feb 2026), indicating improved confidence and confidentiality, but also highlighting persistent operational pressure and recurrent workload–staffing mismatch.

The dominant issue is recurrent late finishes (81% of reports), concentrated in specific medical wards (Cheetham Hill, George Earl, McCallum, Simpson), consistent with rota gaps / below-minimum staffing and associated safety signals.

Safety signals are present and increasing in the reporting period there were 9 safety concern reports and 7 fined breach events (rest/shift limits), suggesting prior under-reporting and current fatigue risk.

The **General Medical Council National Training Survey (NTS) 2025** analysis demonstrates that Torbay and South Devon continue to compare favourably overall, including marginal year-on-year improvements in clinical supervision (including out-of-hours supervision), reporting systems, handover, educational governance, and facilities. However, there were marginal reductions in satisfaction related to workload and teamwork. National Training Survey indicators also identify pressure points for Torbay around the intensity of night work and access to senior clinical support out-of-hours, which align with themes emerging from exception reporting.

NTS indicators show Torbay is **worse than UK average** for trainees feeling forced to cope beyond competence OOH (13% vs 7% UK; and 15% overall vs 9% UK in current post)

Across all three sources, the principal, consistent themes are:

Improved confidence and visibility through accessible reporting systems
 Recurrent unscheduled late finishes and safety concern signals linked to rota gaps and staffing below minimum levels
 Continued need to strengthen out-of-hours support and rota resilience in acute services
 The importance of sustained board-level oversight, clear escalation arrangements and system-level action rather than case-by-case responses

The assurance ratings in this report are based on a review of the above source papers and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Ten Point Plan programme governance and delivery	Satisfactory	Unchanged
Exception reporting (process, responsiveness and confidentiality)	Satisfactory	Improved
Workforce and rota resilience, including safety signals from exception reporting and the National Training Survey	Limited	Unchanged

Appendices

Appendix 1 - April 2026 Quarterly Report – 10 Point Plan Programme
 Appendix 2 - GoSWH Report – Point 7 Exception Reporting (Full version)
 Appendix 3 - GMC NTS 2025 – Working Lives of Resident Doctors Summary
Included in the Quality and People Items for Information Pack

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

Resident Doctor Representative Committee (RDRC) – routine oversight of resident doctor experience
Postgraduate Medical Education Committee (PGMEC) – escalation and education governance

Key recommendations and actions requested

The **Quality and People Committee** is asked to:

NOTE the significant increase in exception reporting following national reform, and the assurance this provides regarding reporting culture and system accessibility.

NOTE that exception reporting data now identifies persistent and recurrent workforce pressure, rather than isolated events.

SUPPORT a targeted care group level review of **actual resident doctor workload versus work schedules** on high-volume wards identified as hotspots. There is some “soft intelligence” that 3 weeks post EPIC “go live”, inpatient processes are significantly improved, which may impact on Resident doctor workload.

EXPECT further work to strengthen **rota resilience and escalation arrangements**, particularly in acute medical services.

AGREE the overarching assurance ratings outlined above.

How does this report further our Trust strategy?

This report supports the Trust strategy by:

- Strengthening **patient safety and quality** through better visibility of workforce risk
- Supporting **staff wellbeing and retention**, particularly for resident doctors
- Enabling **data-driven oversight** of workforce and training pressures
- Reinforcing an **open, learning-focused culture**, consistent with Just Culture principles

How does the report support the Triple Aim?

Aim	Impact
Population Health and Wellbeing	Improved clinical safety through better managed fatigue and supervision
Quality of Services Provided	Earlier identification of workforce risks affecting care quality
Sustainable Use of Resources	Better understanding of unplanned overtime and rota gaps

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Exception reporting highlights safety risks linked to workforce gaps.
Leadership and Governance	Clear board-level oversight via QPC
Performance	Operational pressures identified but not yet fully mitigated.
People and Culture	Supports openness, wellbeing and engagement
Strategy and Business Intelligence	Data informs workforce and service planning.
Finance	Increased overtime and breach payments identified

Risk

Risks lodged on Datix:

External Standards affected by this report and associated risks

NHS England **10 Point Plan – Improving Resident Doctors' Working Lives Terms and Conditions of Service** for Resident Doctors (v13, February 2026)
Care **Quality Commission** – staffing, supervision and safety