



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Date: Thursday 2 July 2026

Time: 12.30 am -2.30 pm

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

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TSDFT Public Board of Directors

The Board Room - Hengrave House



Torbay and South Devon
NHS Foundation Trust

02/07/2026 12:30 - 14:30

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**MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
 PUBLIC BOARD OF DIRECTORS MEETING
 HELD IN THE BOARDROOM AND MS TEAMS
 AT 12.30 PM ON THURSDAY 7TH MAY 2026**

Present:	Dr M Beaman	Chairman
	Mr J Teape	Chief Executive
	Mr J Corrigan	Chief Finance Officer
	Mrs L Edwards-Smith	Non-Executive Director
	Mr A Ghadiali	Non-Executive Director
	Mr M Greaves	Non-Executive Director
	Dr C Lissett	Chief Medical Officer
	Mrs N McMinn	Chief Nursing Officer
	Ms J Piper	Chief People Officer
	Mr C Saxby	Non-Executive Director
	Mr S Tapley	Chief Strategy and Planning Officer
	Mr S Wadham-Sharpe	Interim Chief Operating Officer
In Attendance:	Mr R Williams	Non-Executive Director
	Ms C Parnell	Chief of Staff
	Ms J Adams	Intermediate Care Lead, Jack Sears (for item 47/05/26)
	Ms O Bath	Staff Governor
	Ms J Bassett	Director of Midwifery and Gynaecology (for items 61/62/05/26)
	Mrs L Densham	Deputy Lead Governor
	Mrs S Fox	Corporate Governance Manager
	Ms J Harris	Associate Director of Communications and Partnership
	Ms A Shipman	Member of the Public (for item 47/05/26))
	Mr A Stilliard	Governor
	Mr G Yardy	Governor
	Members of the Public	

WELCOME AND INTRODUCTIONS

- 44/05/26 The Chairman welcomed all those in attendance in particular Sam Wadham-Sharpe since his appointment as Interim Chief Operating Officer, and Cath Parnell, Chief of Staff.
- The Chair wished all present to note that the Board was a meeting held in public, which meant members of the public were welcome to observe the Board conducting its business, it was not a public meeting.
- Five questions from the public had been received in advance of the meeting, all of which had been shared with the Board.

The questions broadly related to the Trust's developing strategy and the importance of clarity about the future of services, including at Torbay Hospital and its emergency department, the decision regarding the Section 75 arrangement with Torbay Council taken in March, the Trust's approach to funding for an older population and our work on pathology and estate arrangements. All the questions and answers would be published on the Trust's website within the next 24 hours.

A question about the nature of the Trust's Public Board of Directors meeting being held in public had been received and was detailed below:

Why is this an 'in Public' meeting and not a Public Meeting. Concerned residents would like to see the people making decisions that affect our lives. Stating the room is not big enough is an unacceptable excuse. Hire a bigger room.

We understand the importance that people place on being able to see how decisions are made and to engage with us.

The Board of Directors meets in public as part of its formal governance process, which allows members of the public to observe the meeting while the Board conducts its business. This is different from a public meeting, where there is broader participation.

Attendance in the room is prioritised for our governors, who represent our local communities, our staff and those who have been invited to attend to speak to agenda items. Alongside this, we provide access via MS Teams so that more people can observe the meeting than would be possible in a physical space alone.

We are also mindful of the financial challenges we face and the need to use our resources carefully. For that reason, we seek to make best use of our existing facilities while ensuring meetings remain accessible.

We publish our papers in advance and provide opportunities for members of the public to submit questions, and we remain committed to continuing to strengthen how we engage with our communities.

PRELIMINARY MATTERS

45/05/26

Apologies for Absence, Quoracy and Declarations of Interest

Apologies for absence were received from Emily Long, Director of Corporate Governance and Paul Richards, Non-Executive Director and the Chair confirmed the meeting as quorate.

Robert Williams wished to place on record that he had been appointed to a non-executive director role at the Integrated Care Board (ICB), which could be considered a conflict. This was noted albeit his term did not commence until he had departed his role at Torbay and South Devon.

46/05/26

Unconfirmed Minutes of the Meetings held on 5th and 26th March 2026

The Board received the minutes of the meetings held on 5th and 26th March 2026, circulated with the agenda pack. The action log was reviewed, and updates were received on outstanding actions.

An amendment was agreed in respect of the minutes of the meeting held on 26th March to provide confirmation that the Board had unanimously approved the recommendations with no opposition. **Action: SF** (post meeting note – actioned)

The Board APPROVED the Unconfirmed Minutes from the Public Board meeting held on 5th and 26th March 2026 as a true and correct record, noting the amendment agreed detailed above.

47/05/26

Patient Story

The patient story was presented by Ms J Adams and Annette Shipman and concerned Ms Shipman's care following multiple falls at home.

Annette initially attended the Trust's Emergency Department and was then admitted to the hospital where she was diagnosed with RSV viral infection; falls due to peripheral neuropathy; osteoarthritis and frailty.

Annette was discharged to Brixham Hospital to begin her rehabilitation and then to Jack Sears to provide support to improve her co-ordination, build stamina and enable her to become as independent as possible with personal care, and go home with ongoing support.

Annette was asked about her experiences of the Trust and she said she found her time in the Emergency Department to be chaotic with members of staff 'running' around the department. She was also placed on a hard chair to wait, which she found uncomfortable due to her condition and was unable to attract anyone's attention when she needed to go to the toilet. Annette suggested it would be helpful to have a separate area for older people with conditions such as hers.

The Board recognised her concerns and the increased waiting times for patients in the Emergency Department. It was also noted that the Trust was undertaking work to identify how it could support those patients who could be better cared for at home with support, or for example at the Trust's Frailty Hub, so they did not need to come into the Emergency Department. It was also recognised that when older people spent time in a hospital bed it dramatically reduced their ability to rehabilitate and return home.

Annette was asked what the Trust could have done better in terms of the care she received. She said that the care she received once she left the Emergency Department was excellent, noting that patient transport was very good in that they always arrived on time, but you had to wait a long time until they were able to pick you up to take you home on the return journey. Annette said she found Brixham Hospital and the team she was with very efficient. She added that she had been placed in a single room but had not realised it was because she had an infection. Annette also emphasised the importance of being listened to as a patient.

Annette was thanked for attending the Board and sharing her story, which had provided the Board with a number of issues to consider and on which to reflect.

48/05/26

Report from the Chairman

The Chair briefed the Board on the following issues:

- Thanks were placed on record to Chris Balch for his support to the Board firstly as a Non-Executive Director and latterly Chair, as he had now stood down from his role.
- Medicines for Members event with a focus on the improvements to patient satisfaction provided by patient choice.
- Meetings with the SW Regional Director and Chief Medical Officer.
- Meeting with Chair of Royal Devon University Hospitals.
- NED recruitment, with interviews taking place on Monday 11th May.

- Attendance at a regional meeting with other Chairs and Chief Executives.
- Meeting with Chair of the ICB.
- Finally, the Chair placed on record his and the Board's thanks to Robert Williams who was leaving the Trust to take up a Non-Executive role with the ICB.

The Board received and noted the Chairman's report.

49/05/26

Chief Executive's Report

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

- The Board had approved a revised plan in March included a Cost Improvement Programme (CIP) of £50m and deficit plan of £62m. Since that time the Trust had been granted £58m of deficit support funding on the condition the Trust's delivered a break-even plan. This had increased its CIP to £54m.
- A Board question had been received in respect of planning, as follows:
Can the Board share what representations the Trust has made to senior NHS administrations over the last five years regarding the additional costs of our significantly older population and how this may not be properly considered within a national funding formula which focuses on deprivation.
We have consistently made the case, through regional and national forums, that Torbay and South Devon face a distinct set of challenges, particularly in relation to age, frailty and the complexity of need within our population.
This includes contributing through system-level discussions across Devon and engaging with NHS England where opportunities arise.
At the same time, we are operating in a very challenging financial environment, with a requirement to deliver significant improvement while continuing to provide safe, high-quality care.
We will continue to advocate for funding approaches that recognise both deprivation and the additional costs associated with supporting an older population, alongside our focus locally on making best use of the resources available to us.
- It was further noted that the Trust had generated additional funding in 2025/26 and had spent almost £70m on capital projects, one of the highest spends on capital development in recent years.
- The Trust's new electronic patient record (EPR) had gone live and thanks were extended to both colleagues from the Royal Devon University Hospital and University Hospital Plymouth for their support before, during, and after the implementation phase.
- The Chief Executive's report detailed several successes including: UNICEF Baby Friendly Initiative reaccreditation; surgical hub receiving national accreditation; Angela Abbot receiving Chair Allied Professional Officer's Gold Award for Excellence; professional achievement in the Mortuary team; Dr Carl Edwards attending a Royal Garden Party; and Jenny Piedot being awarded the Queen's Nurse award.

- The Board was asked to note the work taking place to relocate the provision of Cellular Pathology Services to Gadeon House as part of a joint initiative with the Royal Devon University Hospital. The Board noted that at present the Trust could only offer generalist pathology posts to consultants but the joint model at Gadeon House would provide the opportunity for consultants to specialise, which was how they wanted to work and would make the posts more attractive. Gadeon House would also provide a fit for purpose environment for clinicians and allow them to deliver turnaround times required by both trusts.
- A Board question in respect of Gadeon House had been received, as follows:

Development of Gadeon House for the long-term provision of Cellular Pathology Services - We understand that the Trust has decided to revisit its approach to Pathology to be more medic-led. Can the Board confirm whether the Trust has been locked into a deal with Gadeon House in Exeter?

We are progressing work on our pathology services as part of the wider Peninsula Pathology Network, including ensuring the right clinical leadership and expertise is in place to shape future services. This includes bringing clinicians together through established clinical reference groups to inform that work.

In relation to Gadeon House, the Board should be aware that we have entered into a lease arrangement with Torbay Council as freeholder, supported by time-limited capital funding from NHS England. This decision followed an options appraisal and business case and was taken through our governance arrangements on an urgent basis, reflecting the need to address significant estates safety risks associated with our current cellular pathology facilities.

The investment enables the development of safe, fit-for-purpose laboratory accommodation for cellular pathology services, while urgent and time-critical pathology services will continue to be delivered locally from Torbay Hospital.

Implementation will take place in a phased and managed way, with clinical leaders closely involved throughout, and with a continued focus on maintaining service quality, turnaround times and patient care.

- Following the Board's decision to serve notice to the Council on the Section 75 agreement, work was taking place in partnership with the Council to establish revised arrangements for the future.
- A Board question in respect of Adult Social Care had been received, as follows:

Adult Social Care in Torbay – How did the Board consider the risk of Torbay Council undertaking a judicial review when deciding to end the Section 75 arrangement, and does this continue to be a risk to the Trust?

In reaching our decision on the Section 75 arrangement, we considered a full range of risks and implications, including those relating to legal challenge, and took appropriate advice as part of that process.

We have continued to work closely with Torbay Council, the Integrated Care Board and other system partners through the transition arrangements now in place.

As reflected in the Chief Executive's report, our focus throughout is on maintaining continuity of services, with no immediate changes to how people receive care, and ensuring that any future changes are carefully planned and appropriately engaged.

As a Board, we remain focused on supporting colleagues, maintaining safe, high-quality services and working constructively with partners in the best interests of the population we serve.

The Board noted the report of the Chief Executive.

50/05/26

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 this was the last time the BAF in its current form would be presented to the Board, noting the item later in the meeting to review and approve revised risk management processes.

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

TO APPROVE

51/05/26

Risk Management Framework – approval of core documents and migration to DCIQ

The Board received the Risk Management Framework – approval of core documents and migration to DCIQ report, circulated with the agenda pack.

The Board reviewed the suite of documents that detailed the Trust's revised risk management process, noting they had been previously discussed at both Audit and Risk Committee and a Board Development session.

Thanks were placed on record to, in particular, Mark Greaves, Cath Parnell and Kaajal Chotai (external consultant) who had supported this work.

Once approved, work would take place to embed the new processes into the Trust's governance arrangements.

The Board:

- **Approved the Risk Management Strategy;**
- **Approved the Risk Management Policy;**
- **Approved the Risk Appetite Statement;**
- **Approved the proposed BAF domain structure and its alignment to the Trust's strategy and five signature moves; and**
- **Noted the transitional reporting arrangements for May and June 2026, including the use of the Organisational Risk Overview as the interim risk summary while DCIQ was configured and Yellowfin dashboards were being built.**

52/05/26

Strategy Report

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

- The Trust's Strategy was being refreshed in response to the Government's decision to delay the New Hospitals Programme; current financial challenge;

the Trust's position in the national oversight framework; and the introduction of the 10 Year Plan.

- The Strategy would set the direction of the Trust and establish principles of where the Trust would need to work with its stakeholders and decision-making principles. It was not about service relocations and would not replace any statutory consultation and engagement that might be required.
- In order to inform the Strategy a number of listening activities had taken place the detail of which were in the report, alongside the feedback received.
- In addition a significant number of partner engagement events had taken place, including with Trust Governors, which were detailed in the report.
- The report detailed the key themes identified from this engagement and how they were being used to shape delivery planning and community conversations.
- If the Board approved the Strategy, the report detailed the next steps in terms of engagement and mobilisation.
- The Board would receive monthly updates on progress.
- A query was raised around the Trust's role as convenor in neighbourhoods and whether this had been welcomed. It was noted that this work was taking place through the Local Care Partnerships; it had not been fully accepted but stakeholders were keen to work with the Trust and there had been no discontent.
- JT wished to thank those present for taking the time to provide feedback to inform the Strategy document. He said that it was a living document and would need to be updated as necessary as the Trust worked to deliver it.
- A Board question had been received in respect of the Trust's Strategy:

Recognising community 'anxiety about losing local services and the importance of transparency and early engagement' and 'the importance of avoiding misinterpretation of the strategy as pre-determining service changes', can the Board clarify their commitment to services remaining at Torbay within their new Strategy, and can the Board provide reassurance that they will maintain A&E as a 24/7 service?

We recognise that colleagues, patients and our communities feel strongly about local services, and we have heard clearly the importance of being transparent and avoiding any suggestion that decisions have already been made.

Our strategy sets the overall direction for how we improve care for the 300,000 people we serve and the 6,500 people who work in our organisation. It is principles-based and does not set out specific proposals about individual services, locations or access points. There is a clear separation between agreeing the strategy and any future service change processes, which would be developed separately, with full clinical involvement and meaningful engagement with our communities.

This reflects how the strategy has been designed - to set direction and priorities, not to prescribe specific service relocations or pre-determine sites or access points.

Torbay Hospital continues to provide a 24/7 emergency department, and there are no current plans to change this. As a Board, we remain committed to sustaining safe, high-quality services for our population, including services provided at Torbay Hospital.

The Board approved the Trust Strategy.

FOR REVIEW

53/05/26 Planning 2026/27 – April Update

The Board received the Planning 2026/27 – April Update Report, circulated with the agenda pack. The following was discussed:

- As reported as part of the Chief Executive's report since the Board had approved the Plan, £58m of deficit support funding had been granted on the condition the Trust's delivered a break-even plan. This had increased CIP to £54m.
- Work had taken place on the maturity of CIP plans noting that at the end of April maturity was at 70%. This time last year the figure was 45%, recognising the significant progress that had been made in the last year.
- If the Trust could deliver its plans over the next three years, noting the level of underlying deficit it would have to address, it could reach a balanced budget.
- The need to ensure that there was close scrutiny of the impact on quality and care as CIPs were progressed was acknowledged – noting that all CIPs were subject to Equality Impact Assessments (EQIAs).
- The process of reviewing EQIAs was discussed, noting that they were reviewed by an Executive with any that were felt to have a high level of impact on quality and safety refused. It was agreed a paper would be presented to QPC on the EQIA review process and how any concerns were escalated. **Action: NM**
- It was reported that the Trust had received challenge from Region on two areas of performance submitted in its operating plan: faster diagnosis in Quarter 1 and ambulances that breached 45-minute handover times. The Board was informed that Region had been reminded that faster diagnosis and the reduction in Quarter 1 had been signed off by them and the national team as part of the Trust's Epic go live submissions. They were also informed that the Trust would commit to system working on improving ambulance handovers, but that this would require the Ambulance Trust to work with the Trust on improving conveyance profiles as well internal improvements.
- It was reported that workforce elements of the Plan would be progressed through the Workforce Programme Group, which had oversight of the Trust's workforce programmes. An updated Workforce Plan would be presented to the Board in June.

The Board AGREED the overall assurance level relating to the financial plan submission of TSDFT as SATISFACTORY, noting that work continued to reduce plan delivery risk relating to CIP maturity.

54/05/26 2026/27 Our Plan for Better Care

The Board received the 2026/27 Our Plan for Better Report, circulated with the agenda pack. The following was discussed:

- The Board noted the Year 1 close down report and the transition into Year 2.
- The Year 2 plan was structured around the Trust's signature moves and enablers.
- Concern was raised around the need for the Trust to have the right level of resource in place to deliver its plans for Year 2. ST explained that, for example, expert clinical support was in place to support a review of trauma and orthopaedics; support was in place for integrated neighbourhood teams; and one of the Trust's Deputy Medical Directors who was a GP and public health consultant was providing support in that arena.
- The benefits of gaining the view of external consultants, in particular from outside the NHS, as they would bring different experiences to the Trust, was noted.
- Lessons learnt from Year 1 were discussed and how they were being captured and used to inform the Year 2 plan. It was reported that one area of learning was that the Year 1 Plan contained too much 'business as usual' rather than transformational areas work. There was also concern around the Trust's ability to resource the Plan, whilst taking account of staff health and wellbeing.

The Board:

- **Noted the progress made in stabilising leadership, governance, performance, finance and workforce domains, and the learning taken from Year 1;**
- **Took assurance that appropriate foundations were now in place to support delivery in Year 2; and**
- **Supported the transition into Year 2, recognising the shift from foundational improvement to strategic transformation aligned to the Trust strategy.**

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

55/05/26

Audit and Risk Committee

The Board noted that the meeting had discussed in particular the Freedom to Speak up process and that it was not currently possible to gain assurance that the system was robust. Cyber Security was also discussed.

The meeting received the draft Head of Internal Audit Opinion which had moved from Limited to Satisfactory. It would remain Satisfactory as long as there were no adverse internal audit reports published and if all outstanding audit recommendations were closed.

External Audit had reported at the meeting the improved engagement from the Finance Team for this year's audit, compared to last year's.

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

56/05/26

Finance and Operations Committee

The Board noted the successful implementation of the EPR, and how all teams worked together to deliver implementation. The efforts of the Trust's Epic leads and their clinical leadership were noted, alongside colleagues from Royal Devon University Hospital and University Hospital Plymouth.

The Committee discussed a number of risks including limited progress of the Devon Target Operating Model for Digital and the current gap in leadership in the Trust; and the need to manage the adult social care debt as part of the Section 75 contract withdrawal.

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

57/05/26

Operational Performance Report

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

- NHS England had asked the Trust to take a reporting holiday between 29 March and 15 July as part of the EPR go live process.
- Internal reports would continue to be produced, noting there were currently some discrepancies in reporting that were being resolved.
- The Finance and Operations Committee would be undertaking a deep dive on Urgent and Emergency Care and four-hour performance following the investment in the Emergency Department.
- The report detailed the activity delivered with the elective sprint funding that had been provided, noting that agreed elective activity had been delivered, but performance improvements had not been realised due to increased demand.
- Work was taking place to review the Operational Report and IPQR to improve reporting to both the Board and Finance and Operations Committee.
- Two of the assurance elements in respect of RTT and Cancer had been reduced from satisfactory to limited based on agreement with the regional and national performance teams linked to the EPR implementation. Clear plans were in place to recover the activity.

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

58/05/26

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 end deficit position of £22.4m against a plan of £8m. The adverse variance related to the withholding of deficit support funding in quarters 3 and 4.
- All capital allocations had been spent by the end of the year.
- The Trust's cash position of £35.5m was higher than planned, noting this cash was not spare, but was needed to ensure the Trust could capital spend in 2025/26.

The Board AGREED the overall assurance level relating to the financial position of Trust as SATISFACTORY assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce. The Board also noted that financial performance was off plan by £14.4m at the year end , reflecting withholding of Quarter 3 and Quarter 4 deficit support funding (DSF) £15.4m, partially offset with £1.0m of additional dental income. The Trust had received Public Dividend Capital Revenue Support to mitigate the cash impact of the loss of DSF

59/05/26 **EPR Status Report**

The Board received the EPR Status Report, circulated with the agenda pack.

It was noted that the Trust was in a stabilisation phase following implementation. A formal review would take place later in the month with the Epic team. Following that the Trust would move from stabilisation to activity recovery, noting the Trust was delivering between 80-90% of expected activity at this time of the year. A programme for benefits realisation was in the process of being established and progress would be reported to the Board.

Three areas were noted where there were currently concerns in respect of recovery: Orthopaedics; Dermatology; and ENT.

The Board AGREED the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed. It was recommended the Board took significant assurance that progress was good and that strong foundations had been created. Two independent NHSE assessments had described the program as “exemplar”. This level of assurance was also based on the risks identified and the work being undertaken to mitigate these.

60/05/26 **Quality and People Committee**

The Board was briefed that the following issues had been discussed by the Committee:

- Discharge-related incidents were increasing and impacting on patient flow.
- Reports presented to the Committee including national Staff Survey; Freedom to Speak up and WRES and WDES, when triangulated, clearly highlighted the challenges facing the Trust.
- The WRES and WDES reports highlighted concerns around persistent bullying and harassment and the work taking place to address this.
- Deterioration in the number of patients reaching the stroke unit in four hours, below the national average, and the work taking place to improve this position.
- A report was received on the working lives of resident doctors including the 10 point plan, Guardian of Safe Working Hours and GMC National Training Survey. The Committee noted the positive feedback from the Training Survey, but it highlighted pressure points around the intensity of night work and access to senior clinical support out of hours. It was noted that work would be taking place through the Medical Care Group to look at support provided out of hours.
- The Committee welcomed the improved approach to triangulating data across multiple sources to identify and better understand key themes impacting on staff experience and safety.

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

61/05/26 **Perinatal Governance Report**

The Board received the Perinatal Governance Report, circulated with the agenda pack.

It was noted that overall assurance was limited, which reflected the increased scrutiny of perinatal activities. No MOSS safety alerts had been made and the service had achieved full compliance with the Maternity Incentive Scheme.

The service continued to receive targeted national support, with robust executive oversight.

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

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

62/05/26

Maternity and Neonatal Bi-Annual Staffing

The Board received the Maternity and Neonatal Bi-Annual Staffing Report circulated with the agenda pack. The following was discussed:

- Evidence supported compliance against national standards. The obstetrics and gynaecology medical workforce continued to experience capacity issues, but this was an improving picture following recruitment.
- Neonatal staffing met current standards but remained an ongoing challenge.
- The service continued to experience periods of high escalation on labour wards which could affect flow, but escalation processes were in place.
- Although the Trust currently met neonatal medical staffing requirements, the standards were changing and the Trust might not be able to meet the new standards.
- Concern was raised that the report stated that the fill rate was sometimes as low as 64%. It was explained that the national activity tool did not align with the Trust's model and assurance was provided that all shifts were appropriately resourced to ensure the Trust met national staffing standards. It was agreed future reports would provide clarity in respect of this issue.

Action: NM

The Board noted:

- **The mitigations taken within the maternity service to ensure safety and quality;**
- **The ongoing service requirements of the Obstetrics and Gynaecology team;**
- **The rise in sickness rates within maternity staff and the mitigations taken to address this;**

- **The significant fall in vacancy rate for midwifery staff within this reporting period;**
- **The ongoing action plan to address the challenges in relation to QIS nurses in SCBU; and**
- **That workforce recommendations form part of the recommendations of the Maternity and Neonatal Improvement Support report (MatNeolST – formerly MSSP).**

63/05/26

Health Inequalities

The Board received the Health Inequalities Report, circulated with the agenda pack. This report had been debated at the Quality and People Committee, noting that it could only give limited assurance due to the current stage of maturity and that the new EPR would be able to provide enhanced data that could be used to inform this area of work.

It was recognised that once the Board had robust data work would need to take place to understand what it was telling the Trust in terms of the journey time for people from deprived areas, and what to do about it.

Work had commenced to produce an action plan that would be enhanced by neighbourhood teams who would be best placed to address any inequities.

The Board AGREED the overarching assurance rating and took LIMITED assurance as to those matters reviewed.

64/05/26

WRES/WDES Equality Objectives and Action Plan

The Board received the WRES/WDES Equality Objectives and Action Plan Report, circulated with the agenda pack. The following was discussed:

- The data that informed the report was taken from the Trust's electronic staff record, staff survey and TRAC at the end of March. It needed to be remembered that the data was reliant on self-disclosure.
- It was noted that the data in respect of Board members needed to be clear if this referred to all the Unitary Board Directors or just the Executive Members, as given the small numbers this did affect the subsequent narrative.
- The action plan would be aligned to the Trust's culture plan and overseen by the Quality and People Committee and through the Culture Insights Review Group.
- Work continued to enhance the Trust's staff network; embed a restorative and just and learning culture; take forward senior recruitment; and address talent opportunities for under-represented groups.

The Board:

- **Noted the findings of the 2026 WRES and WDES reports and the persistent disparities identified for Global Majority and Disabled staff;**
- **Approved the Equality Objectives and action plan priorities for 2026/27 as set out in the Trust's Diversity and Inclusion Framework;**
- **Supported the recommended focus areas for 2026/27 including: development of staff networks, embedding of the Restorative Just and Learning Culture approach, equitable senior recruitment processes, and talent development opportunities for underrepresented groups; and**

- **Noted that WRES and WDES submissions would be submitted to NHS England by the required deadline.**

FOR INFORMATION

65/05/26 Review of Directors' Interests

The Board noted the Register of Directors' Interests circulated with the agenda pack.

CLOSING MATTERS

66/05/26 Any Other Business and Review of Meeting

The Board noted that Liz Edwards-Smith had stood down as Chair of Charity Committee, which would be taken over by Ash Ghadiali. She said that it had been a privilege to Chair the Committee and that she would continue to be involved in its work as a committee member.

The Chair highlighted several areas of work that had been discussed during the meeting: the need for Finance and Operations Committee oversight of CIP performance and links to quality and safety; inter-relationship between the Finance and Operations and Quality and People Committees; and the three areas of concern in respect of activity step up following the EPR implementation.

67/05/26 Board Assurance Framework (matters for review or escalation)

No issues were discussed.

68/05/26 Board Workplan

The Board received and noted the Board Workplan.

69/05/26 Date and Time of Next Meeting:

The next Board meeting in public is scheduled to take place at 12.30 pm, Thursday 2nd July 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
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. Agreed to close.	Closed
24/03/26	Chief Executive's Report – further update on Pathology to be provided in next report.	JT	May Update – included in Chief Executive's briefing. Agreed to close.	Closed
29/03/26	Operational Performance Report – review of equity of waiting lists to be undertaken.	SWS	May Update - would 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	May Update - this would be addressed through the work detailed above. Agreed to keep action open until data had been received.	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. Agreed to close.	Closed
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. 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 system communications and working needed strengthening – this was being facilitated	Closed

			by a system working party that the ICB were chairing along with an updated version of the regional maternity OPEL that was being released towards end of April Safety led escalation was 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. The challenge we had around closure from system partners had been raised. Agreed to 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 18 th March. Agreed to close.	Closed
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	May Update: agreed to close the action. These issues would be addressed in the new BAF.	Closed
53/05/26	Planning Update – present paper on EQIA review process to QPC.	NM		

Board of Directors

Chief Executive's report

Date of meeting	Date report produced
02.07.2026	24.06.2026

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
Phone:		Date:	25.06.2026
Email:	jane.harris18@nhs.net		

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

N/A

Executive summary

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

Appendices

Appendix 1: Proposal: rotating Board meetings in public across our neighbourhoods

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.

The Board is asked to approve to a 12-month pilot to rotate Board meetings in public across our neighbourhoods as set out in Appendix 1.

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 been the tension colleagues are experiencing between increasing demand, constrained resources and the desire to continue to provide high-quality, compassionate care, alongside a strong sense of pride in their teams and professionalism.
3. My twice-monthly Meet Joe sessions continue to provide a valuable opportunity to hear directly from colleagues and in the past two months I appreciated being able to hear directly from colleagues at Totnes Hospital, Union House (Torquay) and Torbay Hospital. I also joined, participated in and/or hosted our corporate induction and Trust Talk in the past two months.
4. Since my May report I have spent time with our volunteers at our annual volunteer thank you event, hosted our annual our people celebration event and our latest quarterly our people awards breakfast. I have met with and celebrated our Aspire students and our end-of-life ambassadors at Rowcroft Hospice. I had great pride in re-signing our commitment to the Armed Forces Covenant and in joining long-serving colleagues, governors, partners and community representatives in marking 100 years since the foundation stone of Torbay Hospital was laid. I have joined our theatres colleagues to mark 30 years of day surgery at Torbay Hospital and spent time with the Chairs of our Leagues of Friends and Nurses League at our quarterly meeting.
5. I have continued to meet regularly with pathology colleagues, along with fellow executives and senior leaders, as we progress long-term solutions for pathology services.
6. My routine meetings with the Integrated Care Board, NHS England, the Peninsula Acute Provider Collaborative, Torbay Council and our Council of Governors continue and provide valuable opportunities for discussion and to listen to diverse voices.
7. I continue to meet regularly with our local MPs, Steve Darling and Caroline Voaden, and Martin Wrigley when required.

Leadership update

8. I am delighted to confirm that following a robust recruitment process we have appointed Sam Wadham-Sharpe to be our substantive Chief Operating Officer.
9. Sam has been our Interim Chief Operating Officer since May and joined us as Deputy Chief Operating Officer last year.

10. I am delighted we have appointed Sam to this role and I know he will be a fantastic appointment for our organisation. In his last year working here he has gained the confidence of our teams across our services, has a visible presence, and brings with him wide experience of operational management.
11. As I shared with Board in May, following a restructuring of our executive and senior management arrangements, Emily Long, Director of Corporate Governance and Trust Secretary, left 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.
12. I have also now concluded the review of the Executive Team and new portfolios are in place. It is pleasing to have a stable team in place with shared values and commitment to Torbay and South Devon and I am confident that our renewed Executive Team will provide the expertise we need alongside caring and compassionate leadership during a time of significant change.
13. We have concluded a successful recruitment to our Non-Executive Director vacancies and have appointed three new Non-Executive Directors and one Associate Non-Executive Director.
14. I am delighted to welcome Arwel Griffith and Joanna (Jo) Webber to their first Board of Directors meeting. They start in post on 01 July 2026.
15. We have also appointed Karen Cox as a Non-Executive Director and Karen will start on 01 September 2026 to support an effective handover before Paul Richards leaves us in the autumn after many years dedicated service.
16. We have also appointed Debbie Stark as Associate Non-Executive Director. Debbie will start in post later this year.
17. These new appointments alongside our renewed and substantive executive team will provide us with a timely opportunity to refresh our Board development programme and this work will be taken forward via the Chief People Officer and our Chair.

Plan for 2026/27

18. As the Board will be aware we have an incredibly challenging plan to deliver in 2026/27 including a savings programme of £54m which is more than 7% of our budget. We also have some very challenging targets in areas we know we need to improve and we are developing clear recovery plans to address these issues.
19. Details of our progress including our plan for better care (our programme of work for the year) are included within the main agenda.
20. It is also important to reflect the incredibly hard work of my colleagues across the organisation as we are looking to address several ambitious change programmes alongside keeping the day to day running of the organisation on track. I remain extremely grateful and in awe of many of my colleagues who go over and above daily to meet the challenges we face.

Voluntary redundancy scheme

21. As shared previously, we have been progressing a voluntary redundancy (VR) programme as part of our wider approach to workforce redesign and financial sustainability.
22. The scheme is entirely voluntary and has been designed to offer choice for colleagues where it is safe and practical for roles to change or reduce. There is no expectation on colleagues to apply, and applications have not been automatically approved.
23. Applications were considered through a robust two-stage panel process, ensuring decisions were consistent, fair and based on a clear assessment of risk.
24. We have been clear that no applications would be approved where this would compromise patient safety, service continuity or the long-term sustainability of our workforce and that has remained the case throughout.
25. Through this process, we have been able to support a reduction of around 75 WTE, contributing to our overall workforce reduction requirement and delivering recurrent savings, while maintaining safe services.
26. The programme is now in its final stages. Colleagues confirmed their decisions in mid-June and we are currently finalising settlement agreements, with completion expected in early July.
27. We recognise this has been a difficult and uncertain period for many colleagues, and we have continued to provide support throughout.

Annual Members Meeting 2026

28. The Membership Committee of our Council of Governors has reviewed the approach to our Annual Members' Meeting (AMM) and has agreed a revised model for future delivery.
29. Rather than continuing with a standalone, formal meeting format, the Committee agreed that the AMM should evolve into a broader community health event, designed to strengthen engagement with members, patients and local communities.
30. As part of this approach, the AMM will rotate across our five neighbourhoods over a five-year cycle, ensuring that each community has the opportunity to host and engage with the event. This is intended to improve accessibility, reach a more diverse audience, and reflect our commitment to place-based working.
31. This change aligns with the direction set out in our emerging strategy, particularly our focus on neighbourhood-based models of care, stronger partnerships with communities, and more meaningful engagement with local people. Positioning the AMM as a community event supports a more visible and inclusive presence, creating opportunities for dialogue, learning and co-design with the populations we serve.
32. For 2026, the event will take place at Paignton Library on the afternoon of Wednesday 30 September. The format will include a marketplace-style event, bringing together Trust services alongside partners from the voluntary,

community and social enterprise (VCSE) sector, and creating space for wider engagement with the public.

33. The event will also provide an opportunity to run a small number of focused engagement sessions linked to the development of our organisational strategy, enabling members and local communities to contribute directly to shaping our future priorities.

34. The formal statutory requirements of the AMM will continue to be met within this model, with arrangements designed to ensure that the required business is conducted clearly and transparently alongside the wider engagement activity.

35. An expression of interest for the marketplace is currently open to our services.

Governor elections

36. We currently have six vacancies across three public constituencies which means that our Council of Governors is not currently fully representative of the populations it serves, at a time when major strategic priorities and delivery plans are being progressed.

37. Under our Constitution, public governors are elected to represent the interests of members and the public and the Council of Governors has a statutory role in ensuring those interests are properly represented. The Constitution allows for elections to be held to fill vacancies that arise between routine election cycles.

38. Our next scheduled routine election cycle is in 2027. If a by-election is not held in 2026, the above vacancies will therefore remain unfilled until 2027, resulting in a prolonged period without full public representation in several constituencies.

39. At their meeting on 13 May 2026 the Council of Governors decided to run a public governor election in 2026 on the basis that proceeding with elections ensures that public constituencies are properly represented during the period leading up to 2027, demonstrates the Council's commitment to public voice and accountability and avoids allowing uncertainty about future legislation (under the NHS Modernisation Bill) to create a prolonged gap in representation.

40. The Governor elections for 2026 are due to open for nominations at the end of June and will close at the end of July. A communications plan has been developed to ensure that these opportunities are communicated widely and effectively.

Proposal: rotating Board meetings in public across our organisation

41. Following discussion at the most recent Board development session and approval in principle by the Executive Committee on 19 June, in appendix 1 we have set out a proposal to pilot for 12 months rotating our Board meetings in public across our neighbourhoods.

42. The proposal sets out the rationale for the proposal along with the key considerations for assurance.

43. Board are asked to review the proposal and to consider approving the pilot.

Segmentation and league table publication

44. The Quarter 4 NHS Oversight Framework (NOF) segmentation data was published online earlier this month. These relate to performance across January to March 2026.
45. In this latest update, we have moved from Segment 3 to Segment 4, with a score of 2.60, having previously been between 2.41 and 2.53. This is reflected in our league table position, where we have moved from 83rd to 102nd (joint) out of 134 trusts.
46. This is not the position we wanted to be in, particularly given the progress we have been making.
47. Overall, our position remains mixed. We are performing strongly on effectiveness and experience and are above average on patient safety. However, we are below average on workforce and low performing on finance and access.
48. The finance position reflects the loss of deficit support funding at system level and the impact this has had on us.
49. More broadly, the data reinforces a consistent set of areas where we need to improve, particularly access to care, workforce experience and some aspects of patient safety.
50. This reflects both the pressure our services are under, and the experience people are having when accessing care which is presently longer than we are aiming for. Recovery planning is underway for these areas, and this is included elsewhere on the agenda.

Capital investment programme

51. We have continued to make good progress across our capital programme, with several significant developments now complete or moving forward. These investments are improving our estate and creating better environments for care, but they are only possible because services have continued to operate throughout.
52. In Emergency Department, theatres, OMFS and maternity in particular, colleagues have continued to deliver care in the middle of major building work. That has required flexibility, resilience and a willingness to adapt day-to-day, and it is important to recognise the impact that has had on teams as well as the difference it has made for patients.
53. We welcomed the Lord Lieutenant of Devon to formally open our redeveloped Emergency Department at Torbay Hospital in early June, following a £14.2 million investment. Delivered in phases to allow services to continue, the redevelopment has created a significantly improved environment for patients arriving in urgent need - with more space, better flow through the department, and greater privacy and dignity.
54. Colleagues have worked through a prolonged period of disruption to make this possible, often adapting to temporary layouts and changing pathways. The benefit of that is now visible in a calmer, more organised environment, where

patients can be assessed more quickly and teams can work more effectively together.

55. Work continues to refurbish and modernise our day theatre facilities, alongside the expansion of oral and maxillofacial surgery (OMFS). This is creating the capacity and environment needed to support more complex surgical work and reduce waiting times.
56. Alongside this, the planned relocation of the Surgical Admissions Unit will improve how patients move through planned care. Patients will experience a more straightforward journey ahead of surgery, with less unnecessary movement around the Torbay Hospital site, while teams are better able to manage flow through theatres.
57. As with the Emergency Department, this work is taking place while services remain fully operational. Theatre and surgical teams are managing significant change alongside maintaining activity, which has required careful coordination and sustained effort over a long period.
58. The refurbishment of our cardiac catheter laboratories remains a key clinical priority. These facilities are central to the diagnosis and treatment of heart disease, including in emergency situations.
59. Work is progressing to modernise these facilities so that they remain safe, reliable and able to meet growing demand. This is essential to ensuring we can continue to provide timely access to life-saving interventions for our population.
60. We are continuing to invest in our maternity services to improve the environment in which care is provided. Enhancements to maternity triage on level 4 of the women's health unit at Torbay Hospital are supporting women to be assessed more quickly and in the right setting when they arrive.
61. We have also refurbished our birthing pool, now to be known as *The Cove*, creating a more welcoming and calmer space for women choosing this option for their birth. A small ribbon cutting event is planned for early July to mark this investment and recognise the work of the maternity team.
62. As with other areas, these improvements have been delivered while services have continued to operate, and we are grateful to maternity colleagues for the way they have supported this alongside providing safe, compassionate care.
63. Alongside these developments, we continue to manage the well recognised risks associated with the Tower Block at Torbay Hospital which remains a significant focus for us.
64. The building is ageing and presents several well recognised infrastructure and compliance challenges. As with other areas of the site, colleagues are continuing to deliver care in this environment while we put in place measures to manage risk day to day.
65. Our priority is to ensure that we continue to provide safe care for patients while managing these risks. We have in place a comprehensive programme of

mitigation, including strengthened governance, enhanced monitoring, and a range of operational and estates actions to manage risk on a day-to-day basis.

66. This work is supported by ongoing engagement with external partners including the fire service, NHS England and regulators.
67. At the same time, we are progressing plans for a long-term solution. This includes development of a replacement inpatient ward block, which remains one of our highest capital priorities and is central to addressing the underlying risks associated with the current Tower Block.
68. This is a complex and challenging position, requiring us to carefully balance the management of immediate risks with the need to maintain services for local people while progressing a long-term solution.
69. The former Dartmouth Clinic site was sold at auction on 28 May 2026, following its closure in May 2023 when services moved to the new health and wellbeing centre in the town.
70. We remain committed to ensuring that assets no longer required for healthcare are used to best effect. The capital receipt from the sale will be reinvested into local services, helping to support improvements for patients and the longer-term sustainability of our estate.

Resident doctor industrial action

71. We undertook detailed planning in advance of the sixteenth round of industrial action by resident doctors, scheduled for 15–19 June. This included identifying activity that would need to be stood down to maintain safe services, with a particular focus on protecting urgent and emergency care.
72. When the industrial action was stood down at short notice, teams worked at pace to reinstate activity wherever it was safe and practical to do so. This included reviewing cancelled elective work, rebooking patients at the earliest opportunity and restoring planned services in a controlled way, recognising the operational constraints and the need to maintain patient safety.
73. Alongside this, there remains national uncertainty, with resident doctors currently voting on whether to accept the Government's latest offer on pay, training capacity and terms and conditions. The outcome of this ballot will determine whether the current dispute is resolved or whether further industrial action may follow.
74. In parallel, we have continued to focus on improving the working lives of resident doctors, aligned with the Government's 10-point plan.
75. Recent changes to exception reporting have provided a clearer and more reliable picture of working patterns. Reporting has increased significantly, reflecting improved confidence in the system, and highlighting recurrent pressures linked to rota gaps, workload and activity in a small number of high flow areas.
76. We are using this insight to focus on targeted service level action, including reviewing workload against planned rotas in identified hotspots, strengthening out-of-hours escalation and senior support, and monitoring the impact of wider

system changes on flow and workload. This represents a shift from responding to individual reports towards addressing the underlying drivers of pressure.

77. This builds on areas where the resident doctor experience is already strong, including flexibility in self-directed learning time, access to rest facilities through the Resident Doctor Mess, and consistently good supervision and team support. We have also strengthened wellbeing and pastoral support through departmental champions and more coordinated input from education teams.
78. Our next focus is on improving rota alignment with demand, strengthening out-of-hours support, and reducing variation in experience between services.

Electronic patient record update

79. Following our successful Epic electronic patient record go-live on 03 April 2026, teams have been working through the stabilisation period, building confidence with the system and putting into practice new digital ways of working. From mid-August, our Thrive training will begin, offering EPR users practical tips on further personalising Epic and optimising workflows so they can get the most value from the digital patient information now available at their fingertips. This will be delivered in collaboration across the One Devon EPR partnership, supporting shared learning and continuous improvement.
80. We have also been confirming super users to support the University Hospitals Plymouth (UHP) go-live on 23 July 2026. From this point, we will have a Devon-wide EPR in place across our organisation, UHP and the Royal Devon, marking a major milestone in our One Devon digital transformation. Having a single EPR system will mean that patients don't have to remember their medical history or repeat the same information to different members of staff, making their care journey more joined-up.
81. The MY CARE patient portal is proving extremely popular with patients, with over 24,000 sign-ups since launch. This places us among the top-performing Epic trusts for initial uptake and demonstrates strong patient appetite for digital access to their care. Later this summer, appointment integration between the NHS App and MY CARE will be introduced, further supporting patients to take a more active role in their healthcare across different NHS services.

Successes – our people and teams

Marking 100 years since the foundation stone was laid at Torbay Hospital

82. I recently joined colleagues, partners and community representatives to mark 100 years since the foundation stone of Torbay Hospital was laid.
83. The event was deliberately small and provided an opportunity to recognise the contribution of those who have shaped the hospital over generations. Long serving colleagues played a central role in the evening, including taking part in the planting of a commemorative magnolia tree and marking the occasion in a simple and meaningful way.
84. Those attending included governors and representatives from our volunteer organisations, including the Torbay Hospital League of Friends, Torbay Hospital Radio and the Torbay Hospital Nurses League, alongside wider health and care partners and community organisations.

85. The event reflected both the history of the hospital and the continued contribution of colleagues today. It also provides a point from which to look ahead, with early planning now underway for November 2028, when we will mark 100 years since the hospital first opened.

Celebrating 30 years of day surgery at Torbay Hospital

86. I recently joined colleagues, past and present, to mark 30 years of day surgery at Torbay Hospital.

87. This milestone is a testament to the sustained commitment of teams who have developed and grown the service over three decades. Day surgery has transformed how care is delivered for local people, enabling thousands of people each year to receive timely treatment and return home on the same day, improving experience and supporting recovery closer to home.

88. The event provided an opportunity to recognise the contribution of colleagues who have shaped the service over time and to reflect on the difference it continues to make for our communities today.

Official opening of our community frailty service (The Harbour)

89. I was pleased to join colleagues and partners to mark the official opening of The Harbour at Newton Abbot Hospital.

90. The Harbour began operating in autumn 2025 and has been developed in phases, with the formal opening recognising the expansion of the service and the difference it is now making for patients and our communities.

91. The service brings together a multidisciplinary team to support older people living with frailty, providing joined-up assessment, diagnostics and treatment. This includes same day emergency care (SDEC), alongside the Harbour at Home service, enabling patients to be assessed and treated quickly and, where possible, supported to remain in their own home.

92. Since opening, the service has received over 850 referrals, with more than half of patients supported to remain at home as a safe alternative to hospital admission.

93. The Harbour is a practical example of our strategy to support people to live well in their neighbourhoods. It brings care closer to home, strengthens how we respond to urgent need outside hospital, and enables teams to work together around the person in a more coordinated way.

94. This approach is improving patient experience and independence while also reducing avoidable hospital attendance and supporting better flow through our acute services.

Our people awards 2026

95. In May, I was delighted to co-host with our Chair our annual Our People Awards Celebration bringing together more than 200 of our people.

96. Alongside celebrating our internal award winners from throughout the year, we announced our annual our people award winners. Gabriel Moroti, a nurse on New Forrest Ward, received the Our People's Choice individual award for supporting someone during their first stay in hospital when they were feeling vulnerable.

George Earle Ward was announced as the Our People's Choice team winner for the compassion and dedication shown to a patient throughout their stay on the ward. Both winners were chosen by public vote and all finalists were nominated by patients, carers or families.

97. The People Partner Award was presented to Lancelet Support, recognising its intensive, compassionate and person-centred work with some of the most vulnerable and hardest-to-reach people in our communities.
98. Our Charity Champion Award was presented to Helen French, Admin Team Leader in the Breast Care Unit, for her fundraising in support of Torbay and South Devon NHS Charity.
99. Our first Volunteer of the Year Award was presented to Sam Mead, Way Finder and Transporter at Torbay Hospital, recognising his friendly, cheerful approach and the support he gives to patients, visitors and colleagues.
100. Our awards are an important part of how we recognise and reward our people. But this wouldn't be possible without the generous support of our corporate sponsors: Nevada Construction, Bailey Partnership, MW Benney, Stride Treglown Architecture, Services Design Solution, Hulley and Kirkwood Consulting Engineers, Arque Ltd, Multiverse and Peninsula Projects Consulting. Their support reflects the strength of our wider partnerships and their shared commitment to recognising the people who provide health and care across Torbay and South Devon.

Rapid response and reablement services in Torbay rated as good by the Care Quality Commission

95. Our rapid response and reablement services based at St Edmunds have recently been rated 'Good' by the Care Quality Commission (CQC) following inspection.
96. This is a positive outcome and reflects the quality of care being delivered by the team, particularly in supporting people to remain independent at home and return home quickly and safely after hospital admission.
97. The report did not identify any areas requiring urgent action, and colleagues are continuing to build on this strong foundation through ongoing improvement work.
98. St Edmunds plays an important role within our wider community services, particularly in providing short-term, responsive support for people when they are discharged from hospital or at risk of admission.
99. This rating provides assurance about the quality and effectiveness of these services and is a testament to the commitment and professionalism of the team.

Priority areas

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

101. In my report to Board in May, I set out the rationale for our investment in cellular pathology (histopathology) services at Gadeon House. This reflected the need to address significant estates safety risks associated with the current cellular pathology accommodation at Torbay Hospital, alongside a time limited opportunity to secure national capital funding.

102. Since that report, there has been increased external interest and media coverage, particularly in relation to arrangements between Torbay Council and Royal Devon University Healthcare NHS Foundation Trust. This has led to understandable questions from colleagues, governors, partners and the public about how those arrangements relate to our own plans and the wider context for estate development in Torbay.

103. Our position

Our investment in Gadeon House relates specifically to the future of our cellular pathology services.

We have secured £4.6m of ring-fenced NHS England capital funding to develop a new, purpose-built laboratory. This follows our own options appraisal which identified the need to address longstanding safety risks in the current accommodation.

This investment will enable us to carry out routine cellular pathology work in a modern, fit-for-purpose environment, improving safety for our colleagues and resilience for the service overall.

As part of this:

- there will be an interim step to relocate cytology activity to release space and address immediate safety risks on the Torbay site
- the full transition of routine cellular pathology services is expected over the next 12 to 18 months, subject to detailed design, planning and ongoing engagement
- arrangements for any urgent and time-critical cellular pathology work needed to support care at Torbay Hospital will be built into the final operational model

Cellular pathology is a clinical support service rather than a patient-facing service. These changes are therefore about how we provide safe, sustainable laboratory facilities and diagnostic support, rather than changing where patients receive care.

104. What this means for patients

There are no changes to where patients receive care.

We know people may be concerned about whether changes to cellular pathology could affect urgent and emergency care or cancer pathways at Torbay Hospital. These arrangements are being designed to ensure that patients continue to receive safe and timely care.

Cellular pathology does not directly support emergency department care in the same way as services such as blood tests. Most cellular pathology work supports diagnosis and treatment decisions over several days, including for cancer pathways and national standards are based on these timeframes

Where cellular pathology results are needed more quickly to support clinical decisions - for example during surgery, or as part of specific cancer pathways -

arrangements will be in place to ensure this can continue to happen safely and within the required timeframe.

This means that urgent and time-critical cellular pathology work needed to support care at Torbay Hospital will continue to be provided through clear and agreed processes, including through the acute service laboratory on the Torbay site where this is clinically required.

These changes are about improving how we provide laboratory services, not about moving patient care away from Torbay.

105. Our pathology colleagues

We know this has been a difficult and uncertain period for colleagues working in pathology services and we want to be clear that they are central to shaping what happens next.

We are continuing to engage directly with our cellular pathology teams, including regular briefings and opportunities to ask questions and raise concerns.

Colleagues are also closely involved in the design, fit-out and day-to-day planning of the new laboratory at Gadeon House, helping to make sure the service is safe, practical and works well for both colleagues and patients.

This work will continue as we move through the next phase of detailed planning and implementation, and we will continue to provide updates as plans develop.

106. Clarifying arrangements at Gadeon House

There are separate arrangements within Gadeon House which it is important to distinguish clearly:

- we have entered into our own lease with Torbay Council to support our cellular pathology services
- Royal Devon University Healthcare NHS Foundation Trust has a separate lease arrangement and plans to move a number of its pathology services into the building

These arrangements are co-located but contractually and financially independent and some of the external commentary has not fully reflected that distinction.

107. Peninsula Pathology Network

Alongside our local plans, work continues across the Peninsula Pathology Network to consider the longer-term sustainability of pathology services.

It has not been possible to agree a single peninsula wide model and further work is required to develop a clinically safe, sustainable and deliverable approach including:

- The target operating model
- financial assumptions and proposed savings
- governance arrangements.

Clinical colleagues in cellular pathology, microbiology and blood sciences are working together across the network to understand demand, share expertise and

consider future options. This work is at an early stage and no decisions have been taken.

Our Board has been clear that it will only support any future model where:

- patient safety and quality come first
- the model is clinically credible and deliverable
- financial assumptions are transparent and robust

This position does not change our commitment to the development of cellular pathology at Gadeon House, which addresses significant estates safety risks associated with the current cellular pathology accommodation at Torbay Hospital.

108. Wider context and stakeholder communication

We have provided a statement to Torbay Council and wider stakeholders to support the understanding of these arrangements and the broader context.

This sets out clearly that:

- the current cellular pathology facilities at Torbay Hospital present significant safety risks which cannot be sustained over the longer term
- the development of Gadeon House provides a practical, deliverable solution, enabled by time limited national capital funding
- urgent and time critical pathology services will continue to be delivered locally from Torbay Hospital, through the Acute Services Laboratory.

The statement also sets this alongside our wider estate approach, including our purchase of the site at Edginswell from Torbay Council:

- in the short term, the use of Edginswell provides additional capacity off the main hospital site, including opportunities to increase staff parking and improve access for patients and visitors
- in the longer term, and subject to planning, it provides potential to accommodate support services and future facilities, helping to release space on the main hospital site for redevelopment over time.

Taken together, these actions reflect a coordinated and practical approach to addressing immediate estate risks while supporting the longer-term development of Torbay Hospital and its infrastructure

109. We recognise that pathology services are fundamental to patient care, and that these changes raise important questions. We will continue to keep Board updated as this work progresses, including as further detail is developed through both our local implementation and the wider Peninsula Pathology Network.

110. Our focus

Our priority is to ensure that cellular pathology services are safe, reliable and sustainable for the future, while continuing to support high-quality care for our communities locally.

We will continue to keep patients, colleagues and the wider community informed as this work progresses.

Investing in our future – robotic surgery

111. We have taken the decision to invest £1.3 million in robotic surgery at Torbay Hospital, following a six-month clinical pilot which enabled our teams to evaluate the technology in practice before any commitment to purchase.
112. During this pilot, our surgical teams achieved a number of significant milestones, including what is believed to be the world's first robotic day case colectomy (bowel cancer removal), with the patient able to return home on the same day.
113. The team has since delivered further milestones, including what is understood to be the UK's first day case high anterior resection, as well as the first day case intra-thoracic stomach repair in the South West demonstrating how more complex procedures can be delivered safely without an overnight stay.
114. This investment will enable more people to benefit from minimally invasive surgery closer to home, with the potential for reduced post-operative pain, shorter recovery times and a quicker return to normal activities. It also supports the continued development of day surgery, allowing an increasing range of procedures to be undertaken safely as day cases.
115. The decision to invest has been supported by a £500,000 contribution from Torbay Hospital League of Friends, reflecting their long-standing commitment to improving care for local people.
116. This represents an important step in the ongoing development of our surgical services, building on 30 years of day surgery at Torbay and ensuring that patients continue to benefit from advances in clinical practice and technology.

Corridor Care action plan

117. Corridor care remains a significant challenge both locally and nationally. It represents care being delivered in environments that are not designed for patients and does not meet the standards of dignity, safety and experience that we expect.
118. The underlying causes are complex and sit across the whole health and care system, including sustained demand, high bed occupancy and delays in patient flow. These pressures mean that at times we are delivering care in ways that we would not wish to normalise.
119. In June, we brought together colleagues from across our services for a focused Eliminating Corridor Care event. The purpose of the day was not only to review performance and data, but to deepen our understanding of the real experience of patients and colleagues and to strengthen a shared, organisation-wide response.
120. Importantly, this work was informed by 'Go See' visits carried out in advance of the event, where colleagues went to the point of care to observe, listen and understand first-hand the realities of delivering care in these environments.

121. These insights, alongside patient and staff stories, reinforced the impact of corridor care on dignity, privacy and safety, as well as on the experience of colleagues working in these conditions.
122. A clear and consistent message from colleagues was that corridor care should not be accepted as 'business as usual'. This has been reflected in a set of personal pledges made by attendees, focused on maintaining zero tolerance for corridor care, putting patient experience at the centre of decision-making, and supporting teams to take practical action and challenge where needed.
123. Alongside this, the event has acted as a catalyst for immediate improvement activity. Twenty-six teams have already registered to undertake focused, locally-led improvement projects, supported by the Improvement and Innovation team. These projects are designed as practical tests of change within teams' control, recognising that sustainable improvement will require both system-wide action and local ownership.
124. This work marks the start of a more structured programme to reduce and eliminate corridor care, aligned to our wider improvement priorities around patient flow, discharge and the delivery of care in the right place. Further detail on priorities, measures and delivery arrangements will be brought back to Board as this work develops.

Adult Social Care in Torbay

125. Work continues to support the safe and effective transition of Adult Social Care services back to Torbay Council, following notice being served on the current Section 75 partnership arrangements.
126. This is a significant programme of work for both organisations. Our priority is to ensure continuity of care for people who use our services, and to support colleagues through the transition, while maintaining safe and effective delivery.
127. Progress has been made in strengthening programme governance and developing a more detailed delivery plan, working closely with Torbay Council. This includes further work to clarify the scope of services to transfer and to ensure that the practical arrangements for workforce, services and contracts are well understood.
128. There are a number of risks and dependencies associated with a change of this scale, including workforce, financial and estate considerations. These are being actively managed through joint arrangements with the Council and through our internal governance processes.
129. A more detailed paper is being considered in private session, reflecting the complexity and sensitivity of this work.

Maternity services

130. We welcome the recent publication of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (Ockenden Report) and Amos Review and would like to recognise the experiences of the women, babies and families who contributed to it across England. It is right that these experiences are listened to and acted upon.

131. The safety, wellbeing and experience of women, birthing people and babies is our absolute priority for our maternity services and a key priority for our organisation. Most births in our care are safe, and our teams work with professionalism, compassion and dedication every day.

132. We are working closely with our colleagues, Devon's Maternity and Neonatal Voices Partnership and our partners at NHS England and NHS Devon to continually review and improve our maternity and neonatal services, and people's experiences of them.

133. Following the regional insights visit on 11 June, it was acknowledged that our maternity and neonatal services are working collaboratively, and that it was clear we are listening to both our service users and our staff.

134. We will carefully review the findings and recommendations of these reports and, where needed, take further action to strengthen the care we provide.

135. We would encourage any family who has concerns about their care to come forward so we can listen, support them and learn.

Commitment to our Armed Forces community

136. I recently had the opportunity to formally re-sign the Armed Forces Covenant on behalf of our organisation, reaffirming our commitment to those who serve or have served in the Armed Forces, and their families.

137. This recognises the important role that Armed Forces personnel, veterans and reservists play in our communities and our responsibility as a local employer and provider of health and care services to ensure they are treated fairly and are not disadvantaged in accessing employment or care.

138. The Covenant also reflects the contribution made by colleagues within our organisation who have links to the Armed Forces, including those currently serving as reservists.

139. I would like to recognise the role of our Armed Forces Community Staff Network in supporting colleagues, raising awareness and helping to shape how we continue to develop this work.

140. Through this commitment, we will continue to strengthen the support we offer as an employer, including promoting flexible working where appropriate and recognising the specific needs of this group.

141. Re-signing the Covenant builds on the work already underway across our organisation and with system partners and reinforces our ongoing commitment to supporting Armed Forces communities across Torbay and South Devon.

National, regional and local issues and topics of interest

Working in partnership with our Leagues of Friends

142. I would like to recognise the continued and significant contribution of Torbay Hospital League of Friends, who donated more than £1.58 million to the hospital between April 2025 and March 2026, excluding their recent commitment to support investment in robotic surgery.

143. This level of support reflects a longstanding and valued partnership, with funding enabling a wide range of improvements to services and facilities, supporting both patient experience and the working environment for colleagues.
144. We are also supported by a further seven Leagues of Friends across our community hospitals and services (Ashburton, Brixham, Dawlish, Newton Abbot, Paignton, Teignmouth and Totnes). Collectively, these organisations make an important contribution in different ways - through funding, volunteering and direct support to teams and patients - helping to enhance care across Torbay and South Devon.
145. We greatly value the combined support of all our Leagues of Friends. Their ongoing contribution plays an important role in enabling us to continue to care for our people and our communities.

Working in partnership with Torquay Rotary Club

146. I would like to recognise the ongoing support of Torquay Rotary Club and the difference this partnership continues to make for our colleagues and patients.
147. Working alongside our Torbay and South Devon NHS Charity, Torquay Rotary is supporting one of our colleagues to take part in the Rotary Youth Leadership Awards (RYLA) programme, providing an opportunity to develop leadership skills and confidence.
148. In addition, Torquay Rotary Club has donated £1,000 to our Charity to support the purchase of equipment aimed at reducing deconditioning for patients on our inpatient wards, helping people to maintain strength, mobility and independence during their stay in hospital.
149. They have also continued to provide practical support for the Heartsease Garden (our baby loss garden) at Torbay Hospital, enhancing and maintaining this very special place.
150. Together, these contributions reflect a valued partnership with our local communities, supporting both the development of our people and improving the experience of care for patients and families.

Nursing and Midwifery Council (NMC) registration and revalidation process

151. The NMC has informed us of the discovery of an historical issue within its registration and revalidation process.
152. For a nursing or midwifery professional to join or remain on the NMC register, they must declare any health or character issues that may affect their ability to practise safely and effectively. Declarations are first considered by a specialist NMC team, and all cases of concern should be referred to an Assistant Registrar – an internal post-holder – for a decision.
153. All declarations are assessed on a case-by-case basis.
154. Following the publication of 2024's Independent Culture Review, a change in its board and executive leadership and the implementation of a three-year transformation plan, concerns were raised about the NMC's historical failure to follow its processes for investigating health and character concerns. This

included not consistently referring registration and revalidation applications which included health and character declarations to an Assistant Registrar.

155. The NMC has undertaken a rapid review of 18,060 registration and revalidation applications during a 12-year period to determine whether the correct process was followed in each case. The review determined that no further action was required in 17,639 cases (98%).
156. The NMC has also undertaken risk assessments to establish if it should restrict a professional's practice through an Interim Order. At this stage, it has not been deemed necessary to seek any Interim Orders, however risk assessments are kept under close review.
157. The NMC has now contacted 421 nursing and midwifery professionals who need to provide further information prior to a decision being made by an Assistant Registrar. They will be given information about what this means for them and what information they need to provide. They will also be told to inform their employer.
158. The NMC has explicitly advised employers not to take action solely because an employee may be within the affected cohort until its review has concluded, which could take up to six months. Where employer information is required, the NMC will seek it directly after obtaining employment details from the registrant. This means the Trust does not need to initiate a retrospective review or local action at this stage. However, we should be prepared to respond promptly to any NMC enquiries and to support affected staff in a fair, compassionate and proportionate way.
159. Any related enquiries will be routed through an agreed senior lead, and coordinate any case-specific response with workforce, HR, legal and relevant professional leadership teams. Communications should reinforce that this is a historic NMC process issue rather than evidence of wrongdoing by staff, while recognising that affected employees may feel anxious and require support.
160. We will offer wellbeing support to any of our nurses who have been affected and Board will be kept informed of any developments

Local media update

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

Key media releases and responses

[Marking 30 years of day surgery at Torbay Hospital with significant investment in robotic technology](#)

[Marking 100 years since the foundation stone was laid for Torbay Hospital](#)

[Reaffirming our commitment to our Armed Forces community](#)

[New community service is helping people to remain independent and avoid a hospital admission](#)

[Sam Wadham-Sharpe appointed as substantive Chief Operating Officer](#)

[Former Dartmouth Clinic sale confirmed](#)

[Community event to support people who are living with cancer](#)

[Rapid response and reablement services in Torbay rated Good across all areas](#)

[Lucie faces her fear of needles to champion blood donation](#)

[£14.2m Emergency Department redevelopment opens at Torbay Hospital](#)

[Torbay Hospital League of Friends continues to support local care with £1.58 million donated in 12 months](#)

[Celebrating our peoples kindness and compassion](#)

[Torbay surgical hub gains national accreditation](#)

[Jess Piper appointed as substantive Chief People Officer](#)

Coverage

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

Appendix 1: Proposal: rotating Board meetings in public across our neighbourhoods

Purpose

To strengthen our connection with the communities we serve by rotating Board meetings in public across our neighbourhoods - improving visibility, accessibility and local engagement.

This approach complements plans to rotate the Annual Members' Meeting (AMM) across the same neighbourhoods, creating a consistent and recognisable model for community-facing governance.

Recommendation

Agree to a 12-month pilot to rotate Board meetings in public across our neighbourhoods.

Proposed approach

We currently hold six Board meetings in public each year. Under this proposal these would rotate across our five neighbourhoods (Coastal (Dawlish and Teignmouth), Moor to Sea (Ashburton, Dartmouth and Totnes), Newton Abbot, Paignton and Brixham and Torquay)

Proposed venues (subject to suitability checks):

- Coastal – Lower ground floor meeting room, Dawlish Hospital
- Paignton and Brixham – Oyster Meeting Room, Kings Ash House
- Moor to Sea – Ashburton health and wellbeing centre meeting room or first floor room in Dartmouth health and wellbeing centre
- Newton Abbot area – Meeting room hire at Newton Abbot Library or similar site
- Torquay – Union House, Torquay or Torbay Hospital

Venues would be agreed annually, providing a predictable and visible presence across our geography.

Approach to attendance and engagement

In-person attendance will be focused on those formally involved in the meeting, including Board members, governors and invited presenters.

This reflects the role of governors as part of the formal governance of our organisation, while maintaining open and transparent public Board meetings.

Public observation will be supported through a digital-first approach. Board meetings in public will not routinely accommodate general public attendance in person.

Instead, they will continue to be accessible online.

Meetings are already shared via an MS Teams link, and this will continue as an initial approach. We will also work with the Digital Horizons team to improve the quality, consistency and reliability of online access across venues, including exploring secure livestreaming options where appropriate.

Since March 2026, we have also introduced a more proactive approach to public questions, inviting queries in advance through social media and local media channels.

This will continue alongside the proposed changes, with questions considered within the meeting and full responses published where appropriate.

This approach balances local visibility - through the Board meeting in different neighbourhoods - with consistent and accessible public observation across our geography.

Added value when hosting on our sites

Where meetings are held on NHS sites, there is an opportunity to increase visibility and connection with colleagues by:

- encouraging Board members to walk the site ahead of meetings
- providing opportunities to meet local teams and services
- aligning patient stories and agenda items with local priorities or areas of focus.

This supports a more visible and connected Board, strengthening understanding of services, pressures and opportunities across our neighbourhoods.

Key considerations

Accessibility and inclusion

- step-free access, lifts (where applicable) and accessible toilets
- public transport links and clear travel guidance
- hearing loop / accessibility support where required

Parking and travel

- availability of local parking, including blue badge spaces
- minimising impact on operational services
- clear guidance issued in advance
- coordination of travel and timing for Board members and presenters

Digital and AV requirements

- reliable WiFi and hybrid capability
- screens/projectors and sound quality suitable for Board meetings
- AV capability to support consistent online access
- exploration of appropriate livestreaming options
- a standard technical checklist for all venues

Space and layout

- capacity for Board, officers, governors and invited participants
- layout that supports visibility and effective discussion
- ability to manage Board meeting in private before/after Board meeting in public

Operational delivery

- annual forward plan of venues
- corporate governance support for logistics
- consistent approach to papers, timing and conduct of meetings
- arrangements for refreshments and breaks appropriate to each venue

Cost and value for money

- maximise use of NHS estate
- limited external hire (e.g. Newton Abbot Library) within modest budget
- overall cost expected to be low and manageable

Benefits

- improves visibility of Board meetings across our geography
- strengthens transparency and trust with local communities
- creates a regular, predictable presence in each neighbourhood
- supports wider ambitions around community voice and engagement
- complements rotation of the Annual Members' Meeting which starts this September

Risks and mitigations

Risk	Mitigation
Variable AV / online experience	Standard technical checklist and site testing in advance
Risk of disruption to online meetings	Explore secure livestreaming options
Increased logistical complexity	Six meetings in public per year; plan venues well in advance
Accessibility constraints at some venues	Only approve venues meeting minimum standards
Cost pressures	Prioritise NHS sites; tightly manage external hire
Risk of drift from formal Board purpose	Maintain consistent structure and expectations
Risk of disruption at physical venues	Appropriate venue selection and on-site arrangements

Next steps

If approved we would aim to begin the rotation in November 2026 (following the Annual Members' Meeting (AMM) community health event in September) and:

- confirm approved venue list following basic suitability checks
- work with Digital Horizons team to agree AV requirements and digital delivery model
- develop a simple operational checklist (access, AV, layout, comms)
- build venues into the annual Board calendar
- review after the first 12 months, alongside AMM rotation

Board of Directors

Board Assurance Framework and Corporate Risk Register

Date of meeting	Date report produced
2 July 2026	24 June 2026

Author(s)		Report approved by	
Name and title:	Cath Parnell Chief of Staff	Name and title:	Cath Parnell Chief of Staff
		Date:	24 June 2026

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

n/a

Executive summary

The Board Assurance Framework (BAF) is the key source of evidence to the Board that the Trust's strategic objectives are being delivered, as well as analysing the risks, controls and assurances affecting each objective.

In April 2026 Board approved a new BAF framework with 10 domains designed to ensure oversight of risks to the delivery of the Trust Strategy and the Trusts highest strategic risks.

The BAF development work is now entering its second monthly cycle, using an iterative approach with the Executive and Board Sub Committees, to strengthen the process, improve the quality of narrative, and support more timely review ahead of formal reporting to Board.

The first cycle identified issues with the timing and flow of BAF review, therefore this cycle will focus on earlier Executive engagement to ensure updates are reviewed and refined in good time, along with reviewing the constructive feedback received from the Committee on ways to develop seamless integration with the workplans, agendas and report alignment.

The following table highlights the changes to the BAF between May 2026 and June 2026

BAF Domain	Change
Quality, Safety, Clinical Outcomes and Patient Experience	No Changes from May 2026
People and Culture	Narrative updated to include broader controls and assurance added (CIP, workforce controls, temp staffing, staff voice, EDI, sexual safety, violence/aggression, leadership development) C3, C4 and C6 assurance ratings reduced from Satisfactory to Partial.
Health Inequalities and Population Health	No changes
Partnership and System	Risk appetite changed from Moderate to High, with tolerance increasing from >12 to >20 as agreed by at Board Development
Organisational Transition	Risk appetite changed from High to Moderate as agreed by at Board Development
Digital and Data	Addition of a new AI governance control rated Limited, signalling a newly recognised risk area.
Performance	New content on elective recovery, RTT oversight, corridor care, winter planning, cancer recovery, and ICB contractual impacts C3 assurance rating worsened from Partial to Limited.
Finance	New references to severe capital constraint, backlog pressure, estates risk, and need for central capital support.
Leadership and Governance	No Changes
Strategy and Business	** risk materially expanded to include tower fire safety : this includes: • new control for tower fire safety management • new major gap in control and assurance on lack of embedded fire safety arrangements • new actions including oversight group, programme, risk register, summit, and external agency engagement.

The work on transferring the Trusts risks onto the new DCIQ platform continues and is on track as per the agreed project timelines. As part of this work the Corporate Risk Register (CRR) has completed its initial development cycle, confirming that the principal corporate risks are broadly correct and aligned to the BAF. Further work is now required to improve definitions, strengthen commentary and ensure clear Executive ownership of the narrative and review process which will form the basis on the first full implementation cycle during July 2026.

The draft working version of the new CRR is provided as Appendix 2 for information.

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
Board Assurance Framework	Satisfactory	No Change
Draft Corporate Risk Register	Satisfactory	

Appendices

Appendix 1 - Board Assurance Framework
Appendix 2 - Draft Corporate Risk Register

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

Executive Committee
Quality and People Committee
Finance and Operations Committee

Key recommendations and actions requested

To receive and note the Board Assurance Framework and Draft Corporate Risk Register, 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
All BAF objectives	Yes

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



Torbay and South Devon
NHS Foundation Trust

Board Assurance Framework

2026/2027

June 2026v2

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:

1–3 Very Low

4–6 Low

8–12 Moderate

15–25 High

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 appetite levels applied to each risk category, using NPSA-aligned scoring bands

<i>Appetite</i>	<i>NPSA Band</i>	<i>Possible Scores</i>	<i>Tolerance</i>	<i>What this means in practice</i>
Very Low	1–3	1, 2, 3	>3	<i>The Trust will take all reasonable steps to eliminate or mitigate these risks. Any residual risk above the threshold requires Board visibility.</i>
Low	4–6	4, 5, 6	>6	<i>Preference for safe delivery options with low degree of inherent risk. Risks are actively managed and must be escalated where controls are insufficient.</i>
Moderate	8–12	8, 9, 10, 12	>12	<i>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.</i>
High	15–25	15, 16, 20, 25	>20	<i>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.</i>

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.

Board Assurance Framework – Summary of Principle Risks

Signature Move	BAF Domain/ Principal Risk	Overarching Risk Wording	Committee	Director Lead
Reimagining acute and specialist care	Quality, Safety, Clinical Outcomes and Patient Experience	There is a risk that the Trust is unable to consistently deliver safe, high quality care with good clinical outcomes due to sustained workforce pressures, demand and capacity constraints, and estates limitations and despite established governance and safety controls, gaps in capacity, patient flow and triangulated assurance increase the risk of patient harm and poor experience, avoidable morbidity and mortality, and potential regulatory and reputational impact	QPC	Chief Nursing Officer / Chief Medical Officer
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, resulting in increased temporary staffing, staff burnout, reduced quality of care and inability to deliver transformation.	QPC	Chief People Officer
Living well in neighbourhoods	Health Inequalities and Population Health	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	There is a risk that the Trust fails to develop effective partnerships within the ICS and with local authorities	Board	Chief Executive
Smart use of technology	Digital and Data	There is a risk that digital infrastructure is insufficient to support transformation and is vulnerable to cyber threats	FOC	Chief Strategy and Planning Officer
Foundation	Finance	There is a risk the Trust does not achieve financial sustainability given the underlying deficit of c.£100m	FOC	Chief Finance Officer
Foundation	Performance	There is a risk the Trust does not meet constitutional standards for access, waiting times and quality	FOC	Chief Operating Officer
Foundation	Leadership and Governance	There is a risk the Trust does not maintain compliance with statutory and regulatory requirements	ARC	Chief Executive – Delegated to Chief of Staff
Foundation	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 There is a risk that the Trust is unable to maintain safe, compliant and sustainable services within the Tower estate due to significant fire safety and infrastructure risks, resulting in potential harm to patients, staff and visitors, service disruption, regulatory enforcement, urgent decant requirements, and material financial and reputational impact.	Board	Chief Strategy and Planning Officer
Foundation	Organisational Transition	There is a risk that the transition of Section 75 services impacts on service continuity and quality	Board	Chief Executive

Board Assurance Framework 2026/2027

Signature Move: Reimagining acute and specialist care			Ref:	BAF-QS	
BAF Domain: Quality, Safety, Clinical Outcomes and Patient Experience			Appetite:	Very Low	
Executive Lead: Chief Nurse / Medical Director		Committee: Quality and People Committee		Tolerance:	>3
Initial Score: 4x4=16	Current Score: 3x4 =12	Target Score: 2x4= 8		Linked risks: BAF-WF (workforce), BAF-FN (finance), BAF-PF (performance)	
Risk: There is a risk that the Trust is unable to consistently deliver safe, high quality care with good clinical outcomes due to sustained workforce pressures, demand and capacity constraints, and estates limitations and despite established governance and safety controls, gaps in capacity, patient flow and triangulated assurance increase the risk of patient harm and poor experience, avoidable morbidity and mortality, and potential regulatory and reputational impact.					

Ref	Key Controls	Assurance Summary	Rating
C1	Clinical governance framework incl. QPC oversight, clinical audit programme and mortality reviews (SHMI, HSMR) providing structured oversight	QPC reports to Board; national clinical audit results; mortality dashboard; SHMI/HSMR trends. Ward to Board triangulation, thematic deep dives,	Satisfactory
C2	Patient Safety Incident Response Framework (PSIRF) and incident reporting systems supporting identification, investigation and learning.	PSIRF annual plan delivery; incident data and trend analysis reported to QPC	Satisfactory
C3	Clinical outcomes checking incl. GIRFT, NCEPOD, specialty-level outcome data and clinical effectiveness programme to track performance	GIRFT action plans and progress; NCEPOD recommendation tracking; clinical outcome KPIs by specialty reported to QPC, peer reviews, accreditation status	Partial
C4	Safe staffing including establishment reviews and escalation processes to manage workforce pressures	Monthly safe staffing reports to Board; NQB red flag reporting	Partial
C5	Infection prevention and control programme incl. HCAI surveillance to minimize avoidable harm	IPC annual report; mandatory surveillance data; IPC Committee oversight	Satisfactory
C6	CQC registration, self-assessment against fundamental standards and patient experience programme to monitor patient experience	CQC inspection reports; FFT results; complaints and PALS trends; national patient survey results	Partial

Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Specialty outcomes are not routinely triangulated at committee level	Implement specialty outcomes dashboard linking mortality, harm, complaints and staffing	Chief Medical Officer	Q2 26/27
GC	Vacancies and temporary staffing continue to create safety risk in key services	Accelerate recruitment and retention for high-risk services and strengthen escalation triggers	Chief People Officer	Q2 26/27
GC	Ageing estate and equipment continue to constrain safe care delivery	Prioritise critical backlog, equipment replacement and risk-based capital mitigation	Director of Estates and Facilities	Q3 26/27
GA	Limited independent assurance over the impact of operational pressures on quality, safety, and patient experience	Introduce peak demand quality impact review with escalation triggers, daily triangulated dashboards and independent committee oversight.	Chief Nursing Officer	Q1 26/27

Board Assurance Framework 2026/2027

Signature Move: Caring, skilled people ready for tomorrow			Ref:	BAF-WF
BAF Domain: People and Culture			Appetite:	Moderate
Executive Lead: Chief People Officer		Committee: Quality and People Committee	Tolerance:	>12
Initial Score: 4x4=16	Current Score: 4x4 =16	Target Score: 3x4= 12	Linked risks: BAF-QS (quality), BAF-FN (finance), BAF-ST (strategy)	
Risk: There is a risk the Trust cannot recruit, retain and develop the workforce needed to deliver safe and effective services, resulting in increased temporary staffing, staff burnout, reduced quality of care and inability to deliver transformation.				
Ref	Key Controls	Assurance Summary		Rating
C1	Workforce strategy and annual workforce plan aligned to operating plan, including workforce CIP delivery	Workforce KPI dashboard to QPC and Board (vacancies, turnover, sickness, agency), staff survey, CIRG dashboard, workforce controls, temp staffing usage, WTE reductions against plan		Partial
C2	Recruitment and supply routes including apprenticeship pipeline	Monthly recruitment tracker; time-to-hire metrics; , apprenticeship levy, NHSE contract delivery, placement numbers, NETs survey, Quality panels		Partial
C3	Staff health and wellbeing programmes and occupational health services	Staff survey results; sickness absence data; wellbeing programme uptake, sickness and absence data, ER data		Partial
C4	Continued professional development (CPD) including education, training and professional development, leadership and management development	CPD reports (NHSE & Trust) , Mandatory and essential training compliance; CPD apprenticeship levy, NETs, attendance records, feedback from learning, TNA's, skills gap analysis		Partial
C5	Restorative, Just and Learning Culture plan, and strategies to address equality, diversity and inclusion, sexual safety, violence and aggression	CIRG dashboard, WRES/WDES data; staff survey results and action plans, EDI Committee reports, incident data, staff network engagement and feedback, ER data		Partial
C6	Staff engagement and staff voice	CIRG, staff survey, FTSU, trade union feedback, staff networks, listening and feedback mechanisms		Partial
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Workforce strategy requires refresh to align to Trust strategy and signature moves	Develop new People Strategy aligned to Trust strategy	Chief People Officer	Q2 26/27
GC	Persistent vacancies in nursing, medical and AHP workforce groups	Expand recruitment pipeline; grow-your-own; advanced practice expansion	Chief People Officer	Ongoing
GA	Limited real-time workforce data to support operational decision-making	Implement integrated workforce dashboard linked to ESR, SafeCare and rostering	Chief People Officer	Q3 26/27

Board Assurance Framework 2026/2027

Signature Move: Living well in our neighbourhoods			Ref:	BAF-HI	
BAF Domain: Health Inequalities and Population Health			Appetite:	Moderate	
Executive Lead: Chief Strategy and Planning Officer		Committee: Quality and People Committee		Tolerance:	>12
Initial Score: 4x4=16	Current Score: 3x4 =12	Target Score: 3x3= 9	Linked risks: BAF-PS (partnership), BAF-ST (strategy), BAF-QS (quality)		
Risk: There is a risk that the Trust's plans do not sufficiently address health inequalities across its population, resulting in widening gaps in outcomes, failure to meet Core20PLUS5 requirements and poor population health management.					
Ref	Key Controls	Assurance Summary			Rating
C1	Population health management approach embedded in neighbourhood planning	PHM data packs per neighbourhood; Core20PLUS5 performance monitoring			Partial
C2	Joint Strategic Needs Assessment informing commissioning and service design	Annual JSNA refresh; Health and Wellbeing Board reports			Satisfactory
C3	Neighbourhood health and care team development programme	Neighbourhood model milestones; community engagement feedback			Limited
C4	Prevention and early intervention service programmes	Screening uptake; immunisation coverage; smoking cessation referrals			Partial
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required		Owner	Target
GC	Neighbourhood model not yet fully operational — development in early stages	Develop and implement neighbourhood team operating model across all localities		Chief Strategy and Planning Officer	Q3 26/27
GC	Limited PHM analytical capability at neighbourhood level	Build PHM data infrastructure and analytical capacity with ICS partners		Chief Strategy and Planning Officer	Q4 26/27
GA	Outcome data for prevention programmes not yet routinely collected	Develop outcomes framework for prevention and early intervention services		Chief Strategy and Planning Officer	Q4 26/27

Board Assurance Framework 2026/2027

Signature Move: Joined-up care, every step of the way			Ref:	BAF-PS
BAF Domain: Partnership and System			Appetite:	High
Executive Lead: Chief Executive Officer		Committee: Board (direct oversight)	Tolerance:	>20
Initial Score: 4x4=16	Current Score: 3x4 =12	Target Score: 2x4= 8	Linked risks: BAF-HI (health inequalities), BAF-OT (transition), BAF-ST (strategy)	
Risk: There is a risk that the Trust fails to develop effective partnerships within the ICS and with local authorities, resulting in fragmented care pathways, failure to deliver integrated care and inability to influence system decisions.				
Ref	Key Controls	Assurance Summary		Rating
C1	Active Trust participation in Devon, Cornwall and IoS ICS governance structures	Board reporting on ICS decisions and impact; CEO report to Board		Satisfactory
C2	Joint working with Torbay Council through Section 75 agreement	S75 partnership board minutes; integrated performance reporting		Satisfactory
C3	Provider collaborative participation and mutual aid arrangements	Provider collaborative board reports; peer review outcomes		Partial
C4	Place-based partnership governance with LA and VCSE sector	Place partnership board reports; community engagement outputs		Partial

Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	ICS governance structures still evolving post-cluster — TSDFT influence uncertain	Proactive engagement in ICS design; secure representation in key forums. TSD Board sign off of new governance structures.	Chief Executive	Q1 26/27
GC	Provider collaborative arrangements not yet fully mature	Strengthen provider collaborative governance and joint working protocols. New arrangements being established across the ICB for transformation need to be embedded.	Chief Operating Officer Chief Medical Officer / Chief Nursing Officer	Q2 26/27
GA	No formal mechanism for assessing partnership effectiveness	Develop partnership effectiveness framework and annual review cycle	Chief Strategy and Planning Officer	Q3 26/27

Board Assurance Framework 2026/2027

Signature Move: Smart use of technology for better care			Ref:	BAF-DD			
BAF Domain: Digital and Data (System-aligned)			Appetite:	Low			
Executive Lead: Chief Strategy and Planning Officer		Committee: Finance and Operations Committee		Tolerance:	>5		
Initial Score: 5x4=20		Current Score: 4x4 =16		Target Score: 3x4= 12		Linked risks: BAF-QS (quality), BAF-ST (strategy), BAF-LG (governance)	
Risk: There is a risk that digital infrastructure is insufficient to support transformation and is vulnerable to cyber threats, resulting in service disruption, data breaches, failure to deliver digital-enabled care and DSPT non-compliance.							
Ref	Key Controls		Assurance Summary			Rating	
C1	Cyber security strategy with monitoring, patching and incident response plan		Cyber KPI dashboard; penetration testing; CareCERT compliance			Partial	
C2	Data Security and Protection Toolkit (DSPT) compliance programme		Annual DSPT submission; internal audit of DSPT assertions			Satisfactory	
C3	Digital strategy and investment prioritisation aligned to Trust strategy		Digital programme board reports; benefits realisation tracking			Partial	
C4	Information governance framework incl. DPO, SIRO and Caldicott Guardian		IG Committee reports; DSAR compliance; data breach data			Satisfactory	
C5	Business continuity plans for critical digital systems incl. disaster recovery		BCP testing outcomes; DR testing schedule and results			Limited	
C6	Established a control framework for the safe, lawful and ethical use of artificial intelligence (AI)		Approved Trust policy, Defined governance and documentation, Committee papers			Limited	
Type	Gaps in Control (GC) / Gaps in Assurance (GA)		Actions Required		Owner		Target
GC	Legacy systems and technical debt creating cyber vulnerability		Infrastructure modernisation programme; legacy system replacement roadmap		Chief Strategy and Planning Officer		26/27 onwards
GC	Disaster recovery capability not yet tested to required standard		Implement and test DR for all critical clinical systems		Chief Strategy and Planning Officer		Q2 26/27
GA	Board-level digital literacy and cyber risk awareness needs strengthening		Annual Board cyber awareness session; NED digital champion		Chief Strategy and Planning Officer		Q1 26/27

Board Assurance Framework 2026/2027

Signature Move: Foundation				Ref:	BAF-FN
BAF Domain: Finance				Appetite:	Low
Executive Lead: Chief Finance Officer		Committee: Finance and Operations Committee		Tolerance:	>5
Initial Score: 4x4=16	Current Score: 3x4 =12	Target Score: 2x4= 8	Linked risks: BAF-WF (workforce),BAF-PF (performance), BAF-ST (strategy)		
Risk: There is a risk the Trust does not achieve financial sustainability given the underlying deficit of c.£100m, resulting in inability to invest in transformation, regulatory intervention and failure to deliver safe services within available resources.					
Ref	Key Controls		Assurance Summary		Rating
C1	Annual financial plan with monthly monitoring, forecasting and variance analysis		Monthly finance report to F&OC and Board; NHSE financial returns		Satisfactory
C2	CIP/efficiency programme with PMO oversight and QIA process		CIP tracker with scheme-level RAG; QIA sign-off log		Partial
C3	Capital programme governance and prioritisation framework		Capital planning group reports; CDEL compliance monitoring		Satisfactory
C4	Financial controls framework incl. SFIs, SoD and budget holder accountability		Internal audit of key financial controls; counter-fraud reports		Satisfactory
C5	System-level financial recovery group and ICS financial framework		ICS financial reporting; system recovery group minutes		Partial
Type	Gaps in Control (GC) / Gaps in Assurance (GA)		Actions Required	Owner	Target
GC	CIP delivery risk — significant proportion of schemes unidentified or early stage		Accelerate CIP identification; transformation-led efficiency programmes through Finance Delivery Group	Chief Finance Officer	Ongoing
GC	Agency expenditure above NHS England ceiling		Strengthen agency controls; accelerate substantive recruitment, Rostering Compliance	Chief Finance Officer / Chief People Officer	Q2 26/27
GC	Capital prioritisation considering significant Estates risks		Continued prioritisation of capital to minimise risk, engage with Estates regional team to highlight risks and secure central capital	Chief Finance Officer	Q3 26/27
GA	Medium-term financial plan continued development		Update 3–5 year financial recovery and sustainability plan	Chief Finance Officer	Q2 26/27
GA	Only £1m capital available against a year zero backlog of £54m		Review prioritisation of constrained capital allocation for 2027/28 planning	Chief Finance Officer	Q3 26/27

Board Assurance Framework 2026/2027

Signature Move: Foundation			Ref:	BAF-PF	
BAF Domain: Performance			Appetite:	Low	
Executive Lead: Chief Operating Officer		Committee: Finance and Operations Committee		Tolerance:	>5
Initial Score: 4x5=20	Current Score: 4x4 =16	Target Score: 3x4= 12	Linked risks: BAF-QS (quality), BAF-WF (workforce), BAF-FN (finance)		
Risk: There is a risk the Trust does not meet constitutional standards for access, waiting times and quality, resulting in patient harm from delayed care, regulatory action and loss of stakeholder confidence.					
Ref	Key Controls	Assurance Summary		Rating	
C1	Integrated Performance Report covering all constitutional standards	Monthly IPR to F&OC and Board with exception reporting and trend analysis. Elective recovery deep dive to be presented to June FOC. Work ongoing to improve reporting and dashboard creation, meeting scheduled with Midlands CSU for support.		Satisfactory	
C2	Elective care recovery programme with waiting list management and validation	RTT and PTL review process being led by the performance team; specialties requiring intervention identified. Weekly RTT senior leaders check and challenge meeting in place with outputs feeding June FOC paper. Work ongoing to review 26/27 operating plan trajectories.		Partial	
C3	Urgent and emergency care improvement programme and flow management	Corridor care trust wide event 23 rd June. Senior team agreed focus and data pack on 16 th June. Winter planning commences June 26 led by Head of Ops. To be linked to above. Awaiting commissioning plan for care coordination re-procurement		Limited	
C4	Community services capacity and demand management	Community waiting list data more visible and to be reviewed in care group delivery reviews. Counting and coding continues to be reviewed following Epic go live.		Limited	
C5	Estates and facilities management incl. statutory compliance programme and productivity impact assessments	Statutory compliance dashboard; condition survey data; PAM score		Partial	
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target	
GC	Elective waits remain above constitutional standards in several specialties	Specialty-level recovery plans; outpatient, theatre and diagnostics productivity programmes in place	Chief Operating Officer	Q2 26/27	
GC	UEC performance below trajectory and national standard, and increased use of corridor care	UEC improvement plan, corridor care working group in place, GIRFT review expected	Chief Operating Officer	Q2 26/27	
GC	Activity recovery following reductions for Epic implementation is behind plan	Full review being undertaken and targeted work with consultants	Chief Operating Officer	Q1 26/27	
GC	ICB contractual changes for elective activity risk altering elective plan and risk to meeting trajectories.	Elective plan being re-worked with proposal planned for executive committee and FOC.	Chief Operating Officer	June 2026	
GC	Cancer waiting times performance recovery not in line with plan submitted to NHSE as part of go live	Recovery plan now in place with capacity sourced. Updated plan and trajectories submitted to Board and region.	Chief Operating Officer	Q2 26/27	
GA	Community services performance data not consistently available	Develop community services performance framework with KPIs	Chief Operating Officer	Q2 26/27	

Board Assurance Framework 2026/2027

Signature Move: Foundation			Ref:	BAF-LG
Leadership and Governance			Appetite:	Very Low
Executive Lead: Chief Executive (delegated to Chief of Staff)		Committee: Audit and Risk Committee	Tolerance:	>3
Initial Score: 3x4=12	Current Score: 2x4 =8	Target Score: 2x3= 6	Linked risks: BAF-QS (quality), BAF-FN (finance), BAF-DD (digital)	
Risk: There is a risk the Trust does not maintain compliance with statutory and regulatory requirements, resulting in regulatory action, prosecution, loss of license conditions and failure to meet duties as a Foundation Trust.				
Ref	Key Controls	Assurance Summary		Rating
C1	Board and committee governance structure with clear ToR and accountability	Annual governance review; Board effectiveness review; well-led self-assessment		Satisfactory
C2	Risk management framework incl. strategy, policy, BAF and corporate risk register	ARC oversight; internal audit of risk management; Risk Group reports		Partial
C3	Internal audit programme and counter-fraud plan	Head of Internal Audit Opinion; audit tracker; counter-fraud annual report		Satisfactory
C4	Regulatory compliance monitoring (CQC, NHSE and statutory requirements)	Provider information returns; NHSE oversight framework; annual report		Satisfactory
C5	Freedom to Speak Up, complaints and whistleblowing arrangements	FTSU guardian reports to Board; complaints trends and learning		Partial
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Risk management framework undergoing major refresh — Datix Web to DCIQ migration	Complete DCIQ configuration; implement new risk management operating manual	Chief of Staff	Q1 26/27
GC	BAF being restructured to align to Trust strategy	Implement new 10-domain BAF structure with signature move alignment	Chief of Staff	Q1 26/27
GA	Policies overdue for review — compliance rate requires improvement	Policy review acceleration programme with clear prioritisation	Chief of Staff	Q2 26/27

Board Assurance Framework 2026/2027

Signature Move: Foundation			Ref:	BAF-ST	
BAF Domain: Strategy and Business			Appetite:	High	
Executive Lead: Chief Strategy and Planning Officer		Committee: Board (direct oversight)	Tolerance:	>20	
Initial Score: 4x5=20	Current Score: 4x4 =16	Target Score: 3x4= 12	Linked risks: BAF-QS (quality and patient safety), BAF-PF (performance and service continuity), BAF-FN (finance and capital), BAF-LG (statutory and regulatory compliance), BAF-DD (digital and infrastructure), BAF-PS (partnership and mutual aid)		
Risk: There is a risk that the Trust's transformation programmes do not deliver the required scale of change within the planned timescales, resulting in failure to address the underlying deficit, unsustainable services and inability to realise the Trust strategy There is a risk that the Trust is unable to maintain safe, compliant and sustainable services within the Tower estate due to significant fire safety and infrastructure risks, resulting in potential harm to patients, staff and visitors, service disruption, regulatory enforcement, urgent decant requirements, and material financial and reputational impact.					
Ref	Key Controls	Assurance Summary		Rating	
C1	Trust Strategy approved by Board with five signature moves and three stages	Annual strategy delivery report to Board; implementation milestones		Partial	
C2	Transformation programme governance with SROs, programme boards and PMO	Transformation dashboard; benefits tracking; milestone reporting		Partial	
C3	Business continuity planning arrangements for critical services	BCP testing programme; EPRR assurance; annual EPRR self-assessment; Tower Fire Safety Recovery Programme; Tower fire risk register; decant and mutual aid planning; reporting to Executive Committee, FOC/QPC and Board		Partial	
C4	Green Plan and environmental sustainability programme	Carbon footprint monitoring; Greener NHS dashboard; Green Plan tracking		Satisfactory	
C5	Comprehensive fire safety management system for the Tower estate, including clear accountability, statutory compliance, fire risk assessment, prevention, detection, containment, evacuation, staff behaviours, business continuity and emergency response arrangements.	Defined executive accountability for Tower fire safety, supported by comprehensive fire risk assessment processes, fire authority engagement, NHSE and ICB engagement on long term solutions, fire prevention and detection controls, compartmentation and evacuation arrangements, operational fire safety procedures and escalation through the Tower Fire Safety Recovery Programme.		Limited	
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required		Owner	Target
GC	Transformation programme capacity — insufficient PMO resource	Strengthen PMO capability; develop delivery framework with SRO accountability		Chief Strategy and Planning Officer	Q2 26/27
GC	Business continuity plans not yet tested across all critical services	Implement BCP testing programme covering all critical functions		Chief Operating Officer	Q3 26/27
GC / GA	The Tower presents a significant fire safety and service continuity risk. There are gaps in embedded operational controls, staff behaviours, assurance, decant planning, compartmentation, detection and capital mitigation. Current controls reduce but do not eliminate the risk to patients, staff, visitors, statutory compliance and continuity of critical services.	Establish a Board-level Tower Fire Safety Recovery Programme with executive SRO, dedicated oversight group, clear risk reduction plan, Tower risk register, fire authority engagement, mutual aid and decant planning, capital prioritisation, weekly progress tracking and formal reporting to Executive Committee, FOC/QPC and Board.		Chief Executive Officer	Q2 26/27
		Strengthening fire management resource capacity.		Chief Executive Officer	Q2 26/27
GA	No established benefits realisation framework for transformation programmes	Develop and implement benefits realisation methodology and tracking		Chief Strategy and Planning Officer	Q2 26/27

Board Assurance Framework 2026/2027

Signature Move: Foundation			Ref:	BAF-OT
BAF Domain: Organisational Transition			Appetite:	Moderate
Executive Lead: Chief Executive		Committee: Board (direct oversight)	Tolerance:	>12
Initial Score: 4x5=20	Current Score: 4x4 =20	Target Score: 3x3= 9	Linked risks: BAF-PS (partnership),BAF-WF (workforce), BAF-FN (finance), BAF-QS (quality)	
Risk: There is a risk that the transition of Section 75 services impacts on service continuity and quality, resulting in disruption to adult social care, loss of integrated model benefits, workforce instability and adverse impact on vulnerable service users.				

		Assurance Summary	Rating
C1	S75 transition programme board with joint Trust/Council membership	Programme board reports to Board and Council; milestone tracking	Partial
C2	Transition risk register with regular review and escalation processes	Risk register review at each programme board; escalation as needed	Satisfactory
C3	Staff engagement and communication plan for affected workforce	Staff feedback; TU consultation outcomes; workforce stability metrics	Partial
C4	Service continuity planning for all in-scope services during transition	Service continuity impact assessments; service user feedback; quality metrics	Limited

Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Transition timeline and scope not yet fully agreed with Torbay Council	Joint CEO/DAS sessions to agree transition plan, timeline and resources	Chief Executive	Q1 26/27
GC	Financial disaggregation of integrated budgets not yet complete	Joint finance workstream to model costs and agree transfer arrangements	Chief Finance Officer	Q2 26/27
GC	Workforce TUPE and employment implications not yet fully scoped	HR workstream to complete workforce mapping and TUPE assessment	Chief People Officer	Q2 26/27
GA	Impact on service users and carers not yet assessed	Commission independent impact assessment on service users and carers	Chief Operating Officer	Q2 26/27

Corporate Risk Register

Torbay and South Devon NHS Foundation Trust

DRAFT WORKING EXAMPLE- June 2026

17 risk categories across 10 BAF domains

Cause-Event-Impact format

Corporate Risk Register — Summary Heatmap

DCIQ Risk Category	BAF Domain	Appetite	Score	15+	Dir.	Position
Clinical Safety and Patient Experience	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	12	7	► Stable	Above appetite
Infection Prevention and Control	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	15	1	▲ Increasing	Above appetite
Health and Safety	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	20	4	► Stable	Above appetite
Workforce, Inclusion and Education	People and Culture	Moderate (Low for EDI)	20	5	► Stable	At boundary — overarching above appetite
Legal and Regulatory	Leadership and Governance	Very Low	12	1	▲ Increasing	Above appetite
Communication and Reputational	Leadership and Governance	Very Low	12	0	▲ Increasing	Above appetite
Performance	Performance	Low	20	2	▲ Increasing	Above appetite
Estates and Facilities	Performance	Low	20	3	► Stable	Above appetite
Financial	Finance	Low	25	2	▲ Increasing	Above appetite
Strategy and Transformation	Strategy and Business	High	—	0	—	No risk recorded
Business Continuity	Strategy and Business	Low	12	0	▲ Increasing	Above appetite
Environmental	Strategy and Business	Moderate	12	0	► Stable	Within appetite
Information Governance	Digital and Data (system-aligned)	Low	9	0	► Stable	Above appetite — median above tolerance
Digital, Cyber and Data	Digital and Data (system-aligned)	Low	20	3	● New	Above appetite
Partnership and System	Partnership and System	High	—	0	● New	No risk recorded
Health Inequalities and Population Health	Health Inequalities and Population Health	Moderate	—	0	● New	No risk recorded
Organisational Transition	Organisational Transition	Moderate	12	0	● New	Within appetite

Clinical Safety and Patient Experience

Signature Move: "Reimagining acute and specialist care"

BAF Domain: Quality, Safety, Clinical Outcomes and Patient Experience | Committee: Quality and People Committee

Appetite

Very Low

Tolerance

>3

Current Score

12

Risks at 15+

7

Direction

▶ Stable

Position

Above appetite

Overarching Risk Statement

CAUSE: Sustained demand pressures, workforce gaps in specialist areas, ageing infrastructure and the complexity of integrated care delivery across acute, community and social care settings.

EVENT: The Trust fails to comply consistently with Regulation 12 (Safe Care and Treatment) under the Health and Social Care Act 2008.

IMPACT: Avoidable patient harm, regulatory enforcement action, loss of public and commissioner confidence, and reputational damage to the Trust and its system partners.

Linked Corporate Risks

37 Pharmacy Aseptic (4001)	20
47 MDRRP (1947)	16
233 Stroke Services (3287)	16
43 MH Transfers (2948)	16
51 Obstetric Theatre (2965)	15
55 UTC Acuity (3502)	15
58 Clin Gov Capacity (3928)	15

Commentary

8 risks scoring 15+. MHRA non-compliance. Perinatal incident increase. Stroke performance. NELA mortality outlier. Complaints backlog.

Infection Prevention and Control

Signature Move: "Reimagining acute and specialist care"

BAF Domain: Quality, Safety, Clinical Outcomes and Patient Experience | Committee: Quality and People Committee



Overarching Risk Statement

CAUSE: Ageing estate infrastructure limiting single-room capacity, sustained patient flow pressures, and variability in IPC practice compliance.

EVENT: The Trust is unable to maintain consistent and effective infection prevention and control measures across all clinical settings.

IMPACT: Healthcare-associated infections, outbreaks requiring ward closures, regulatory scrutiny, patient harm and loss of public confidence.

Linked Corporate Risks

56 IPC Overarching (3944)	15

Commentary

E Coli above target. MSSA rates increased. Limited ASW assurance on IPC controls. Hand hygiene at 90%. Improved data quality.

Health and Safety

BAF Domain: Quality, Safety, Clinical Outcomes and Patient Experience | Committee: Quality and People Committee



Overarching Risk Statement

CAUSE: Significant estate backlog maintenance (£120m+), limited capital envelope, ageing buildings not designed to modern safety standards, and high footfall across acute and community sites.

EVENT: The Trust is unable to minimise health and safety related incidents affecting staff, patients and visitors to an acceptable level.

IMPACT: Serious injury or harm; HSE enforcement action; increased insurance and litigation costs; workforce impact through injury-related absence.

Linked Corporate Risks

92 Fire Risk in Tower Block due to failure to meet Statutory Standard (2878)	25
41 Flammable Storage (2801)	20
227 Community Security (3664)	16
182 RTC Buildings (4124)	15

Commentary

Estate fragility combined with limited capital. Risk well understood at Board. Planned programme in place but cannot be fully mitigated within current funding. Increased fire risk.

Workforce, Inclusion and Education

Signature Move: "Caring, skilled people ready for tomorrow"

BAF Domain: People and Culture | Committee: Quality and People Committee

Appetite

Moderate (Low for EDI)

Tolerance

>12

Current Score

20

Risks at 15+

5

Direction

► Stable

Position

At boundary — overarching above appetite

Overarching Risk Statement

CAUSE: National and regional workforce shortages, competition for talent across the peninsula, high cost of living, and the pace of organisational change.

EVENT: The Trust does not have sufficient permanent workforce capacity and capability to meet patient need safely and sustainably.

IMPACT: Increased reliance on temporary staffing, workforce fatigue, deterioration in quality and safety, inability to deliver transformation, and regulatory non-compliance.

Linked Corporate Risks

44 Workforce Overarching (1697)	20
49 Radiographer Shortage (4136)	16
48 SACT Nursing (2037)	16
50 Breast Radiotherapy (3456)	16
196 Haematology (3789)	15
158 Sexual Safety	12

Commentary

Plan for Better Care People programme in place. Key specialist vacancies in radiotherapy, haematology and oncology nursing. EDI risk managed within category at Low appetite.

Legal and Regulatory

BAF Domain: Leadership and Governance | Committee: ExCo / Audit and Risk Committee

Appetite	Tolerance	Current Score	Risks at 15+	Direction	Position
Very Low	>3	12	1	▲ Increasing	Above appetite

Overarching Risk Statement

CAUSE: Increasing external regulatory oversight, high volume of legal and regulatory activity, and the complexity of operating across multiple regulatory frameworks.

EVENT: The Trust fails to maintain consistent compliance with its legal and regulatory obligations.

IMPACT: Regulatory enforcement action, licence conditions, reputational damage, financial penalties, and loss of stakeholder confidence.

Linked Corporate Risks

180 Trust Wide Legal and Regulatory Compliance (3955) 15

Commentary

Increasing NHSE oversight. PWC Devon-wide review. Board self-assessment. Clear structures in place but volume of activity is high.

Communication and Reputational

BAF Domain: Leadership and Governance | Committee: ExCo / Audit and Risk Committee

Appetite	Tolerance	Current Score	Risks at 15+	Direction	Position
Very Low	>3	12	0	▲ Increasing	Above appetite

Overarching Risk Statement

CAUSE: Significant strategic change across the Trust, sustained media and political scrutiny, and active community engagement on service reconfiguration.

EVENT: Negative publicity, public perception or uncontrollable events adversely affect the Trust's reputation.

IMPACT: Loss of public confidence, impact on patient choice, difficulty recruiting and retaining staff, strained partner relationships.

Linked Corporate Risks

316 Trustwide Learning From Deaths Process (3775)	12

Commentary

Cardiology case for change generating public concern. ASC future under scrutiny. Maternity services receiving attention.

Performance

BAF Domain: Performance | Committee: Finance and Operations Committee

Appetite

Low

Tolerance

>6

Current Score

20

Risks at 15+

2

Direction

▲ Increasing

Position

Above appetite

Overarching Risk Statement

CAUSE: Sustained growth in demand, system flow constraints, workforce gaps in key specialties, and operational disruption from Epic implementation.

EVENT: The Trust fails to meet national access standards and contractual performance requirements.

IMPACT: Patient harm through delayed treatment, regulatory intervention, failure to meet RSP exit criteria, financial penalties.

Linked Corporate Risks

46 Cancer Waits (1815)	20
52 Patient Flow (1070)	15

Commentary

Non-compliant with national cancer waiting time standards. Lowest quartile for some tumour sites. Cancer recovery plan in place. UEC improved but resilience not demonstrated.

Estates and Facilities

BAF Domain: Performance | Committee: Finance and Operations Committee



Overarching Risk Statement

CAUSE: Backlog maintenance exceeding £120m, NHP deferred to mid-2030s, limited capital, and buildings not designed to modern clinical or safety standards.

EVENT: The Trust is unable to maintain and operate its estate to NHS HTMs and statutory requirements.

IMPACT: Service disruption, safety incidents, regulatory non-compliance, infection control breaches, inability to deliver clinical transformation.

Linked Corporate Risks

39 Estates Overarching (1083)	20
72 Cancer Services Building Poor Condition (4201)	20
182 RTC Buildings (4124)	15

Commentary

£120m+ backlog. NHP deferred. BBF programme contributing. Residual stock remains significant concern. Count TBC — pre-reclassification from Service/Business Interruption.

Financial

BAF Domain: Finance | Committee: Finance and Operations Committee

Appetite

Low

Tolerance

>6

Current Score

25

Risks at 15+

2

Direction

▲ Increasing

Position

Above appetite

Overarching Risk Statement

CAUSE: Deep-rooted structural deficit, system-wide pressures across Devon ICS, historic underfunding, high temporary staffing costs, and Epic financial impact.

EVENT: The Trust fails to deliver sufficient improvement to achieve its five-year financial recovery plan.

IMPACT: Continued regulatory intervention, further financial restrictions, increased health inequalities, inability to modernise, erosion of sustainability.

Linked Corporate Risks

242 Financial Sustainability & Plan Delivery (2996)	25
243 Finance Systems and Reporting Risk (4370)	20

Commentary

Highest-scoring risk on the register. Significant deficit. NHSE segmentation. Five-year recovery plan dependency. Impacts all other risk domains.

Strategy and Transformation

BAF Domain: Strategy and Business | Committee: Finance and Operations Committee

Appetite	Tolerance	Current Score	Risks at 15+	Direction	Position
High	>20	—	0	—	No risk recorded

Overarching Risk Statement

No overarching risk currently recorded. To be populated as the Trust implements its new strategy and the five signature moves are translated into delivery plans.

Linked Corporate Risks

No linked risks

Commentary

No Datix risks allocated..

Business Continuity

BAF Domain: Strategy and Business | Committee: Finance and Operations Committee

Appetite	Tolerance	Current Score	Risks at 15+	Direction	Position
Low	>6	12	0	▲ Increasing	Above appetite

Overarching Risk Statement

CAUSE: Ageing physical and digital infrastructure, dependency on critical third-party suppliers, workforce supply fragility, and multi-site operational complexity.

EVENT: A major disruption to critical Trust services caused by infrastructure failure, cyber incident, supply chain failure or environmental event.

IMPACT: Inability to deliver safe care, significant operational and financial disruption, regulatory scrutiny, reputational damage.

Linked Corporate Risks

No linked risks – Tower risk currently within H&S risk category

Commentary

NEW category.

Environmental

BAF Domain: Strategy and Business | Committee: Finance and Operations Committee

Appetite

Moderate

Tolerance

>12

Current Score

12

Risks at 15+

0

Direction

► Stable

Position

Within appetite

Overarching Risk Statement

CAUSE: Significant capital required for decarbonisation not currently available, combined with an energy-inefficient ageing estate.

EVENT: The Trust fails to achieve its Green Plan 2040 and Net Zero commitments.

IMPACT: Regulatory non-compliance, reputational impact, missed efficiency savings, failure to meet system environmental commitments.

Linked Corporate Risks

322 Trust's 2040 Green Plan (3566)	12

Commentary

Strong progress on soft sustainability. Decarbonisation requires capital. BBF contributing. Long-term trajectory.

Information Governance

Signature Move: "Smart use of technology for better care"

BAF Domain: Digital and Data (system-aligned) | Committee: Finance and Operations Committee



Overarching Risk Statement

CAUSE: Volume and complexity of personal data processed across integrated services, combined with Epic transition and data migration.

EVENT: The Trust experiences a breach of information governance requirements through unauthorised access, disclosure or misuse.

IMPACT: ICO enforcement, financial penalties, patient harm, loss of public trust, legal liability.

Linked Corporate Risks

No linked risks

Commentary

Split from Information & Technology. GDPR compliance maintained. Epic data migration adding complexity. IG Toolkit on track.

Digital, Cyber and Data

BAF Domain: Digital and Data (system-aligned) | Committee: Finance and Operations Committee

Signature Move: "Smart use of technology for better care"



Overarching Risk Statement

CAUSE: Ageing IT infrastructure, accelerated digital transformation through Epic, increasing cyber threat landscape, dependency on cloud services, and BAU systems not replaced by Epic.

EVENT: The Trust's IT systems fail to meet demands or are compromised by a cyber attack or system failure.

IMPACT: Loss of clinical systems affecting patient safety, data loss, service disruption, regulatory failure, inability to realise digital benefits.

Linked Corporate Risks

40 IT Infrastructure (1159)	20
54 Cloud Services (3460)	15
325 Community Dataset (2920)	15

Commentary

NEW category. Linked risks reclassified from Information & Technology

Partnership and System

Signature Move: "Joined-up care, every step of the way"

BAF Domain: Partnership and System | Committee: Finance and Operations Committee

Appetite	Tolerance	Current Score	Risks at 15+	Direction	Position
High	>20	—	0	● New	No risk recorded

Overarching Risk Statement

- CAUSE:** ICS complexity, varying governance frameworks, Section 75 notice, RDUH/UHP pathway interdependencies.
- EVENT:** The Trust fails to maintain effective partnerships and collaborative governance across the Devon system.
- IMPACT:** Fragmented pathways, service gaps, strained relationships, inability to influence system decisions.

Linked Corporate Risks

No linked risks

Commentary

NEW category.. No existing Datix risks

Health Inequalities and Population Health

Signature Move: "Living well in our neighbourhoods"

BAF Domain: Health Inequalities and Population Health | Committee: Quality and People Committee

Appetite	Tolerance	Current Score	Risks at 15+	Direction	Position
Moderate	>12	—	0	• New	No Risk Recorded

Overarching Risk Statement

- CAUSE: Ageing population, deprivation, limited PHM data integration, historic under-investment in preventive care.
- EVENT: The Trust fails to identify and address health inequalities in access, experience and outcomes.
- IMPACT: Widening inequalities, poorer outcomes, failure to meet ICS objectives, regulatory scrutiny.

Linked Corporate Risks

No linked risks

Commentary

NEW category aligned to ICS BAF 2026/27. No existing Datix risks..

Organisational Transition

BAF Domain: Organisational Transition | Committee: ExCo / Board (direct)

Appetite

Moderate

Tolerance

>12

Current Score

12

Risks at 15+

0

Direction

• New

Position

Within appetite

Overarching Risk Statement

CAUSE: Board decision to serve notice on Section 75 partnership with Torbay Council, requiring 12-month transition to revised ASC model.

EVENT: The Trust is unable to manage the transition without disruption to service delivery, workforce stability or financial sustainability.

IMPACT: Disruption to ASC services, workforce attrition, contractual disputes, regulatory scrutiny, reputational damage.

Linked Corporate Risks

289 Section 75 transition	12

Commentary

NEW time-limited domain. 12-month notice from March 2026. Co-design with Torbay Council and Devon ICB.

Board of Directors

Council of Governors' and Board of Directors' Policy of Engagement for Serious Concerns

Date of meeting	Date report produced
25 June 2026	18 June 2026

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

Date: 24 June 2026

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

Executive summary

The Council of Governors and Board of Directors' Policy of Engagement for Serious Concerns is presented to the Board of Directors for review and approval. It has previously been subject to review by a Council of Governors Working Group, at which the previous Chair was present, and was presented to the Council of Governors' at the meeting held on 13th May 2026 where it was approved.

The document has been strengthened to ensure robust processes are in place to assess and manage potential breaches of the Governor Code of Conduct.

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

Appendix 1 – CoG and Board of Directors' Policy of Engagement for Serious Concerns

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

Council of Governors

Key recommendations and actions requested

The Board is asked to approve the CoG and Board of Directors' Policy of Engagement for Serious Concerns

How does this report further our Trust strategy?

The document provides a framework to manage a good working relationship between the Council of Governors and Board of Directors.

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	Yes
Performance	Yes
People and Culture	Yes
Strategy and Business Intelligence	Yes
Finance	Yes

Risk
N/A
Risks lodged on Datix:
N/A
External Standards affected by this report and associated risks
Best practice

Unclassified

Council of Governors' and Board of Directors' Policy of Engagement for Serious Concerns

Unclassified

Document Information

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Date of Issue:	April 2024	Next Review Date:	~~May 2028~~ ~~April 2027~~
Version:	V2.1	Last Review Date:	~~May 2026~~ ~~February 2024~~
Author:	Corporate Governance Manager		
Director Responsible	~~Director of Corporate Governance and~~ Trust Secretary		
Approval Route: Council of Governors and Board of Directors			
Approved By:		Date Approved:	
Council of Governors		February 2023 (V1)	
Board of Directors		February 2023 (V1)	
Council of Governors		February 2024 (V2)	
Board of Directors		February 2024 (V2)	
<u>Council of Governors</u>		May 2026 <u>(V2.1)</u>	
<u>Board of Directors</u>		July 2026 <u>(V2.1)</u>	
Links or overlaps with other policies:			
NHS England Code of Governance for NHS Provider Trusts			
Governor Code of Conduct			
NHS England Your Statutory Duties – A Reference Guide for NHS Foundation Trust Governors – updated in 2022 for system working and collaboration			
NHS England "Director-governor interaction in NHS foundation trusts – A best practice guide for boards of directors" (joint publication by PA Consulting and Monitor 2012)			
We are committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.			
We are committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1.0	New Document	Feb 23	New Document	CoG and Board of Directors
2.0	Revisions	Feb 2024	Revisions to align with Constitution/SO's & Trust policy broadly	CoG and Board of Directors
2.1	Updated	~~May~~ ~~Feb~~ 2026	Policy amended to align with the wishes of CoG	CoG and Board of Directors

Version 2.1, ~~issued~~ July~~February~~ 2026

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1. Introduction

- 1.1. The relationship between the Council of Governors and the Board of Directors is key to the successful delivery of the Trust's functions. The Council of Governors and Board of Directors are each committed to building and maintaining an open and constructive working relationship.
- 1.2. The Chair is the prime connection between the Council of Governors and Board of Directors. In addition, the Trust has well established channels for business-as-usual communications and engagement between the two bodies. Informal and frequent communication are an essential feature of a positive and constructive relationship and benefits the Trust and the services it provides.
- 1.3. In the limited and rare circumstances described below, where Governors have very serious concerns about the functioning of the Trust, the Council of Governors collectively or whether an individual Governor remains eligible to hold the position (for example, due to actual or perceived breaches of the Governor Code of Conduct), they may wish to invoke the formal process set out in this policy.

2. Purpose

- 2.1. The purpose of this policy is to describe the method by which Governors can engage with the Board of Directors in circumstances when they have serious concerns about:
 - 2.1.1. the performance of the Board of Directors,
 - 2.1.2. compliance with the Trust's NHS Provider Licence; or
 - 2.1.3. other matters related to the overall wellbeing of the Trust and its collaboration with system partners.
- 2.2. NHS England's Code of Governance for Provider Trusts (updated in 2022) ("**Provider Code of Governance**") recommends that the Council of Governors establishes a policy of engagement to govern such situations. This policy is intended to provide clear guidance for both the Board of Directors and Council of Governors and has been approved by each respectively.
- 2.3. The policy is not intended to interfere with the usual methods of interaction between the Board of Directors and Council of Governors or the operation of the Trust's Freedom to Speak up: Raising Concerns (Whistleblowing) Policy¹.

3. Definitions and Interpretation

- 3.1. The capitalised terms and expressions defined in the Constitution apply to this policy.
- 3.2. The phrase "overall wellbeing of the Trust" is not defined in the Provider Code of Governance. The Trust interprets the phrase to mean the Trust's ability to deliver services in a way that fulfils its purpose, aligns with its values, creating a just and fair culture and crucially ensures compliance with the Trust's NHS Provider Licence.
- 3.3. The policy should be read in conjunction with the Constitution and other documents relevant to the governance of the Trust, including the Trust's NHS Provider Licence, as well as the Provider Code of Governance.
- 3.4. If there is any discrepancy between this policy and the National Health Service Act 2006, the Constitution or the Trust's Provider Licence, then those documents shall

¹ <https://www.torbayandsouthdevon.nhs.uk/uploads/raising-concerns-policy-h30.pdf>

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prevail over this policy. All Governors and Directors have access to these documents and should familiarise themselves with the contents of them.

- 3.5. A reference to the Chair shall be read as a reference to the Senior Independent Director where the Chair is unavailable or where it would be inappropriate to engage the Chair due to reasons of conflict.

4. Application of the Policy

- 4.1. The policy is not intended to cover minor or technical issues which can usually be resolved via the established channels of communication between Governors and the Secretary and Chair.
- 4.2. The policy seeks to address very serious concerns raised by Governors which cannot be resolved in the normal manner and may be invoked in relation to the following, but non-exhaustive list of situations, outlined below:
- 4.2.1. a Governor's eligibility to remain appointed in accordance with the Constitution where a subjective judgement is to be made; such as an actual or perceived breach of the Governor Code of Conduct;
 - 4.2.2. breakdown of communications between the Trust and its System stakeholders;
 - 4.2.3. extensive breaches of the Trust's Provider Licence whether alleged or actual;
 - 4.2.4. Board of Director's failure to respond adequately to findings from external regulatory bodies such as CQC or HSE of serious failings;
 - 4.2.5. absence of Board of Directors oversight over significant financial or clinical risks which subsequently materialise;
 - 4.2.6. breakdown of trust between the Trust and its workforce;
 - 4.2.7. major operational oversights leading to loss of continuity of service;
 - 4.2.8. loss of confidence of system leaders in the Board of Directors;
 - 4.2.9. failure to respond to a significant transformational opportunity.
- 4.3. The policy is not intended for use where Governors have concerns about the performance of the Chair or any single Non-Executive Director. In these situations, Governors are referred to NHS England guidance, including the Provider Code of Governance and the Statutory Guide for Governors² and, ultimately, paragraph 27 of the Constitution (appointment and removal of Chair and other Non-Executive Directors).
- 4.4. Concerns may be raised through the application of this Policy by Governors as a whole acting collectively, by a sub-set of Governors or by Governors individually.
- 4.5. Where the Council of Governors as a whole is in dispute with the Board of Directors, the procedure in Annex 4 of the Constitution applies.

5. Process for Engagement

- 5.1. Governors should first consult the Trust Secretary who will seek to resolve the concern informally and advise on the appropriateness of raising the matter with the Chair; as outlined in provision 4.1.
- 5.2. The advice of the Trust Secretary is not binding and the Governors retain the right at all times to raise the matter with the Chair. Where it would be inappropriate to raise the concern with the

² [Governors guide August 2013 UPDATED NOV 13.pdf](#)

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Trust Secretary or the Chair, the Senior Independent Director should be approached instead.

- 5.3. Where the matter has not been resolved informally with the support of the Trust Secretary or where Governors have been advised to raise the concern with the Chair, the Governors may raise the concern with the Chair who will seek to resolve the matter informally. Failing that, Governors should make a request for the matter to be investigated within the terms of this policy.
- 5.4. The Trust shall, at its discretion, appoint one of the following to investigate the concerns ("**Investigator**"):
 - 5.4.1. the Chair;
 - 5.4.2. the Senior Independent Director;
 - 5.4.3. a Nominated Officer;
 - 5.4.4. the Trust's internal auditor; or
 - 5.4.5. an external investigator such as a professional services firm whose costs will be paid by the Trust provided the matter is not vexatious within the meaning of the Trust's Complaints Policy³.
- 5.5. The Investigator is entitled to set the detailed terms of reference but will do so in line with the overall statutory roles of the Council of Governors to:
 - 5.5.1. hold the Non-Executive Directors to account for the performance of the Board of Directors; and
 - 5.5.2. represent the interests of the Trust's Members and the public.

The investigation will therefore focus on the Board of Directors', and particularly the Non-Executive Directors', visibility, oversight and response to the matter raised.
- 5.6. The Investigator may involve Directors and Officers at their discretion. Directors who are requested to participate in an investigation shall:
 - 5.6.1. co-operate with requests of the Investigator;
 - 5.6.2. attend meetings and produce documents;
 - 5.6.3. answer questions raised by the Governors which form part of the investigation; and
 - 5.6.4. confirm decisions taken by Directors or the Board of Directors (where appropriate).
- 5.7. Governors who have raised the concern will be invited to submit evidence to the Investigator.
- 5.8. Where concerns are raised with regard to a Governor's eligibility to remain appointed, in accordance with the Constitution, the procedure set out in Appendix 2 shall be followed.
- 5.9. The Governors and Directors agree to respect the confidentiality of the investigation.
- 5.10. Whilst the investigation is ongoing, with the exception of 4.2.1 where such investigation relates to an individual Governor, the Council of Governors agrees to refrain from exercising its statutory power to require one or more of the Directors to attend a Council of Governor's meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors performance of their duties (and deciding whether or not to propose a vote on the Trust's or Director's performance) in relation to the matters under investigation.
- 5.11. The Investigator will review the evidence gathered and will, unless the Investigator is the Chair, report their findings to the Chair. As soon as practicable after the conclusion of the

³ [Complaints Policy](#)

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investigation, the Chair will meet with the Governors who raised the concerns to discuss the findings. The meeting has three possible outcomes:

- 5.11.1. the Governors are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required;
- 5.11.2. the Governors are satisfied that their concerns will be resolved by actions to be taken in light of the investigation or will be otherwise resolved. The Chair will write a report on the concerns and the actions taken, or to be taken, and present it to the Council of Governors in the closed section of the next Council of Governors meeting;
- 5.11.3. the matter is not resolved to the satisfaction of the Governors. The Chair will call a closed extraordinary meeting of the Council of Governors as soon as reasonably practicable to consider the matter further. That meeting may resolve to take no further action or, if two thirds of the Governors present agree the motion, the Trust shall refer the matter to NHS England or an independent arbitrator external to the Trust such as the chair of another NHS provider.

6. Distribution

- 6.1. This policy document will be made available on the Trust's intranet and public website.
- 6.2. Awareness will be raised through Equality Impact Assessment training, all ratifying committees/groups, policies and procedures training and intranet.

7. Key Contacts

- 7.1. For further information about this policy, contact foundationtrust.tsdf@nhs.net.

Appendix 1

PROCEDURE FOR ASSESSING BREACH OF THE GOVERNOR CODE OF CONDUCT**1. INTRODUCTION**

- 1.1. ~~In applying this policy, the Chair and/or Senior Independent Director together with the Trust Secretary shall first assess whether the perceived breach would be deemed as more or less serious; progressing as outlined below.~~ In applying this policy, that an alleged breach of Code of Conduct has occurred with supportive factual evidence, in the first instance be notified to the Lead or Deputy Lead Governor, Chair and/or SID together with the Trust secretary who shall first assess whether the perceived breach would be deemed as more or less serious; progress outlined below.

2. LESS SERIOUS BREACHES

- 2.1. A less serious breach may be managed through informal resolution and may be considered if there is an unintentional breach of the Code, the consequences of which do not fall within the scope of what might constitute a serious breach.
- 2.2. Examples of a less serious breach include but are not limited to:
- 2.2.1. Actions which involve another Governor or impact on the CoG only, e.g. lesser/single episode misconduct at meetings or towards Trust staff, NEDs or colleagues, minor disruptive behaviour, rudeness, disrespectful of the views of other Governors, the Chair and/or Directors;
 - 2.2.2. Inappropriate use of email or other forms of communication, abusive language or aggressive phrasing or vexatious behaviour~~sete~~;
 - 2.2.3. Non-attendance at two CoG meetings or development day training and persistent non-attendance without good reason and/or tendering of apologies, in accordance with the Constitution.
- 2.3. The primary aim is to resolve issues as quickly as possible, so that the formal business of the CoG is not disrupted and Governors maintain their activities and duties appropriately.

3. SERIOUS BREACHES

- 3.1. Examples of a serious breach include but are not limited to:
- 3.1.1. A deliberate breach of the Code;
 - 3.1.2. Where a Governor receives two written warnings regarding compliance with the Code within any rolling 12-month period;
 - 3.1.3. Conduct towards any of the Trust's patients, visitors or staff which is abusive, or which adversely impacts their dignity or wellbeing and / or which is contrary to the principles of equality, diversity and inclusion;
 - 3.1.4. A breach of the Code that is likely to bring the Trust, or the role of Governor, into disrepute;
 - 3.1.5. Failure to manage public/media enquiries appropriately and in accordance with the Code;
 - 3.1.6. A breach of confidentiality, including Data Protection Legislation or misuse of data received in the course of their duties as a Governor;
 - 3.1.7. Fraud, bribery or other financial criminal activities;
 - 3.1.8. Safeguarding issues;
 - 3.1.9. ~~Multiple complaints of minor breach issues.~~

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4. PROCESS FOR MANAGING ALLEGED BREACH OF CODE OF CONDUCT / INFORMAL PROCESS

- 4.1. If an issue or concern arises regarding the conduct of another Governor, the complainant ~~concerned Governor~~ should be clear about their complaint and the remedy required. If there has been a heated exchange or misinterpretation of facts within the CoG, the Lead Governor and/or Chair may intervene and require retraction of the remarks and a formal apology at the time.
- 4.2. Where a Governor is concerned about the behaviour of another Governor, they should raise this directly with that Governor. Where the complainant does not feel sufficiently confident, they may obtain support from the Lead Governor, or Deputy Lead, if appropriate.
- 4.3. Should support from within the CoG be inappropriate, the concerned Governor should discuss the circumstances with the Trust Secretary, who may recommend an alternative advocate. If an advocate is approached, they may only act with the express agreement of the aggrieved Governor, in both action and anticipated response.
- 4.4. The Lead Governor and/or the Deputy Lead will facilitate the process, with the agreement of the Trust Secretary ~~Director of Governance~~ or the Chair.
- 4.5. Where the Governor has raised a concern and seeks a resolution which includes recognition of inappropriate behaviour and non-recurrence, this should be supported at a facilitated meeting attended by the Trust Secretary between the two Governors (with or without an advocate present).
- 4.6. If both Governors accept the proposal then the concern should be considered resolved ~~and the concern is resolved at the meeting~~,
- 4.7. ~~The~~ the matter is noted on the file of the ~~challenged~~ Governor whom the breach has been alleged if found to be in breach, and no further action will be taken.
- 4.8. Arrangements for the meeting should be agreed within five (5) working days or as soon as reasonably practicable, of the complaint being raised.
- 4.9. If there is no resolution at the informal meeting, where arrangements have been agreed and fulfilled, the matter will be considered through the formal process.

5. FORMAL PROCESS

- 5.1. Where the informal approach has failed, or the breach is considered serious, the alleged breach shall be investigated in accordance with this policy.
- 5.2. To avoid doubt, this provision does not apply in relation to matters listed in the Constitution which render a Governor no longer eligible hold the position of Governor where this is objective and clear as a matter of fact; for example holding a criminal conviction.
- 5.3. Where an allegation of a serious breach has been made an investigation shall be conducted in accordance with this policy; typically the investigation will be led by the Chair and/or the SID.

6. ALLEGED SERIOUS BREACH PROCESS

- 6.1. Following notification of an allegation of a serious alleged breach, which is assessed as being a potential Serious Breach, the Trust Secretary, Chair and/or the SID, together with the Lead and Deputy Lead Governor shall consider whether immediate action may be required. This may include the temporary exclusion of the Governor concerned from any meeting or temporary exclusion from their wider role. Where such action is required, the Chair/SID will be informed of the nature of the complaint and action proposed.

7. SUSPENSION OF A GOVERNOR

- 7.1. Suspension is the process of placing on a Governor a requirement that they do not participate in the work of the Council of Governors, while an investigation is undertaken into the allegations reported. Suspension is a neutral act; it is neither a disciplinary action nor an assumption of guilt. A suspended Governor shall continue to be required to adhere to the Governor's Code of

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Conduct.

- 7.2. At any time, the Chair is authorised to take such interim measures as may be immediately required, including the exclusion of the Governor concerned from a meeting or suspension from duties, on the basis that such measures are necessary to:
 - 7.2.1. enable an effective investigation to be undertaken into any concern or complaint about a Governor;
 - 7.2.2. address or prevent any significant disruption to the effective operation of any part of the Trust;
 - 7.2.3. manage risk to the health or well-being of any Governor, employee, volunteer or patient of the Trust;
 - 7.2.4. protect the reputation of the Trust; or
 - 7.2.5. give effect to a proposal by the Council to impose a sanction on a Governor, until such times as the sanction is agreed by the Governor or the determination of an assessor has been received and notified to the Governor.
- 7.3. During any period of suspension from duties, the Governor is not permitted to:
 - 7.3.1. attend or enter the Trust's premises unless he or she is doing so as a patient of the Trust, as a carer or family member of a patient of the Trust or with the consent of the Chair;
 - 7.3.2. contact any of the Trust's Governors, employees, suppliers, volunteers or patients without the express prior permission of the Chair, other than in circumstances where any such contact is purely of a personal nature and unrelated to their position or duties as a Governor or in relation to this process; or
 - 7.3.3. access any of the Trust's email or IT systems.
- 7.4. In these circumstances, any decision by the Chair to suspend a Governor from their duties shall be communicated to the Lead Governor and Deputy Lead Governor as soon as reasonably practicable and is effective when the Governor is notified ~~either verbally or~~ in writing. ~~Any verbal notification shall be confirmed in writing.~~ The Governor will be required to maintain confidentiality in regards to their suspension and the process being undertaken, save that they may disclose information about the process being followed to their advocate ~~Supporter~~, if appropriate.
- 7.5. The Chair shall notify the Council of Governors that an interim measure has been imposed as soon as reasonably practicable. The Chair shall not be required to explain the basis for imposing an interim measure. The Governor shall be removed from the Council of Governors' distribution lists for the period of the suspension.
- 7.6. In order to protect the legitimate interests of a Governor and any Complainant, the Council of Governors shall not be not be entitled to receive any further information regarding the use of this procedure in relation to any Governor until it is notified of any charge on which it is being asked to make a decision.
- 7.7. Notwithstanding the use of this procedure, a Governor is entitled to resign at any time. This will not prevent a full investigation of the complaint, if this is the required by the CoG.
- 7.8. Less serious and serious breaches and sanctions are defined by the Council of Governors.

8. COMMUNICATION

- 8.1. Where the Chair and/or Senior Independent Director together with the Trust Secretary consider the alleged breach meets the threshold of serious breach of the Code of Conduct, the Trust Secretary shall provide details of the complaint to the Governor and advise them that the matter will be investigated in accordance with this policy.

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9. FORMAL COUNCIL OF GOVERNORS' HEARING

- 9.1. The investigation report, along with any comments from the Governor, shall be sent to the members of the COG in sufficient time to be read before the meeting at which it is to be discussed; the investigation report shall include a recommendation as to whether a breach has occurred for the assessment of the COG.
- 9.2. The CoG shall hold an extraordinary meeting in private to consider the investigation report; noting the recommendation and making a decision as to whether or not the recommendation should be accepted and the matter should be closed or whether a breach has occurred; the outcome of which would be dismissal.

Unclassified

Appendix 2
Rapid Equality Impact Assessment (for use when writing policies and procedures)

Policy Title (and number)	CoG and Board of Directors' Policy of Engagement for Serious Concerns		Version and Date	V2.1 ~~May~~ Jan26	
Policy Author	Corporate Governance Manager				
An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.					
EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below					
Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)					
Age	Yes ☐ No ☒	Disability	Yes ☐ No ☒	Sexual Orientation	Yes ☐ No ☒
Race	Yes ☐ No ☒	Gender	Yes ☐ No ☒	Religion/Belief (non)	Yes ☐ No ☒
Gender Reassignment	Yes ☐ No ☒	Pregnancy/ Maternity	Yes ☐ No ☒	Marriage/ Civil Partnership	Yes ☐ No ☒
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)					
Yes ☐ No ☒					
Please provide details for each protected group where you have indicated 'Yes'.					
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion					
Is inclusive language ⁵ used throughout?					
Yes ☒ No ☐					
Are the services outlined in the policy/procedure fully accessible ⁶ ?					
Yes ☒ No ☐					
Does the policy/procedure encourage individualised and person-centered care?					
Yes ☒ No ☐					
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?					
Yes ☐ No ☒					
If 'Yes', how will you mitigate this risk to ensure fair and equal access?					
EXTERNAL FACTORS					
Is the policy/procedure a result of national legislation which cannot be modified in any way?					
Yes ☐ No ☒					
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)					
To provide the CoG with an engagement policy when working with the Trust/Trust Board of Directors.					
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?					
Council of Governors					
ACTION PLAN: Please list all actions identified to address any impacts					
Action	Person responsible		Completion date		
n/a					
AUTHORISATION:					
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them					
Name of person completing the form	Sarah Fox		Signature	Sarah Fox	
Validated by (line manager)	~~Emily Long~~ Cath Parnell		Signature	~~Emily Long~~ Cath Parnell	

Any issues Please contact Diversity & Inclusion Lead
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
¹ Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travellers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

 Version 2.1, ~~issued July~~February 2026

Board of Directors

Our Plan for Better Care

Date of meeting	Date report produced
2nd July 2026	22 nd June 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 an update to the Board of Directors on delivery progress of *Our Plan for Better Care*, the Trust's transformation programme, which underpins delivery of the 2026/27 Operational Plan and wider strategic objectives.

Following the stabilisation achieved in 2025/26 across leadership, strategy, performance, finance and workforce, the programme is now transitioning into a phase of strategic transformation. Delivery is structured across six core domains aligned to the Trust's strategy and signature moves, with clear Executive ownership through SRO-led governance.

Overall, programme assurance has started to weaken in month, despite some early progress. A substantial proportion of delivery is still at an early stage, and some slippage against key milestones is evident. This reflects the challenge of delivering at pace whilst resources and transformation capacity solutions are still being developed through restructures.

The next reporting cycle will focus on maturing performance frameworks, including finalisation of KPIs and baselines, alongside continued strengthening of delivery assurance and benefits realisation.

Delivery of Our Plan for Better Care remains critical to achieving the Trust's operational, workforce and financial objectives, contributing £23.5m towards the £54.4m Cost Improvement Programme (CIP). While forecast delivery remains aligned to the overall CIP target, risks to timing and realisation persist in key areas, particularly where dependencies and resource constraints are impacting pace of delivery. It is recognised that further transformation delivery is likely to be required to

offset risk in the CIP programme, so accelerating work will be desirable to bring forward financial gains, where possible. Opportunity to identify additional savings will be monitored as the coming months unfold.

In-month improvements have been made in risk management, including a reduction and refocusing of workstream risks and strengthened alignment to delivery. An updated risk escalation framework has now been approved and will be implemented in the next reporting cycle to further enhance oversight and ensure timely and appropriate escalation of key risks.

Key programme risks remain, notably workforce capacity, competing organisational priorities, and limited programme delivery support. Action is underway to mitigate these through strengthened prioritisation, enhanced governance, and plans to increase transformation capacity and capability, including the use of external expertise where required.

Overall, the programme is assessed as providing limited to satisfactory assurance, reflecting early progress alongside the scale and complexity of delivery still required.

Appendices

Annex 1: Our Plan for Better Care Oversight Assurance Report July 2026

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

Our Plan for Better Care Oversight Group.

Key recommendations and actions requested

- **Note** the Transformation delivery report and progress made during the reporting period with the Board of Directors invited to Discuss.
- **Acknowledge** the risks to delivery and ongoing work required to improve our risk position.
- **Take assurance** that the transformation programme is executively owned and work is being undertaken to evidence impact to the organisation’s key priorities.

How does this report further our Trust strategy?

Our Plan for Better Care supports delivery of the Trust’s strategy by setting out progress in implementing the transformation required for Phase 1. It demonstrates how activity is aligned to the Trust’s five signature moves and enabling priorities, ensuring that transformation delivery is directly driving forward the Trust’s strategic objectives and intended outcomes.

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 The 2026/27 Transformation Plan builds on the stabilisation and foundational improvements delivered in 2025/26 through the Trust's Integrated Improvement Plan and continues under the established banner of *Our Plan for Better Care*.
- 1.2 The Plan is aligned to the Trust's new strategy and is structured around its defined signature moves and enabling priorities, reflecting the key transformation required to deliver the first phase of the strategy.
- 1.3 In May 2026, the Board of Directors reviewed and endorsed the strategic intent of the Plan, including its six transformation domains - Living well in our neighbourhoods; Reimagining acute and specialist care; Joined-up care, every step of the way; Smart use of technology for better care; Caring, skilled people ready for tomorrow; Strategic enablers. Each domain is led by an Executive Director acting as Senior Responsible Owner (SRO), accountable for delivery and for realising the intended outcomes and benefits.
- 1.4 Delivery of this programme is critical to achieving the Trust's Operational Plan for 2026/27 and beyond. Performance across finance and cost improvement, workforce, and operational targets is dependent on the successful implementation of Our Plan for Better Care.
- 1.5 As of May, Workstream Leads have provided monthly highlight reports to their respective SROs, primarily through domain governance forums. SROs undertake a robust review and challenge process to validate assumptions, monitor progress, and provide support where required.
- 1.6 SROs then present escalations to the Our Plan for Better Care Oversight Group, chaired by the Chief Executive. The Oversight Group provides rigorous scrutiny of delivery progress, risks, issues, dependencies, and benefits realisation, and escalates matters requiring Board-level decision or intervention
- 1.7 This report provides a summary of delivery progress as at June 2026, with further detail set out in Annex 1.

2. Delivery Update

- 2.1 As part of the cycle of business, workstream leads produce highlight reports against a set of pre-determined key deliverables. These reports are reviewed with Senior Responsible Owners (SROs) to reinforce accountability for progress and performance. Following which they are presented to the OPFBC Oversight Group for scrutiny and constructive challenge.

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

Table 1:

Domain / Workstream	May 2026	June 2026
1.0 Living Well in our Neighbourhoods		
1.1 Frailty Expansion and Community Bed-Base Care Review		
1.2 Acute Bed-Base Care Review		
1.3 Virtual Ward & Hospital at Home Service		
1.4 Neighbourhood Teams Infrastructure & Support		
1.5 Adult Social Care Transition		
1.6 Innovation & Evaluation Hub		
2.0 Reimagining Acute & Specialist Care		
2.1 Clinical Services Review		
2.2 Improving Productivity		
2.3 Pathology		
3.0 Joined-up Care, Every Step of the Way		
3.1 Pathway Review and Redesign		
4.0 Smart use of technology for better care		
4.1 Digital First incorporating AI		
4.2 Epic Implementation & Benefits, including MY CARE		
5.0 Caring, skilled people ready for tomorrow		
5.1 Workforce Transformation		
5.2 Culture Transformation		
6.0 Strategic Enablers		
6.1 One Devon Shared Services - Finance		

- 2.3 In-month, the Frailty Expansion & Community Bed-based Care workstream has improved to satisfactory assurance, reflecting positive progress, including development of the 7-day Frailty SDEC business case. Progress within the Innovation & Evaluation workstream also remains strong, with a structured baseline assessment of all 28 active pipeline projects now complete, strategic partnerships progressing, and significant external funding (£2m) being secured to accelerate innovation deployment and benefits realisation. In contrast, Acute Bed-Based Care and Virtual Ward & Hospital at Home workstream have declined to no assurance due to limited progress and identified resource gaps. The SRO is actively reviewing how to progress these workstreams, including considerations of leadership, scope, and resource requirements.
- 2.4 Assurance for the Clinical Services workstream has reduced, reflecting a small number of activities currently tracking approximately one month behind plan. Targeted recovery actions are in place and are being actively monitored to restore delivery to schedule.
- 2.5 Assurance for the Epic Implementation & Benefits (including MyCare) workstream has also declined, reflecting the current level of delivery risk within the cash

releasing benefit (CRB) schemes. Scheme-level review meetings have been established to provide closer oversight of progress, ensure early identification of risks and issues, and implement robust mitigation, with escalation through the programme governance structure as required.

- 2.6 Workforce transformation continues to make strong progress, with major consultation programmes underway to strengthen organisational design and workforce productivity. In parallel, cultural transformation has advanced with Board approval of the Learning Academy, progression of the People & Education restructure, and a refreshed wellbeing business case moving to decision. Similarly, One Devon Finance programme has achieved key data and design milestones, including completion of the Chart of Accounts and system readiness activity, to enable future shared service implementation.
- 2.7 The programme as a whole is monitoring 93 deliverables in month, with 55% reported as complete or on track and 37% still in planning phase. Of the 13 deliverables due for completion by the end of May, 7 were delivered, with the remainder now behind plan. Slippage is evident across a number of areas, including Living Well in Our Neighbourhoods, where key milestones such as the X-Ray Car launch, bed-based care options appraisal and Adult Social Care mobilisation have moved beyond original timelines. Clinical Services Review baselining and options appraisal are one month behind schedule. Two GIRFT compliance reviews remain overdue, with meetings scheduled in June to complete these.
- 2.8 Recovery actions and revised delivery dates are in place. However, the position reflects ongoing delivery pressure, with revised completion dates now approved for four deliverables across Frailty, Productivity and Shared Services – Finance.

3 CIP Delivery Assessment

- 3.1 As previously reported delivery of this transformation programme is critical and intrinsically aligned to the Trust's Operational Plan for 2026/27 and subsequent years. Achievement of key operational targets across finance and cost improvement, workforce, and performance is dependent on the successful implementation of Our Plan for Better Care.
- 3.2 Following remapping of some CIP schemes in month Our Plan for Better Care contributes £23.5m of the challenging £54.4m CIP target for 26/27 (43% of original plan). Table 2 summarises the CIP position by workstream
- 3.3 Year to date delivery stands at £0.7m, with full year delivery of £1.8m and a forecast outturn of £22.2m, leaving a variance of £1.3m against the latest schemes. The most significant variance relates to the acute bed-based care review, reflecting the slippage outlined earlier, alongside the community bed-based care reconfiguration which is now forecast from M6 as opposed to M4.
- 3.4 There remain additional CIP schemes, outside of the remit of OPFBC, including non-pay schemes in Procurement and Medicines Optimisation, together with local Care Group schemes. The forecast outturn of these schemes totals £32.2m bringing the total forecast outturn position to £54.4m in line with the overall CIP target.

Table 2:

Our Plan for Better Care Workstream Dashboard									
Workstream	Original Plan	Latest CIP Schemes	Transacted YTD	Transacted Full Year Delivery	Forecast Outturn (Transacted & Forecast)	Forecast Outturn High Delivery Risk	Forecast Outturn Medium Delivery Risk	Forecast Outturn Low Delivery Risk	Variance Between Original & Forecast Outturn
1.1 Frailty expansion & community bed based care review	£ 1,225,995	£ 1,221,000	£ -	£ -	£ 894,616	£ -	£ -	£ 894,616	£ 326,384
1.2 Acute Bed Based Care Review	£ 1,206,000	£ 1,208,480	£ -	£ -	£ 609,524	£ -	£ 409,524	£ 200,000	£ 598,956
1.4 Neighbourhood infrastructure and support	£ 401,000	£ 401,000	£ -	£ -	£ 401,000	£ 80,000	£ 321,000	£ -	£ 0
1.5 Adult Social Care Transition	£ 11,390,000	£ 10,408,003	£ 573,757	£ 930,642	£ 10,352,905	£ 1,898,003	£ -	£ 8,454,902	£ 55,098
2.2 Improving Productivity	£ 1,150,000	£ 1,150,000	£ -	£ -	£ 1,150,000	£ -	£ -	£ 1,150,000	£ 0
4.2 Epic implementation & benefits including MyCare	£ 5,056,312	£ 4,654,497	£ 86,642	£ 908,422	£ 4,650,842	£ 1,643,789	£ -	£ 3,007,053	£ 3,655
5.1 Workforce Transformation	£ 2,896,600	£ 2,896,600	£ -	£ -	£ 2,655,162	£ -	£ -	£ 2,655,162	£ 241,438
5.2 Cultural Transformation	£ 1,574,000	£ 1,574,000	£ -	£ -	£ 1,505,000	£ -	£ -	£ 1,505,000	£ 69,000
Our Plan for Better Care Total	£ 24,899,907	£ 23,513,580	£ 660,399	£ 1,839,064	£ 22,219,049	£ 3,621,792	£ 730,524	£ 17,866,733	£ 1,294,531
Other Non Pay - Procurement	£ 1,915,000	£ 1,925,000	£ 62,449	£ 374,779	£ 1,993,999	£ -	£ -	£ 1,993,999	£ 68,999
Other Non Pay - Medicines Optimisation	£ 2,600,000	£ 2,661,316	£ -	£ -	£ 2,315,853	£ -	£ -	£ 2,315,853	£ 345,463
Other Care Group Schemes	£ 25,004,877	£ 26,319,943	£ 2,691,326	£ 7,424,562	£ 27,890,938	£ 3,431,646	£ 1,315,440	£ 23,143,852	£ 1,570,995
Total	£ 54,419,784	£ 54,419,839	£ 3,414,174	£ 9,638,405	£ 54,419,839	£ 7,053,438	£ 2,045,964	£ 45,320,437	£ 0

4 Improvement focuses in month

- 4.1 In month, there has been an improvement focus on key performance indicators, risk management and dependency management. KPI development has been strengthened through joint review sessions between the PMO, Financial Improvement Director, SROs and workstream leads. This has ensured a balanced set of measures covering both delivery outputs and programme outcomes, with a clear focus on evidencing progress and realisation of intended benefit. Updated KPIs are now embedded within highlight reports and have been shared with the Oversight Group for input, ahead of finalisation in the next reporting cycle.
- 4.2 In respect to risk management, a comprehensive review of all risks rated 15 and above has been undertaken with SROs and workstream leads, reducing the total from 18 to 7 since the previous reporting period. This has strengthened alignment of risks to programme delivery, rather than business-as-usual activity, and introduced a more consistent and standardised approach to risk scoring. Annex 1 details the risks identified by OPFBC Oversight group for onward reporting to Board.
- 4.3 In parallel, discussions with the Chief Nursing Officer have led to approval of an updated risk escalation framework. This will be implemented in the next reporting cycle to strengthen oversight and support the timely and appropriate escalation of key risk.
- 4.4 In addition to strengthened risk management, workstreams have also enhanced the identification and management of dependencies. This includes clearer ownership, improved sequencing of interdependencies, and a more consistent shared understanding of requirements, collectively supporting more effective, coordinated

delivery across the programme. This work will continue into the next reporting period.

5 Programme Risks

- 5.1
- The most significant programme risks include competing operational, clinical and transformation priorities, as they reduce available staff capacity and focus, potentially leading to delays, diminished quality of inputs, and increased risk to delivery and assurance timelines. This continues to be mitigated through strengthened Executive prioritisation, clear SRO accountability, and robust governance and reporting arrangements.
- 5.2
- Limited access to dedicated programme delivery support, alongside the impact of voluntary redundancies, creates another notable programme risk to OPFBC by reducing available capacity and specialist expertise across key functions. This may lead to delayed progress, weaker coordination and governance, and diminished quality of outputs. Mitigating actions are underway, including the commissioning of short-term supplementary resource, alongside plans to establish a dedicated transformation team as the organisational redesign progresses recognising this is still several months away from completion.

6 Assurance recommendations and summary

- 6.1
- The Board of Directors are invited to:
 - **Note** the Transformation delivery report and progress made during the reporting period with the Board of Directors invited to **Discuss**.
 - **Acknowledge** the risks to delivery and ongoing work required to improve our risk position.
 - **Take assurance** that the transformation programme is executively owned and work is being undertaken to evidence impact to the organisation’s key priorities
- 6.2
- Noting the above, the Board are asked to AGREE the recommended assurance rating and take LIMITED -SATISFACTORY assurance as to those matters reviewed.

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



Torbay and South Devon
NHS Foundation Trust

Board of Directors

Committee Chairs' Report

Date of meeting	Date report produced
2 July 2026	25 June 2026

Author(s)		Report approved by	
Name and title:	Sophie Byrne PA to Chairman	Name and title:	Sarah Fox Corporate Governance Manager
		Date:	26 June 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

Audit and Risk Committee – 25 June 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:

- Annual Report 2026/26 - Satisfactory
- 2025/26 Financial Statements - Satisfactory
- Quality Account 2025/26 - Satisfactory
- Going Concern Review - Satisfactory
- Final Head of Internal Audit Opinion - Satisfactory
- EA Findings Report and Auditor's Annual Report
- Letter of Representation

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

[Diligent Boards: South Devon Health Information Services: Current Books](#)

ASSURANCE RECOMENDATION:

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

ALERT:

ADVISE:

ASSURE:

To recommend for board approval:

- Annual Report 2026/26
- 2025/26 Financial Statements
- Quality Account 2025/26
- External Auditors' Letter of Representation

To note:

- Unqualified external audit report

RISK:

CELEBRATE OUTSTANDING:

Move to satisfactory Head of Internal Audit Opinion

Committee Chairs' Report – 17 June 2026

Charity Committee

REPORTS RECEIVED BY COMMITTEE:

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

- Charity Committee Written Resolution – Charitable Funds Finance Ledger
- Fundraising Report – Satisfactory
- Annual Review of Fundraising Strategy - Satisfactory
- Finance Report – Satisfactory
- Finance Plan 2026/27 – Satisfactory
- Investment Manager Report

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

[Diligent Boards: South Devon Health Information Services: Current Books](#)

ASSURANCE RECOMENDATION:

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

ALERT:	Committee noted an increased level of requests considered as core NHS provision (and therefore beyond the charity's remit) as a result of budget costs across the organisation. Action to review charitable objects to determine whether remit can be expanded, in particular where requests relate directly to improved staff wellbeing and environment.
ADVISE:	Committee reflected on the positive impact of legacy funding to resource HeARTs activity and engage diverse partners and stakeholders across the estate. Members resolved to explore the potential role of the Charity in supporting TSDFT's neighbourhood health strategy.
ASSURE:	A renewed exploration of strategic and operational opportunities (including remit, partnerships and organisational structure) has been tabled for a future committee development session.
RISK:	Committee noted a conflation, in the charity's risk management process, of risk to the charity vs risk to TSDFT, reflecting on the lack of dedicated risk management

	specific to the charity itself. Case studies of NHS Foundation Trusts adopting an independent charity structure in place of a structure where the foundation trust acts as a sole corporate trustee were discussed, leading to an action to review case studies and the relevance of an independent charity model in the context of TSDFT. Additional risk was noted around the charity's existing finance structure which is currently under review. At present, the charity consists of 180 funds, many of which hold a negative balance. Plans to simplify the finance structure and reconcile these balances risk breaching legal limits. The charity is therefore taking advice from the Charity Commission and auditors before taking action to amend this financial structure.
CELEBRATE OUTSTANDING:	Committee commended the charity fundraising team who have overseen an increase in funds raised through staff lottery and have generated additional income through corporate sponsorship and a grant from the health lottery foundation, noting this as a significant achievement in a context of wider economic challenge.

Committee Chairs’ Report – 24 June 2026

Finance and Operations Committee

REPORTS RECEIVED BY COMMITTEE:

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

- Month 2 Finance Report – Satisfactory/Limited – To receive
- Productivity and Financial Sustainability Update – Limited/Satisfactory – To receive
- Agenda for Change Job Evaluation Review for Band 5 Nursing Roles – Satisfactory – To receive
- Operational Performance Report – Limited – To receive
- Elective Activity Report – Limited – To receive
- Tower Fire Risk Comprehensive Review and Action Plan – Limited – To receive
- EPR Progress and Finance Report – 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:

Tower Fire Risk

Finance and Operations Committee

Tower Fire Risk Comprehensive Review and Action Plan (Key Point Summary) 24.06.2026

Current Position

- Substantial risk to life confirmed by Primary Fire Risk Assessment
- Deficiencies in evacuation, detection, passive protection, compartmentation, fire load and controls

Assurance: Limited and risk exceeds Board threshold

Key Issues

- Legacy design: inadequate escape capacity, single principal stair
- Outdated fire detection/ alarm system
- Fire doors, compartmentation and fire-stopping in poor condition
- Combustibles and obstructions in escape routes
- Governance gap: no formal HRB change-control process

Regulatory Position

- DSFRS engagement constructive but conditional on "pace, grip and demonstrable risk reduction"
- April inspections: combustibles, blocked routes, behavioural non-compliance
- Enforcement escalation possible (Notification + Enforcement + Prohibition)
- Trust must comply with Fire Safety Order + Building Safety Act concurrently

Approach

- Immediate interim management controls and strengthened executive level governance. Set up Fire Safety Recovery Group
- Tactical – Development of Fire Strategy – Estates Safety Fund Capital £1.8m for fire compartmentation. Consideration of fire suppression systems.
- Strategic – New Ward Block. Timescales and enabling works interdependencies.

Additional information sources

- Strategic Fire Safety Action Plan (appendix)
- Primary FRA and Secondary FRA Action Plans

Resource Gap

- Estates and fire safety teams at capacity limits
- DSFRS concerned about adviser capacity
- Recruitment for Senior Fire Safety Advisor ongoing

Board Position Required

- Interim continued occupation recommended — decanting poses greater immediate clinical risk
- Occupation conditional on strengthened controls and consistent compliance
- Board to consider acceptance of residual risk (above appetite)
- Reinforces strategic need for £126m new ward block

Current fire risk within the Tower exceeds current Board risk appetite, notwithstanding strengthened governance, enhanced operational control, and recent progress with prioritised immediate mitigations.

While an estimate £126m business case outlines strategic work required to replace the Tower eradicating the Tower fire risk, interim tactical interventions, as yet uncoded, are being proposed to bring the Tower into greater alignment with modern regulations within a shorter timeframe.

A strategic fire safety action plan has been devised, in consultation with stakeholders including DSFRS which prioritises further the fire risk assessment actions list, promotes fire evacuation planning and table-top exercising, introduces a new Tower-wide fire detection & alarm system (FDAS), brings the Tower lifts into evacuation service (after a degree of additional compartmentalisation), removes all external scaffolding, & conducts further work on fire dampers compromised by previous compartment reuse activity. DSFRS escalation, while always a possibility, is not being considered the appropriate route to risk reduction by senior fire officers currently.

Evacuation plans are now in place, training has been conducted, and the entire exercise of evacuating to Tower has been stress-tested (in Exercise Vulcan) with key stakeholders.

Action is ongoing within the Trust to build the package of interim tactical interventions necessary to reduce risk impact further, risk likelihood reduction occurring through better staff awareness of in-ward fire raisers and a structured approach to in-building material inspections (such as thermal imaging of electrical systems).

The package of interventions that reduces the Tower risk to as low as reasonably practicable (ALARP) is to be evidenced and will continue to be the subject of sub-committee scrutiny; it is expected to be shared with stakeholders for external challenge/support.

Noting the need to make a Building Safety Act Review planning application to conduct tactical risk reduction work (which could take a minimum of 12 weeks, but may take up to 36 weeks), the **Board is invited to accept the current residual risk on an interim basis**. Accordingly, **the continued use of the Tower is endorsed** noting that:

- there is an ongoing programme of proactive fire risk management of the Tower, to reduce fire risk (both likelihood & impact) to ALARP; &
- the consideration of clinical risk to patients & the wider community in using the Tower outweighs the clinical risk to the same body in reducing acute bed capacity & displacing services away from the Tower.

It is observed that neither the Committee or the Board have yet to determine our 'red lines'; describing this another way, those matters that should they change/worsen would impact the balance of current judgements and move the Board to close Tower wards accepting that the risk to life within the Tower is greater than its non-use for the community.

	<u>Operational Performance</u> - UEC fell short on plan on all key metrics. - Elective remains slightly behind where pre-EPR go-live modelling suggested. - Cancer is behind on both key metrics (although showing late in-month signs of recovery). - Diagnostics is showing an upturn in many areas. <u>Elective Recovery</u> Deep dives derived the main issues to be in: - ENT - Ophthalmology - Orthopaedics Stabilising pathways through additional insourced capacity is expected to improve lists, together with greater emphasis and discipline on booking/planning process. The temporary unexpected closure of 2 theatres due to maintenance exacerbated the already deteriorating post-EPR implementation position. <u>Productivity & Sustainability</u> Work has been ongoing within departments to identify, aligned to Model Hospital, departures from best of class efficiency. We now broadly know <i>what</i> (how much) and <i>where</i> but not <i>why</i> &, therefore, <i>how</i> to make the improvements opportunity suggests. Two independent analytical support elements have been introduced to help. Substantial work is ongoing.
ADVISE:	<u>FOC Governance</u> A full committee self-assessment has been conducted by committee members, followed by a committee development session, from which a strawman articulating changes has been produced. New FOC chair is working with QPC chair, with external mentoring, to ensure better committee focus and service to the Board, deriving greater alignment of approach to both committees, exploiting more the newly constructed BAF and CRR. <u>Agenda for Change Band 5 Review</u> The scale of scope for this review is being determined (due to complete Jul 26). Review governance is in place & ready to begin; the lengthy review is to conclude & be enacted by Oct 28.

Central funding is anticipated (up to £5m) with financial risk to the Trust being monitored.

ASSURE:

FINANCIAL

Finance – Satisfactory/Limited

Key Financial Measures and Headlines

NHS
Torbay and South Devon
NHS Foundation Trust

Plan	YTD / Forecast	Measure	Month 02 2026/27 £m
Revenue Plan	YTD	Variance to Plan (Adverse) / Favourable	(0.0)
Revenue Plan	Forecast	Variance to Plan (Adverse) / Favourable	0.0
Revenue Plan	Forecast	Undertaken and High Risk Mitigations	(0.0)
Revenue Plan	Forecast	Recurrent Risk to Underlying Position	(1.0)
CIP Plan	YTD	Variance to Target (Adverse) / Favourable	(1.0)
CIP Plan	Forecast	Variance to Recurrent Target (Adverse) / Favourable	(2.0)
Capital Plan	YTD	Variance to Plan (Overspend) / Underspend	1.4
Cash Plan	YTD	Unplanned Cash Support	3.8
Cash Plan	Forecast	Unplanned Cash Support	7.8

Assurance on the financial performance of the Trust at Month 2: SATISFACTORY

Assurance on delivery of financial, CIP and workforce plans: LIMITED

Year to date revenue position on plan, although the provision for lost income recognised in the position (£0.9m) may be understated – the loss may be closer to £2.5m

Forecast revenue forecasting outturn on plan but noting base case risks of £9.3m relating to low maturity CIP and impact of EPR on contract activity.

CIP delivery is £0.8m adverse to plan YTD, forecast CIP is on plan at £54.4m, but with lower recurrent delivery than planned (£2.4m adverse).

Workforce Update: The Trust is reporting worked WTEs 203 below plan. Bank and agency spend is trending downwards but is above plan and national cap limits

Capital Update: £1.4m underspent YTD, forecasting to spend up to CDEL. New allocation of £1.8m approved for Tower Fire Safety.

Cash Update: The Trust closing cash balance for Month was £3.8m above plan, no identified need for cash support in forecast, assuming revenue plan delivery.

- On plan overall; CIP remains slightly behind with adverse non-recurrent/recurrent split although CIP risk continues to reduce.

OPERATIONAL

Operations – Limited/Satisfactory

- Operational performance across the board is, in the main, lagging expectation on all metrics; a Trust-wide event (23 Jun) seeks to uncover & better understand issues to enable more robust recovery plan. Additionally, an elective recovery plan is being put in place.

DIGITAL

EPR - Satisfactory

- Some dissatisfaction to the EPR implementation reported among pockets of staff with concerns voiced over the veracity of certain pathways.
- The long-term governance structure for EPR at One Devon remains unresolved, although a paper is circulating the ICB aimed at resolving this.
- It was noted that it is important that legacy systems are retained until their utility has been fully adopted with EPR.

RISK:	Corporate risk remains largely above currently stated risk appetites; the new CRR being established will warrant a thorough review in Q2 to determine alignment and if risk appetites need challenge.
CELEBRATE OUTSTANDING:	The Estate Team, together with Finance & Clinical/Operational colleagues, have conducted a enormous amount of work to draw together the co-ordinated update to the Tower fire safety risk, deriving immediate prioritised actions (within current funding) & articulating the case for additional mitigation funding (short and longer term). It is evident across multiple papers that the Finance and Operations teams are working more closely together sharing data, enabling triangulation and improved joint analysis to promote information which is being put into context as useful current position knowledge. 23,000 patients signed up to My Care currently noting the target of 50,000 by the end of the performance year.

Committee Chairs' Report – 23rd June 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:

- People Digital Programme Update – Limited – To receive
- Learning Academy – Satisfactory – To receive
- Cultural Insights Report – Limited/Satisfactory – To receive
- Quality Report for Health Care – Limited/Satisfactory – To receive
- External Regulation Oversight – Limited/Satisfactory – To receive
- Formaldehyde in Cellular Pathology – Limited/Satisfactory/Significant – To receive
- Restorative Just and Learning Culture Deep Dive – Satisfactory - Rescheduled
- Clinical Audit Forward Plan – Limited/Satisfactory - To receive
- Mortuary Activity Report June 2026 – Limited/Satisfactory - To receive
- Tower Fire Risk Comprehensive Review and Action Plan – Limited - To receive
- Neighbourhood Health Update – 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:

Continued deterioration of Stroke performance against national 4-hour target. April saw 17% of stroke patients reaching the stroke unit in 4 hours (Sept. 50%, Feb 38%) with no detailed performance recovery/improvement plan presented to committee. Recognition that this is related to patient flow and committee requested to see clear targeted actions from Corridor Care Summit.

Extended discussion on Tower risk. Committee commended Director of Estates and team on extensive work to date to reduce the likelihood of a fire incident and to increase the preparedness of staff.

Trust is not currently compliant with HTM 05-03 comprehensive fire safety training requirements and Training Needs Analysis yet to start. Recognition that whilst we have increased numbers of staff trained, we have not yet got a sufficient pool of competent

	and confident staff familiar with fire and evacuation procedures. Additional training provision has been sourced but no agreed delivery schedule. Discussion that the standard set by Board earlier in the year to have a FEW on every shift (AM/PM) in the Tower may be too challenging to deliver. It was questioned whether this standard was a proportionate response given the mitigations now in place to reduce the incidence of fire. Committee understood that work continues to look at patient placement within the Tower to determine feasibility of most dependent/least mobile patients moving elsewhere in Tower/out of Tower. It was acknowledged that there is currently no duty of candour provision regarding Tower fire risk. Committee understood that capacity and expertise gaps within the estates team needs to be addressed and that analysis of resource need is underway. Recruitment of substantive technical fire resource in hand. Further assurance and clarity requested on: • Outline of the available training provision and numbers of staff trained (e.g. Ward level training, LEAP training, Evacuation Lead training etc.) • Numbers of staff in the Tower currently trained as Fire and Evacuation Wardens • Level of mandatory fire safety training compliance for each of the four wards of the Tower • Data to confirm % of shifts (AM/PM) with Fire and Evacuation Wardens (FEW) on duty • The work underway to understand patient placement approach to minimise the number of non-ambulatory patients within the Tower The level of fire warden / fire and evacuation warden cover on shifts (AM/PM) within the Tower requires independent review/advice alongside clinical component to set a standard that we can be confident is proportionate and supported by external experts
ADVISE:	Learning Academy paper outlined the model and implementation approach. Committee noted absence of timeline and requested this progress at pace. Committee noted the work of the Cultural Insights Review Group particularly the success of the Enhanced Care for Staff Pilot

	(ECSP). Recognition that more proactive measures are needed to address the drivers of issues raised via ECSP. Capacity issues noted within the OD team. Good discussion on Clinical Audit Forward Plan. CNO asked to consider how committee closes the loop on understanding the outcomes of national audits (outliers/good practice).
ASSURE:	Good discussion on new Board Assurance Framework and draft Corporate Risk Register. Clarity on gaps in control and assurance. Acknowledgement of work to do to align QPC workplan and papers to BAF, Strategy and statutory responsibilities. Committee received: • Formaldehyde in Cellular Pathology paper. Assured that current exposure levels remain well within UK regulatory limits. • Mortuary Activity Report paper. Assured on safe, compliant, high-quality care. Clear evidence that recommendations from the <i>Inquiry into the crimes of David Fuller</i> had been addressed and were in practice. Recognition of critical infrastructure requirements particularly immediate Air Handling Unit replacement need.
RISK:	Uncertainty regarding deliverability of the One Devon People Digital business case has prompted an independent review. Wave 2 implementation (July 2026) is also under review. Trust has £906,348 forecast savings in 26/27 plan against this delivery. Some savings will be delivered via People Directorate restructure, but any gap will need to be understood.
CELEBRATE OUTSTANDING:	

Finance and Operations Committee

Operational Performance Report

Date of meeting	Date report produced
24 th June 2026	15 th June 2026

Author(s)		Report approved by	
Name and title:	Sam Wadham-Sharpe Interim Chief Operating Officer	Name and title:	Sam Wadham-Sharpe Interim Chief Operating Office
		Date:	15th June 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 26/27 operating plan. This report will cover performance detail on the progress on the exit measures for UEC performance and Elective performance. A summary of the key areas detailed within the paper is provided below.

Urgent & Emergency Care (UEC) Performance

- Performance below expected standards in all key metrics
- Overall demand reduction but continued increases in ambulance demand
- Trust wide event on 23rd June to enable creation of new unscheduled healthcare plan and performance trajectories.
- Further detail provided in supplementary pack which is the framework for the event on the 23rd June.

Elective Performance Referral To Treatment (RTT)

- Waiting list growth remains within the levels expected through Epic go live modelling
- RTT performance is slightly behind Epic go live modelling, but number of clock stops required to recover performance in year remains as per the model

- Majority of activity and performance issues (65-week waiters) are held in ENT, Ophthalmology and Orthopaedics
- 65-week wait clearance forecast in ENT and Ophthalmology by September
- Orthopaedic current September 65 week wait position is 58
- Detail provided on industrial action cancellations – some activity has been recovered post cancellation
- Further detail provided in the additional elective recovery paper

Cancer

- Performance behind agreed Epic trajectories for both key measures
- Recovery in plan in place and shared with NHSE
- Current activity and performance forecast shows recovery ahead of trajectory in June

Diagnostics

- ~8% performance improvement between April and May
- Continued recovery forecast in endoscopy modalities and non-obstetric ultrasound (NOUS)
- Staffing issues within cystoscopy and urodynamics will cause issues in June performance

Section	Assurance (Performance) (Limited/Satisfactory/Significant)	Trend from Previous Report	Assurance (Plan) (Limited/Satisfactory/Significant)
UEC 4 Hour Performance	Limited	No Change	Limited
UEC Ambulance Handover	Limited	Worsening	Limited
UEC 12 Hour Performance	Limited	Worsening	Limited
RTT 65-week waiters	Limited	No Change	Limited
RTT 18 week, RTT 52-week total waiting list size, % first appointment within 18 weeks	Limited	No Change	Limited

Cancer Performance	Limited	No Change	Satisfactory
Diagnostic Performance	Limited	No Change	Satisfactory

Appendices

Appendix 1 - UEC Improvement Framework

Included in the Finance and Operations Committee Items for Information Pack

Appendix 2 – Detailed Plan for Elective Recovery

Included in the Finance and Operations Committee Agenda Pack – Agenda item 5.1.1

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 Recovery Support Programme (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 as part of the 2026/2027 Operating Plan. This report continues to report on the key areas of performance that are measured nationally as part of the 2026/2027 operating plan, the performance oversight processes led by NHSE South-West, 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 waiting times 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.

2. Purpose of report

1. Due to the national performance reporting schedule, this report will provide the nationally reported performance position for May 2026 in UEC, and April 2026 in all elective metrics, with a greater focus on future performance improvement as described in the previous section.

3. National Benchmarking

- The table below reflects latest published data (as at 15/6/26) 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 (out of 118 Trusts) against the previous reporting month.

Provider	Elective proportion waiting within 18 weeks Rank out of 118 Apr 2026	Elective proportion waiting over 52 weeks Rank out of 118 Apr 2026	Cancer faster diagnosis Rank out of 119 Apr 2026	Cancer 62-day combined Rank out of 119 Apr 2026	Diagnostics proportion waiting over 6 weeks Rank out of 118 Apr 2026	A&E 4-hour performance Rank out of 118 May 2026	A&E 12-hour performance Rank out of 118 May 2026
Torbay And South Devon NHS Foundation Trust	66.4% 44	1.8% 92	48.0% 118	58.5% 113	39.4% 105	64.7% 108	11.7% 76

Metric	Previous available rank	Latest available rank	Improved/Worsened
RTT 18-week wait	42 (March 2026)	44 (April 2026)	Worsened
RTT 52-week wait	91 (March 2026)	92 (April 2026)	Worsened
Cancer FDS	98 (March 2026)	118 (April 2026)	Worsened
Cancer 62-day wait	112 (March 2026)	113 (April 2026)	Worsened
Diagnostic wait over 6wks	106 (March 2026)	105 (April 2026)	Improved
UEC – 4-hour wait	115 (April 2026)	108 (May 2026)	Improved
UEC 12-hour wait	58 (April 2026)	76 (May 2026)	Worsened

*Rank out of 119 Trusts

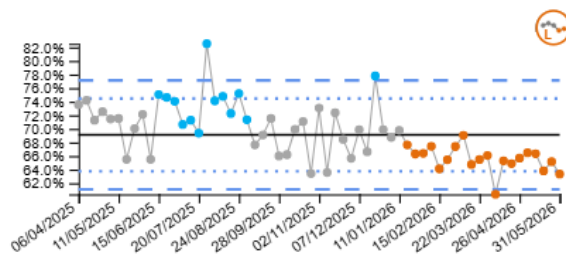
** Rank out of 117 Trusts

4. Urgent and Emergency Care

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS														Torbay and South Devon NHS Foundation Trust										
Data RAG rated against monthly Operational Plan trajectory Bold = national data				Target March 2027	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26					
Urgent and Emergency Care																								
Ambulance handovers - time lost over 15 mins - Actual (hours)						1530	1159	725	943	1823	810	624	559	1283	621	755	952	1390						
Ambulance handovers - time lost over 15 mins - Plan																	641	676	623					
Average handover time (mins) - Actual				30 mins		52	45	32	38	60	33	29	27	45	30	31	38	47						
Average handover time (mins) - Plan				30 mins		44	37	35	34	38	42	42	45	42	41	37	30	30	30					
Total average time in ED (hours/minutes) - Actual				Reduction		05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	06:10	06:06	06:07							
Total average time in ED (hours/minutes) - Plan																								
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Actual				0		688	494	457	426	655	585	549	520	918	740	734	676	839						
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan																	394	655	469					
Percentage of patients waiting over 12 hours in ED - Actual						9.8%	7.4%	6.5%	6.1%	9.7%	8.5%	8.3%	7.5%	13.6%	12.1%	10.6%	9.8%	11.7%						
Percentage of patients waiting over 12 hours in ED - Plan																								
UEC 4-hour target (RAG against local trajectory to national target) - Actual				82%		70.1%	72.2%	73.5%	74.1%	68.3%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.2%	64.7%						
UEC 4-hour target (RAG against local trajectory to national target) - Plan				82%		73.0%	73.0%	76.0%	76.0%	76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%					
% patient discharges pre-noon - Actual				33%		22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%								
% patient discharges pre-noon - Plan				33%		33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%					
Percentage of inpatients with No Criteria to Reside (acute) - Actual				<5%		7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%						
Percentage of inpatients with No Criteria to Reside (acute) - Plan				<5%		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%					

4-hour and 12-Hour Performance

- The Trust did not achieve the operational plan trajectory of 72.0% for 4-hour performance with performance for May 2026 at 64.88%. As part of the Epic go live submission, the forecast was for 4-hour performance to remain at the levels seen in March 25 prior to go live due to the expected delays within the Emergency Department and with flow across the wider Trust. The Trust has seen a 2.5% reduction from the March performance to May but has seen an improvement to 66.67% so far in June.

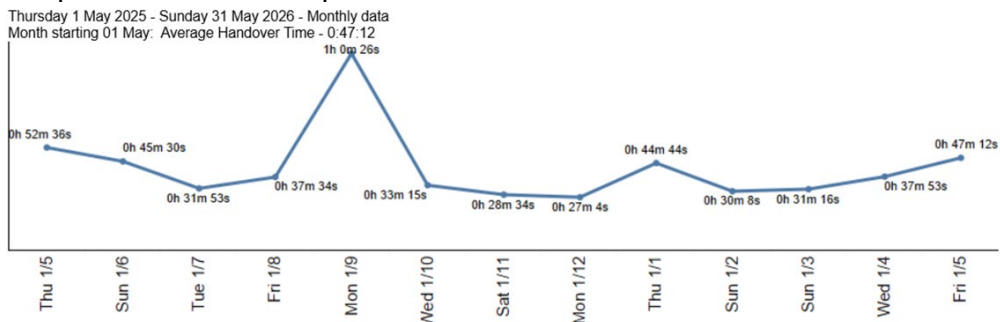
A&E 4hr Performance - All Types (inc booked)

Data source: [Metric Focus: UEC - NHSE SW Weekly Performance Dashboard - Power BI](#) week ending 31 May 2026

2. In May 2026, the Integrated Care Organisation (ICO) managed 11,147 all type UEC attendances. The Emergency Department recorded 7,154 type 1 attendances which is a 1.7% decrease in activity from April 2025.
3. The number of patients waiting longer than 12 hours for admission or discharge in the emergency department increased to 11.7% of total attendances which is a worsening of performance and has resulted in assurance ratings being reduced to limited.
4. The Trust will be undertaking a Trust wide corridor care event on the 23rd June to re-design the current UEC improvement programme. This event will be aimed at galvanising the organisation to develop improvement initiatives to support with a range of opportunities such as demand management, pathway development, emergency zone management, SDEC, ward and flow process, discharge processes, NCTR and community pathways. Further information on the case for change and scope for the work is provided in the supplementary pack and the updated plan will be circulated following this event.

Ambulance Handover Delays

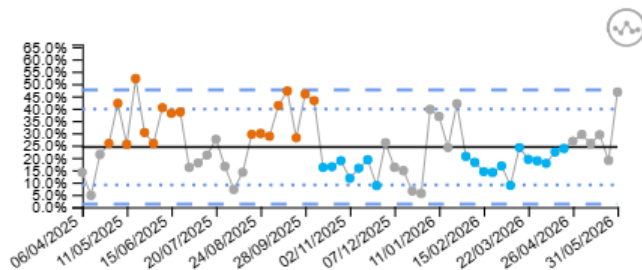
5. The total number of ambulance conveyances to the Trust in May 2026 was 2556 and a 6.4% increase on handovers from May 2025 and 4.6% increase on April 2026.
6. The Trust ambulance handover position worsened through May to an average of 47 minutes and 12 seconds per handover. The current position has improved slightly in June with performance up to the point of publication improving to an average of 46 mins 38 secs against a trajectory of 30 minutes. It should be noted that the first three days of June saw significant performance challenges regionally and performance has improved in the second week of June.



Date Source: Ambulance average handover time: Tableau dashboard E1046

7. During May there was an increase in the total delays over 45 minutes to 751 from 562 in April; the weekly trend in 45-minute breaches can be seen below which currently remains reasonably stable but in excess of the levels expected by regulators. Due to the ongoing challenges with ambulance handovers, assurance levels have been reduced to limited.

Ambulance Delays >45mins



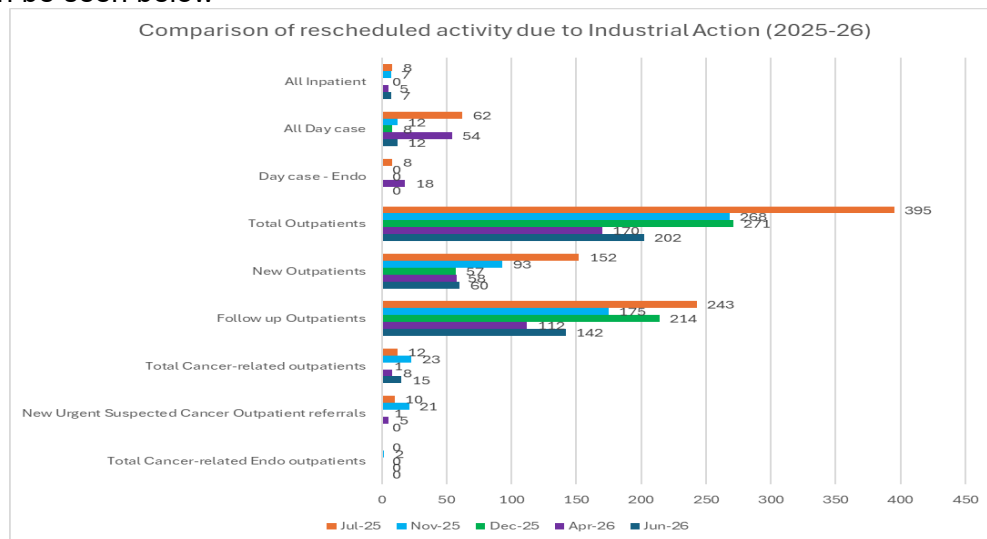
8. The Committee is asked to agree that assurance is **limited** against delivery of the 4-hour performance targets. The committee is also asked to discuss and agree **limited** assurance can be provided on average ambulance handover times and 12-hour performance.

5. Elective Care - RTT

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS													Torbay and South Devon			
Data RAG rated against monthly Operational Plan trajectory	Target	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26		
Bold number = national data	March 2027															
Elective recovery																
RTT 78 week wait incomplete pathway - Actual	0		8	8	9	16	13	16	9	9	13	8	7	9		
RTT 78 week wait incomplete pathway - Plan	0		0	0	0	0	0	0	0	0	0	0	0	0		
RTT 65 week wait incomplete pathway - Actual	0		126	95	97	105	110	109	84	94	83	76	47	76		
RTT 65 week wait incomplete pathway - Plan	0		124	103	83	63	43	23	3	0	0	0	0	0		
RTT 52 week wait incomplete pathway - Actual	0		805	740	615	618	615	647	607	663	604	607	600	799		
RTT 52 week wait incomplete pathway - Plan	0		887	833	780	728	673	586	505	449	383	327	268	571		
RTT % incomplete pathways <18 wks - Actual	73.83%		65.6%	68.2%	69.7%	69.5%	70.4%	69.3%	68.7%	67.5%	67.0%	66.8%	66.4%	62.8%		
RTT % incomplete pathways <18 wks - Plan	73.83%		62.8%	63.1%	63.5%	63.8%	64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	62.8%		
RTT Wait for first appointment <18 weeks - Actual	74.0%		71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%		
RTT Wait for first appointment <18 weeks - Plan	74.0%		65.7%	66.2%	66.7%	67.2%	67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%		
Cancer: 28-day Faster Diagnosis Standard patients diagnosed - Actual	80.88%		70.5%	75.6%	70.1%	62.3%	67.3%	75.7%	76.2%	78.3%	60.6%	79.7%	75.7%	50.4%		
Cancer: 28-day Faster Diagnosis Standard patients diagnosed - Plan	80.88%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	56.4%		
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual	80.75%		69.6%	63.7%	57.8%	64.5%	63.2%	70.4%	71.1%	79.8%	75.2%	67.1%	60.1%	57.4%		
Cancer: 62-day wait for treatment (25/26 target 75%) - Plan	80.75%		74.0%	77.0%	75.7%	75.2%	75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	78.1%		
Cancer: No of patients waiting >62 days to start treatment - Actual			225	223	220	257	176	132	91	119	159	214	201	276		
Cancer: No of patients waiting >62 days to start treatment - Plan																
Cancer: % of patients > 62 days to start treatment - Actual			8.9%	7.9%	7.8%	9.2%	7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%		
Cancer: % of patients > 62 days to start treatment - Plan																
Diagnostics - proportion waiting over 6 weeks - Actual	15%		32.1%	33.9%	36.7%	37.1%	36.8%	29.4%	28.4%	30.4%	35.8%	30.6%	37.4%	41.6%		
Diagnostics - proportion waiting over 6 weeks - Plan	15%							5.0%	4.0%	3.0%	3.0%	3.0%	3.0%	30.6%		
RAG indicator																
Meeting monthly trajectory																
Not meeting monthly trajectory																

- 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 May 2026.
- As part of the Epic go live modelling the Trust expected to see the RTT waiting list grow to 35,500 and a 4% worsening of RTT performance from March by the end of June. At present the Trust is forecasting to remain ahead of waiting list projection with the RTT waiting list currently at 35,177 for May, but RTT performance for May forecasted to be below plan at 60.4% based on current data; teams are actively working on recovery plans.

3. A separate Elective activity and performance recovery paper has been submitted to the committee this month providing additional information and assurance on elective recovery processes. The executive summary from that paper has been included in the executive summary for this paper.
4. The Trust had planned for the resident doctor industrial action in June in line with agreed processes. Scrutiny was given to all proposed elective activity cancellations to ensure the protection of as much activity as possible. The amount of activity protected would equate to ~87% of regular activity and the breakdown of cancellations in comparison to previous rounds of industrial action can be seen below



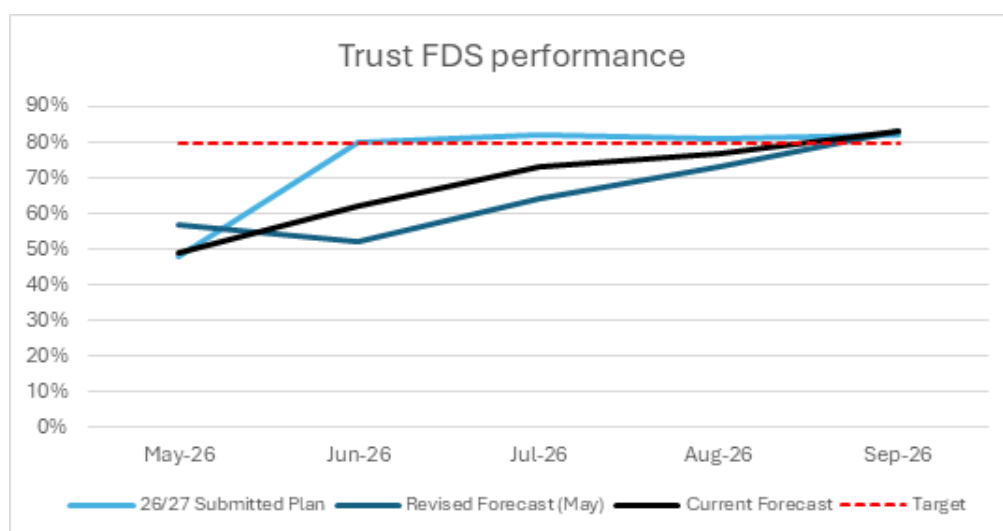
5. Following the cancellation of the industrial action, work has been ongoing to reinstate as much of the cancelled activity as possible. A full breakdown will be provided in next month's paper, however at the time of writing, all of the orthopaedic inpatient long wait cancellations had been reinstated.
6. There are currently concerns that not all of the activity being undertaken is being correctly captured by Epic and the possible impacts this could have on the income position. A joint review is being undertaken between finance and operations at present. A further review is planned between operations and finance to understand the risk of the underperformance on the financial position. At the time of writing the impact on the current underperformance on the income position is still being worked through. It should be noted that the 26/27 elective plan was developed to recover the lost activity later in the year and the actual plan itself was not adjusted to demonstrate this.
7. The piece of work detailed above will be important as in some specialities, the current under delivery of activity has not resulted in a significant worsening of performance. As such, there will need to be a joint proposal created between operations and finance as to whether to recover that activity in year, especially if it would require high-cost solutions to achieve this.

- The committee is asked to agree that assurance is **limited** against delivery of the 65 weeks wait elimination and 52 week wait reduction standards. The committee is also asked to agree that **limited** assurance can be provided on all other RTT metrics within the exit criteria, noting the risks articulated, particularly the expected activity recovery requirements for EPIC stabilisation.

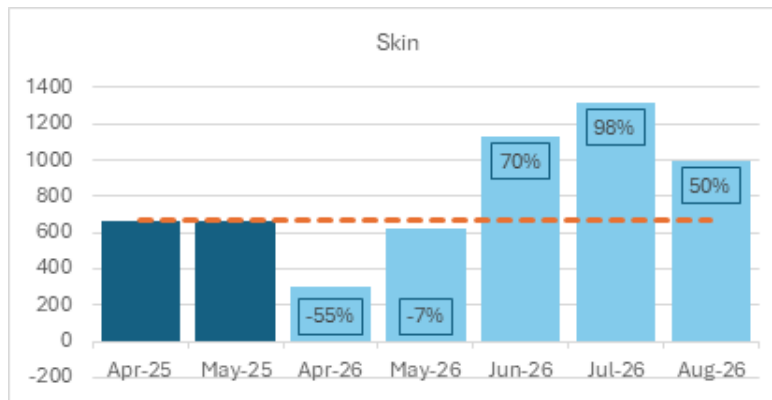
6. Cancer and Diagnostics

- The 28-day faster diagnosis was not met in April with performance at 50.4% against the national target of 80.5% and April trajectory of 56.4%. May forecast is at 49.3% against a May operational plan trajectory of 49.3%. 62-day cancer performance worsened to 57.4% for the same period with a forecast of 50.4% for May.
- On the 18th May the Trust submitted a recovery plan and trajectory to NHSE to detail the actions and expected performance improvement on both the 28-day faster diagnosis standard and the 62-day first treatment standard. The May forecasted position detailed above would have met our original plan but would fall below the performance detailed within the recovery trajectory.
- Additional actions have been taken in May and into June and these have resulted in an improvement in the forecasted position for June onwards which would exceed the recovery trajectory and can be seen below.

Month	March 2026	April 2026	May 2026*	June 2026	July 2026	August 2026	September 2026
26/27 Submitted Plan	79%	56%	48%	80%	82%	81%	82%
Revised Forecast (May)	76%	50%	57%	52%	64%	73%	83%
Current Forecast	76%	48%	49%	62%	73%	77%	83%



- The key specialty driving the highest volume of activity is Dermatology. The below charts describe the volume of activity for Urgent Suspected Cancer appointments, against last year and FDS recovery.



5. As shown in the chart above, additional locum capacity has seen further slots added before the end of June, with the last update (18 May, forecasting 800 activity) now increased to 1,130. With this modelled, the wait for a first appointment at the end of June is expected to be around 30 days. This leads to a current 28-day Faster Diagnosis Standard (FDS) forecast of

Month	April 2026	May 2026	June 2026	July 2026	August 2026
Submitted Forecast (May)	28%	35%	10%	52%	70%
FDS forecast wait, at month end (May)	48 days	35 days	27 days	22 days	20 days
Current Forecast (June)	31%	27%	44%	70%	80%
FDS forecast wait, at month end (June)	48 days	35 days	25 days	22 days	10 days

6. Based on the improvements delivered in dermatology in June, the Trust will be reviewing its cancer performance forecasts monthly with an aim to recovering 28-day FDS performance ahead of the September forecast.
7. The Trust continues to closely monitor the Cancer PTL, particularly the number of pathways waiting more than 62 days, which has increased by 28% since 1 April. This has now stabilised, with current figures below.

	February 2026	March 2026	April 2026	May 2026	June 2026
62-day PTL total	2,313	2,617	3,335	3,332	3,443
62-day backlog (% of total PTL)	214 (9.3%)	201 (7.7%)	276 (8.3%)	317 (9.5%)	311 (9.0%)

8. It is complex to forecast this with any assurance due to the number of stages of a pathway, all of which have been impacted by the planned reduction in elective activity. However, recovery of the PTL backlog and waiting times in key pathway milestones will be monitored and benchmarked, but this is in its infancy due to reporting data in the new EPR. The Trust has maintained its previous forecast for June onwards at present but will continue to review in line with improvements in dermatology.

April 2026	May	June 2026	July 2026	August 2026

2026					
62-day Submitted plan	78.1%	81.7%	78.8%	79.2%	79.9%
Revised forecast	60%	55-60%	70%	72%	75%

9. Diagnostic performance (DM01) remained a challenge throughout FY25/26, and this has continued into FY26/27. The current DM01 position for the Trust in May is 34.2% which is an improvement from April with 41.6% of patients waiting over 6 weeks for diagnostics.

Week End Summary		Patients Waiting			
Test	6+ weeks	Total	Performance (%)		
Audiology - Audiology Assessments	81	628	12.9%	Improvement	
Cardiology - echocardiography	29	534	5.4%	Improvement	
Colonoscopy	101	369	27.4%	Deterioration	
Computed Tomography	27	519	5.2%	Improvement	
Cystoscopy	43	227	18.9%	Improvement	
Dexa Scan	246	483	51.0%	Deterioration	
Flexi sigmoidoscopy	38	122	31.1%	Deterioration	
Gastroscopy	99	372	26.6%	Deterioration	
Magnetic Resonance Imaging	445	1250	35.6%	Improvement	
Neurophysiology - peripheral neurophysiology	2	65	3.1%	Improvement	
Non-obstetric ultrasound	1493	2960	50.4%	Improvement	
Respiratory physiology - sleep studies	0	94	0.0%	No change	
Urodynamics - pressures & flow	7	36	19.4%	Deterioration	
Total	2611	7659	34.9%		

10. Improvements continue to be made in non-obstetric ultrasound following the additional actions put in place during Q4 of 25/26. Worsening in performance was expected across endoscopy modalities in line with Epic go live activity reductions. These modalities are forecast to start improving in July.
11. Improvements are expected in a number of modalities in June including; audiology, Dexa, MRI and non-obstetric ultrasound. These will be slightly offset by a deterioration in performance in cystoscopy and urodynamics due to unplanned staffing absences. Despite this, current modelling is forecasting an improvement to ~30% at end of June.
12. The Committee is asked to agree **limited** assurance against delivery of the 62-day and 28-day cancer performance targets, however, consider that **satisfactory**

assurance can be taken in the impact of the current recovery plans. The committee is also asked to agree **limited** assurance on diagnostic performance at present and discuss if **satisfactory** assurance can be taken on the plans that are in place to recover.

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

Finance & Operations Committee

Month 2 Finance Report

Date of meeting	Date report produced
24 th June 2026	15 th June 2026

Author(s)		Report approved by	
Name and title:	Andrea Wright Director of Operational Finance	Name and title:	Andrea Wright Director of Operational Finance
		Date:	15 th June 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 position at Month 2 for the year ending 31st March 2027.

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the position at Month 1 for the year ending 31st March 2027.

The Trust set a breakeven plan for 2026-27 including £57.8m Deficit Support (DSF) and a CIP target of £54.4m. Trust's financial position at the end of May shows a month end position of **£4.7m** deficit, as planned. The position excluding DSF is **£14.3m** deficit at the end of April, as planned. The Trust was on plan overall, but with the following significant variances noted within this balanced position: under-delivery against CIP target (£0.8m adverse to plan), costs of cover and lost income from Industrial Action (£0.5m adverse to plan) offset with non-recurrent balance sheet flex released to meet these costs (£0.5m favourable to budget), a provision against contract income was made to recognise activity lost through EPR implementation (£0.9m adverse to plan). These adverse variances were offset by other favourable budget variances (£1.7m favourable to plan) mainly undrawn reserves funding for inflation and growth.

The Trust is forecasting delivery of the planned outturn but recognises forecast risks to delivery of between **£9.3m** in the base case and up to **£23.6m** in the

downside risk assessment, with risk to the recurrent underlying position of £3.0m (base case) and £7.0m (downside risk assessment). The Trust will continue to work with operational leads, NHSE and the ICB to accelerate CIP delivery, refine forecast estimates and narrow the forecast range.

Year to date at Month 2 the Trust has recognised CIP delivery of **£3.4m** against a **£4.2m** target (**£0.8m** adverse to plan). Since the plan was submitted intensive work has been undertaken on developing the CIP plans. This has seen a material improvement in plan development and delivery risk assessment, fully developed plans have increased by £21.8m and low risk schemes have increased by £21.1m. The Trust is forecasting full delivery of the £54.4m target.

The Trust is reporting a cash balance of **£24.1m** as at 31st May 2026, **£3.8m** higher than planned, due to slower than planned settlement of capital accruals from 2025/26 capital programme offset with other working capital timing differences. 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.

At Month 2 the Trust has spent **£1.8m** of capital compared to plan of **£3.3m**, an underspend of **£1.4m**. The Trust is forecasting to spend up to capital limits, including an additional £1.8m National PDC Capital towards the Tower Fire Safety scheme.

Information on Month 2 financial performance for Devon ICS is not yet available, although all partner organisations have informally reported on plan financial delivery. All Devon ICS partner organisations have submitted balanced plans.

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.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Financial Performance	Satisfactory	N/A
CIP	Limited	N/A
Financial Risks	Limited	N/A
Workforce	Limited	N/A

Appendices

Appendix 1 – Finance Report

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

N/A

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.

How does this report further our Trust strategy?

This report supports the Trust's strategic objectives to achieve financial sustainability.

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:

Risks to financial sustainability, CIP delivery and adequacy of cash balances are identified Trust risks.

External Standards affected by this report and associated risks

The Trust submits monthly financial returns on the financial position, forecast, CIP delivery and workforce to NHS England.

Finance & Operations Committee

Electronic Patient Record (EPR) Progress and Finance Report

Date of meeting	Date report produced
24 th June 2026	10 th June 2026

Author(s)		Report approved by	
Name and title:	Kevin Pirie EPR Operational Director and Mark Tucker, Head of Strategic Finance	Name and title:	Sam Wadham-Sharpe SRO

Date: 17th June 2026

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

N/A

Executive summary

Progress of the electronic patient record (EPR) implementation:

This report describes our continued progress since go-live on the 3rd April and an overview of Programme finances as of May 2026, Month 2.

Headlines from the Post Live Executive Summary:

Based on observations from the Post Live Stabilisation Assessment, the Staff Survey and, most recently the Post Live Visit Summary alongside the review of headline metrics TSD has been assessed at a WATCH status. Key rating drivers are:

- Pockets of dissatisfaction amongst key user groups
- High impact performance metrics not returning to baseline
- Personalisation and proficiency data

- Failure to establish a confirmed, long-term Governance structure

The full Post Live Summary Report can be found in Appendix 1

Benefits Realisation

As previously reported, benefit register profiles for all transactional benefits have now been translated into approved PODs. The programme's Benefits Analyst is now aligned with the PMO and is supporting the development of the transformational PODs. Outpatient Transformation provides the biggest opportunity for Cash and Non-Cash releasing benefits and is our current priority. Governance and architecture is established (see appendix 2) and a check and challenge process for removing non-viable cash releasing benefits is to be put in place.

15 CRB schemes totalling circa £3.3m now fully developed and signed off

Key Decisions –

- The plan to recruit 1 Devon BAU Analyst team has been delayed whilst the 1 Devon program agrees on the numbers of analysts to be recruited. This needs to be completed by the end of June ahead of the recruitment and on-boarding process in the Summer.

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.

Programme Finances –

To provide an overview of EPR Programme finances and to provide assurance that effective arrangement are in place to manage spend during 2026/27.

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. Post Live Visit Summary Report
2. Benefits Realisation Plan

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 Epic Go-Live has been navigated successfully and adoption of Epic workflows is progressing well. This level of assurance is also based on the risks identified and the work being undertaken to mitigate these.

Note that effective arrangements are in place to manage EPR capital and revenue spending.

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 -	2830, on Datix, no escalation
Datacentres	2831, on Datix, no escalation
Failure to meet cybersecurity and information governance standards	2838, on Datix, no escalation

Risks lodged on Datix:

As detailed above.

External Standards affected by this report and associated risks

N/A

EPR Programme Finance Report

2026/27 in month spend position for capital and revenue against plan.

The tables below show the Month End position for Month 2, May 2026. Values are split between the sub-headings as required for reporting to NHSE.

Capital

Month 02 - May	Month (MTH)			Year to Date (YTD)			Forecast			Full Year Effect (FYE)		
Capital	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Forecast	Variance	FBC Value	FYE Spend	Variance
People	585,223	585,223	0	1,233,252	1,233,252	0	204,748	204,748	0	1,438,000	1,438,000	0
Infrastructure	1,560	1,560	0	31,137	31,137	0	3,014,768	3,014,768	0	3,045,905	3,045,905	0
Software	26,397	26,397	0	64,022	64,022	0	3,168,073	3,168,073	0	3,232,095	3,232,095	0
Data	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	-29,784	-29,784	0	133,784	133,784	0	104,000	104,000	0
Contingency	0	0	0	0	0	0	165,000	165,000	0	165,000	165,000	0
Totals	613,180	613,180	0	1,298,627	1,298,627	0	6,686,373	6,686,373	0	7,985,000	7,985,000	0

Plan values have been matched to spend in month 2. Following the additional funding received in previous years, the Trust has been able to bring forward costs from 2026/27 into earlier years. As a result, the Programme needs to re-assess the budget required for this financial year. This might result in budget being available for the capital investment group to spend on other schemes. An initial view of required spend will be included in the month 3 report

Month 02 - May	Month (MTH)			Year to Date (YTD)			Forecast			Full Year Effect (FYE)		
Revenue	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Forecast	Variance	FBC Value	FYE Spend	Variance
People	452,240	53,135	-399,105	607,265	250,163	-357,102	3,165,717	3,115,819	-49,898	3,772,982	3,365,982	-407,000
Infrastructure	32,203	24,186	-8,017	64,407	50,255	-14,152	322,933	336,184	14,152	386,439	386,439	0
Software	322,132	282,626	-39,506	731,933	561,040	-170,893	3,133,656	3,304,549	170,893	3,865,589	3,865,589	0
Data	42,221	0	-42,221	84,442	0	-84,442	422,208	506,650	84,442	506,650	506,650	0
Other	0	0	0	0	1,494	1,494	0	-1,494	-1,494	0	0	0
TSD budget adjustment	-448,137	0	448,137	-473,443	0	473,443	-175,962	-242,405	-66,443	-649,405	-242,405	407,000
Totals	400,659	359,947	-40,712	1,014,604	862,952	-151,652	6,867,652	7,019,303	151,652	7,882,255	7,882,255	0

Revenue

There is an underspend of £152k at month 2 due to the following variances.

The in-month People variance is because we have capitalised all Programme staff costs, whereas the FBC assumed staff costs from May 26 would be revenue. The programme is still in the stabilisation phase and therefore, the costs can be capitalised. A review of whether future costs, and how much of them can be capitalised will now take place. Software is showing underspend and this is a timing issue. Data is showing an underspend, and this is likely to continue, although too early in the year to be sure. The non recurrent CIP line reflects the decision to capitalise M2 Programme staff costs, so the revenue budget is not needed for M2.

Following Go Live, further work is required to compare FBC budgets with latest cost expectations. The forecast position will be closely monitored.

Risks and Issues

The Programme is managing the following financial risks:

- Programme going over-budget

There is a risk that the programme could go over budget or the phasing of costs and funding are not aligned.

This is being managed by the following mitigations:

- Robust management of the budget, including opportunities to legitimately move costs between years and between revenue and capital.
- Regular review, update and reporting of spend vs plan and identifying variances. Any variances on either capital or revenue will be flagged for further action through internal monthly reporting processes and through the One Devon Programme Board.
- Benefits Realisation Group will be monitoring CRB delivery as part of the CIP delivery process and governance.

Lack of adequate benefits realisation

This risk may result in financial benefits (both cash and non-cash), not being achieved to the level expected and/or within the expected timeframes as described in the FBC.

Mitigations include:

- Benefits Realisation Plan in place, (See Appendix A), along with EPR Benefits Analyst post assisting the PMO team to support delivery.
- Governance on Benefits Realisation – i.e. group; COO is SRO, clarity on ownership for each scheme and POD development, managed through the Trust's PMO as part of the wider CIP governance and reporting structure.
- Emerging benefits are being identified as part of the work with operational and clinical teams. These will be worked up and agreed schemes will be added to the benefit schedule and monitored against alongside the existing schemes.
- Good progress has been made on developing PODs with 15 CRB schemes totalling circa £3.3m now fully developed and signed off
- Two schemes from the original CRB schedule have a scheme status of plans in progress – Reduction in agency and bank spend (£357k) and Escalation beds (£406k) – PODs for these schemes are complete with EQIA sign-off and ready for FDG.

Loss of Income

There is a risk of income loss if the Trust does not deliver the levels of activity included in the Annual Plan, (specifically Elective). Whilst activity numbers were reduced in the plan for April and May to acknowledge the impact of lower expected activity volumes, there is a risk that the activity reduction might be higher than expected. There is also the associated risk of recording accuracy as a result of new processes and pathways being implemented. This could affect where activity is recorded, (ie SDEC vs Inpatient), as well as coding and income impact, for example activity recorded as an outpatient attendance, rather than an outpatient procedure.

Mitigating Actions:

- Creation of an Activity Stabilisation Group (led by Epic initially), meeting twice a week, to report against key high level activity metrics and flagging to Care Groups where activity is below expected volumes to obtain early awareness, allowing investigation and actions to be taken.
- Once monthly data becomes available, creation and sharing of a detailed report with Care Groups, showing actual performance against plan and last year at a granular level. Care Groups will be expected to report back through existing governance routes, explaining any issues and an action plan to mitigate and improve.
- Weekly meetings with Support Services (i.e. Contracting, BI, Performance and Coding) to identify reporting issues and support Care Groups with investigation and actions.

Wider System Working

There are risks and benefits in working with System partners, rather than creating a standalone programme. This risk includes that of changed/increase scope, agreeing who pays and delays in decision making, impacting on timelines and therefore costs of the programme and when the EPR becomes BAU and embedded within each Trust.

Mitigating Actions:

- Individual teams (ie Finance, BI and Coding colleagues in UHP/TSD/RDUH) are building relationships to support working together to ensure alignment in processes to reduce duplication and ensure consistency across providers.
- A One Devon EPR Programme Board is in place until the end of Sept as per the One Devon Programme timeline. Post September arrangements are still to be agreed.
- There is also the opportunity for ongoing sharing of resources and therefore costs to the benefit of all organisations in Devon.



Torbay and South Devon
NHS Foundation Trust

Quality People Committee

Perinatal Quality and Safety – Executive Summary report

Date of meeting	Date report produced
26 May 2026	15 May 2026

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

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 (March 2026). 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 Workforce	Limited	Mitigation in place but long-term continuation of shortfall may impact compliance for Maternity Incentive Scheme
2.2 Alert-Impact of Epic rollout on training compliance	Satisfactory	Stable- Mitigation planned and in place to address shortfall
2.3 Cultural and psychological safety concerns	Limited	Ongoing work to address gaps
3.0 Assure Perinatal mortality	Satisfactory	Mitigations and oversight in place with improving trajectory
4.0 Advise Learning and quality improvement activity	Satisfactory	Progress evident in improvement work that is being monitored via MatNeoIST
5.1 Celebrating success. Baby Friendly Reaccreditation	Significant	Significant work to maintain infant feeding standards alongside intense oversight in other areas of service

Appendices

Appendix 1. Perinatal Governance & Safety Report (1st – 31 March 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

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 safety quality group.

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.
- Continue to support the ongoing culture and wellbeing initiatives
- Note the impact of non-compliance with BR+ establishment recommendations

How does this report further our Trust strategy?

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

How does the report support the Triple Aim

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

Impact on BAF Objectives

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

Risk

N/A

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risks

NHS England licence and regulations
National policy, guidance– Maternity Incentive Scheme (MIS) NHS Resolution
CQC

Perinatal Quality and Safety Report – Executive Summary

1.0 Introduction and background

The purpose of the report is to provide the 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 Workforce

Some workforce pressures remain, including a Birthrate Plus (BR+) midwifery establishment deficit (3.81 WTE) and neonatal Qualified in Speciality (QIS) levels below recommended standards (57% vs 70% benchmark), with reliance on flexible staffing and senior clinical support. There is an action plan in place to mitigate the QIS risk with support from the SW neonatal network. The midwifery establishment requires an uplift in specialist midwifery posts that would support the demographic needs of the population. Additional posts would also enable greater ability to complete the work required for assurance compliance.

2.2 Impact of Epic rollout on training compliance

Training compliance remains below the required $\geq 90\%$ threshold across several staff groups, impacted by operational pressures and EPIC implementation. 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 Cultural and psychological safety concerns

There is a continued focus on addressing a psychological safe culture within the service. Clinical psychology sessions for staff along with the development of a psychological safety strategy are the interventions currently in progress. There is still some feedback that demonstrate areas in which this culture needs to be strengthened, including feedback from staff and learners indicating challenges in raising concerns and reports of bullying/harassment. Although the numbers are small and may not represent all views, an action plan has been developed to focus on learners in practice.

3.0 Assure

3.1 Reduction of perinatal mortality

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

3.2 Improving compliance

Full compliance with all ten Maternity Incentive Scheme (MIS) safety actions for Year 7 has been achieved. This is an improvement from year 6 in which the Trust only achieved 8/10. This demonstrates the tenacity of the team in amending the processes of monitoring and oversight as well as some dedicated support such as clinical effectiveness midwife and perinatal compliance lead. This has resulted in an evident improvement trajectory, particularly in governance, safety processes, and system-wide oversight, supported by perinatal leadership team, executive engagement and regional collaboration.

4.0 Advise

4.1 Learning and quality improvement activity

Supported by the national team the service has continued their focus on learning and quality improvement work. This includes strengthening the collaboration during PMRT reviews, thematic reviews (including neonatal deaths and preterm births), as well as continued implementation of Saving Babies Lives Care Bundle (largely compliant/on track). Recommendations from the perinatal deaths review will be presented to the team in mid-May 2026 with a meeting planned to action plan with the PLT in early June. This will then be presented back to the committee in the next report.

5.0 Celebrating Success

5.1 Baby Friendly Reaccreditation

In March, the maternity service received confirmation successfully of their UNICEF Baby Friendly Initiative (BFI) reaccreditation, demonstrating continued compliance with national standards for infant feeding, parent–infant relationships, and personalised care. The reaccreditation process provided external assurance of the quality of care provided to women and families and reflected the sustained commitment and professionalism of the multidisciplinary team across the service.

5.2 Culture and leadership.

Progress continues to be made in the effectiveness of the perinatal leadership team. The leadership team continue to support psychological safety workstreams and clearer escalation behaviours. The clinical psychology team have begun to support the team. The leadership team are supported by the Devon senior lead from the maternity and neonatal voices partnership (MNVP) who can provide insight from a service user perspective strengthening voices of women and families.

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.
- Continue to support the ongoing culture and wellbeing initiatives
- Note the impact of non-compliance with BR+ establishment recommendations

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
2.1 Workforce	Limited	Mitigation in place but long-term continuation of shortfall may impact compliance for Maternity Incentive Scheme
2.2 Alert- Impact of Epic rollout on training compliance	Satisfactory	Stable- Mitigation planned and in place to address shortfall
2.3 Cultural and psychological safety concerns	Limited	Ongoing work to address gaps
3.0 Assure Perinatal mortality	Satisfactory	Mitigations and oversight in place with improving trajectory
4.0 Advise Learning and quality improvement activity	Satisfactory	Progress evident in improvement work that is being monitored via MatNeoIST
5.1 Celebrating success. Baby Friendly Reaccreditation	Significant	Significant work to maintain infant feeding standards alongside intense oversight in other areas of service

Quality and People Committee

May 2026 Mortality Score Card

Date of meeting	Date report produced: 19.5.2026
26 th May 2026	19 th May 2026

Author(s)		Report approved by	
Name and title:	Mr Chris Manlow – Director of Patient Safety Maria Patterson-AD patient safety	Name and title:	Chief Nurse
		Date:	19 th May 2026

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

N/A

Executive summary

The report is for quarterly assurance to ensure learning from deaths. This report relates to the mortality data period December 2024 – November 2025 (M09)

Key Highlights mortality indicators:

1. The latest HSMR+ for September 24 to August 25 is 107.6 (101.0 – 114.6) and statistically higher than expected. This represents a change in banding compared to the last report produced in January 26 and a 4-point increase in HSMR+.
2. The rolling 12-month trend shows that over the last four periods the HSMR+ has increased with the most recent period being statistically higher than expected.
Trust crude % – 3.7%, Regional crude % – 3.6%, and National % – 3.6% (Plymouth 4.1%, Royal Devon 3.2%)
Trust expected % – 3.4%, Regional expected % - 3.3%, National – 3.6% (Plymouth 2.7%, Royal Devon 3.8%)
3. Elective HSMR+ rate is **106.8** which is within the expected range. The rolling 12-month trend shows a downward trajectory over the last nine periods.
4. SHMI is 96.44 and statistically as expected' and has shown a downward trend.
5. Emergency weekend HSMR+ remains statistically higher than expected. Emergency weekday HSMR+ remains within the expected range. Weekend HSMR+ shows an increasing trend in latter periods. Weekday HSMR+ also shows an upward trajectory over the last three periods.

For escalation:

6. The Trust is not assured that all cases requiring a structured judgment review are being reviewed using this tool. The SJR module has been transferred to the DCIQ electronic system which will enable enhanced oversight however medical staff are not yet familiar with this system. Support is required from medical leadership to ensure clinician engagement.
7. Mortality coding: Due to staffing capacity there has been a delay in coding mortality data. This data is classified as R69 uncoded date falling outside of 41 diagnosis groups which can negatively affect the accuracy and quality of our mortality data. The coding position has improved, all 2025/2026 coding is complete, which should start to show a more positive impact on mortality statistics when it filters through to the data

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from the previous report
Hospital Mortality	Satisfactory	HSMR+ increased – Expected due to the implementation of a new methodology and coding challenges SHMI - decreased Remains steady
Unadjusted Mortality Rate	Satisfactory	
Mortality Analysis	Satisfactory	Increased – anticipated and under review prior to CUSUM alerts
Focused Mortality Reviews	Satisfactory	Congestive Cardiac Failure, Sepsis, Stroke

Appendices

N/A

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

Mortality Surveillance Group, Patient Safety Group, Quality and People Committee (QPC)

Key recommendations and actions requested

The Quality Assurance Committee is asked to accept the report and note the mortality data trends.

How does this report further our Trust strategy?

Reviewing the care provided to people who have died, and gaining the feedback from the bereaved will help improve care for all service users by identifying problems associated with poor outcomes, and working to understand how and why these occur so that meaningful action can be taken.

How does the report support the Triple Aim

Quality of services provided	To provide learning to aid the improvement of service provision and indicate any issues with care

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	This supports the Board in providing visible and effective leadership to ensure the organisation addresses significant issues identified in reviews and investigations.

Risk

N/A

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risks

Care Quality Commission
National guidance – Learning from deaths

February 2026 Mortality Score Care Summary Report

Introduction

The document 'National Guidance on Learning from Deaths' provides a framework for NHS Trusts for identifying, reporting, investigating and learning from deaths in care. From April 2017, Trusts have been required to collect and publish, on a quarterly basis, specified information on deaths by submitting a paper to the Public Board.

Data sourced, includes data from the Trust, Department of Health (DH), and Dr Foster. The report is generated for the Trust Board, Quality Improvement Group, and Mortality Surveillance Group.

This is a summary report a longer report provided to QPC is available on request.

Summary

Torbay & South Devon NHS Foundation Trust Data.

Safety Indicator	Data Source	Target	RAG
Hospital Standardised Mortality Ratio (HSMR+) December 2024- November 2025	Dr Foster's latest benchmark month	Below the 100 line with an aim for a yearly HSMR+ ≤ 90	12-month average 107.6 statistically higher than expected ↑
Summary Hospital Mortality Index (SHMI) November 2024 to October 2025	DH SHMI data	Within the 'as expected' Range	96.44 ↑
SHMI alerts	DH SHMI data		None of the 10 SHMI monitored diagnosis groups are statistically higher than expected
Mortality Analysis	Trust Data Dr Foster DH HSMR data	New CUSUM alerts (Cumulative Sum)	four new CUSUM alerts this quarter (see section X)
Mortality Reviews and Learning	Trust Data	Deep dive work has been commissioned regarding stroke deaths, cardiac	Same

		failure, sepsis and Surgical mortality.	

Assurance and Recommendations

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from the previous report
Hospital Mortality	Satisfactory	HSMR+ increased – Expected due to the implementation of a new methodology and coding issues SHMI – slight increase
Unadjusted Mortality Rate	Satisfactory	Remains steady and in line with regional/national peers
Mortality Analysis	Satisfactory	Increased – anticipated and under review prior to CUSUM alerts
Focused Mortality Reviews	Satisfactory	Review underway regarding sepsis, stroke, surgical, cardiac failure

Recommendations

Members of the Quality and People committee are asked to:

- to receive and note the mortality data and analysis, including the implications for patient safety and quality.
- discuss the findings and analysis shared and confirm whether further assurance is needed at this stage.
- Note the challenges in the completion of structured judgment review cases on the incident reporting system and request continued medical leadership to encourage medical engagement.

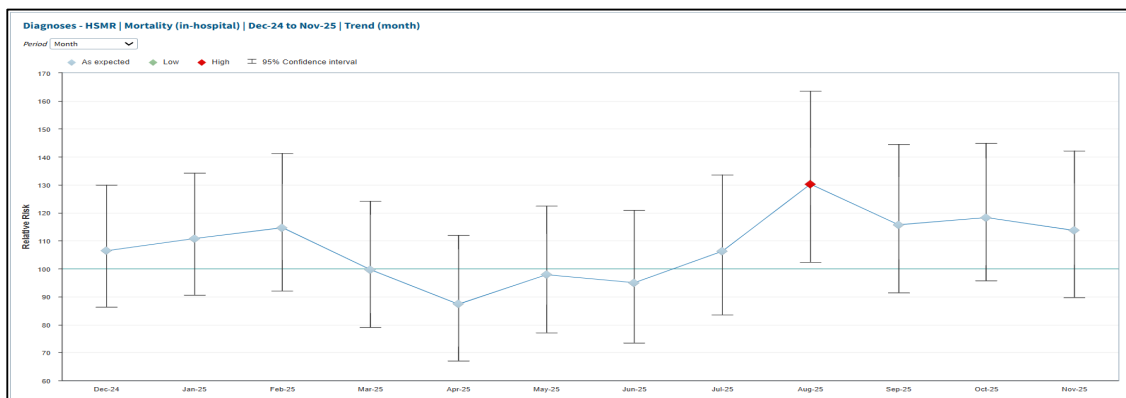
1.0 Mortality coding:

2.0

In the February Mortality scorecard, we reported that coding had a back log to November 2025 of approximately 7000 episodes pre-February 2026. These uncoded episodes are still included in the data and will be submitted to SUS. This impacts negatively on mortality statistics. This position has improved and all 2025/2026 coding is complete. This data is anticipated to show a more positive impact on mortality statistics when it filters through to the data collection.

2.0 Mortality data and trends

- The latest HMSR+ for December 24 to November 25 is **107.6** (101.0 – 114.6) and statistically higher than expected. This represents a change in banding compared to the last report produced in January 26 and a 4-point increase in HMSR+.
- There were 85,548 superspells recorded in the time period and 1244 deaths vs 1193.3 expected deaths. All individual months are within the expected range.
- August 25 in isolation is statistically higher than expected potentially because of a reduced volume of superspells in this month. This is due to the high volume of R69 uncoded data for this month that is excluded from HMSR. July, September to November 25 are also impacted resulting in raised HMSR+ for these individual months.



2.1 CUSUM Alerts

CUSUM is short for 'cumulative sum' These review the sum of the differences between expected outcomes and actual outcomes over a series of patients. Alerts are designed to signal that a pattern of activity appears to have gone beyond a defined threshold.

Compared to the dashboard in the previous report there are four new CUSUM alerts that were not present in the last reported period:

Congestive heart failure, non-hypertensive – Alert in August 25 (74 observed deaths vs 51.9 expected)

Diseases of white blood cells – Alert in February 25 (1 observed death vs 0.2 expected)

Genitourinary symptoms and ill-defined conditions – Alert in January 25 (3 observed deaths vs 1.2 expected)
 Other upper respiratory infections – Alert in September 25 (3 observed deaths vs 0.4 expected)

Six ongoing CUSUM alerts are being monitored. Many of these alerts are caused by variations in mortality in small numbers of patients however a review of Cardiac Failure deaths has been commissioned to understand this specific alert. These trends will be monitored by the mortality steering group, **and further analysis will be commissioned if necessary.**

2.2 New Groups with a statistically higher relative Risk

2.2.1 There are **two new groups** with a Relative Risk that is statistically higher than expected, that were not apparent in the previous report.

- Coronary atherosclerosis and other heart disease (10 observed deaths vs 4.1 expected)
- Other upper respiratory infections (3 observed deaths vs 0.4 expected)

3.0 Focused Mortality Reviews

3.1 Urgent and Emergency Care

Mortality review work looking at the effect of long waits in the ED has been ongoing since 2022. This work has recently been updated for 2025. The data shows that whilst overall mortality has improved and is now at pre-Covid levels, in elderly patients waiting for more than eight hours for a bed mortality has actually increased and is statistically significant in patients over 90 years. This increase has been sustained over the last few years. This work has been presented at the Mortality Surveillance Group.

There is ongoing work looking at Sepsis care, Surgical mortality and Stroke mortality. These are due to report back to the Mortality Surveillance Group later in the year. We have also commissioned some work to review Congestive Cardiac Failure deaths as these have recently flagged as a CUSUM alert.

4.0 Perinatal mortality (Quarter 2 and 3).

4.1 This reports details perinatal still births or neonatal deaths in quarter 4 (Jan – March 2026).

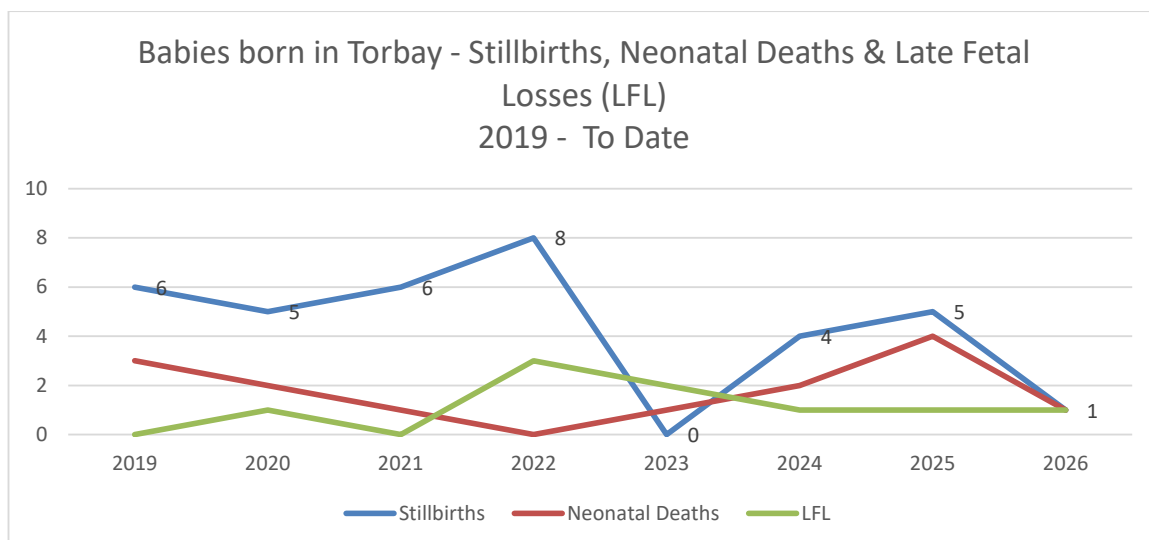
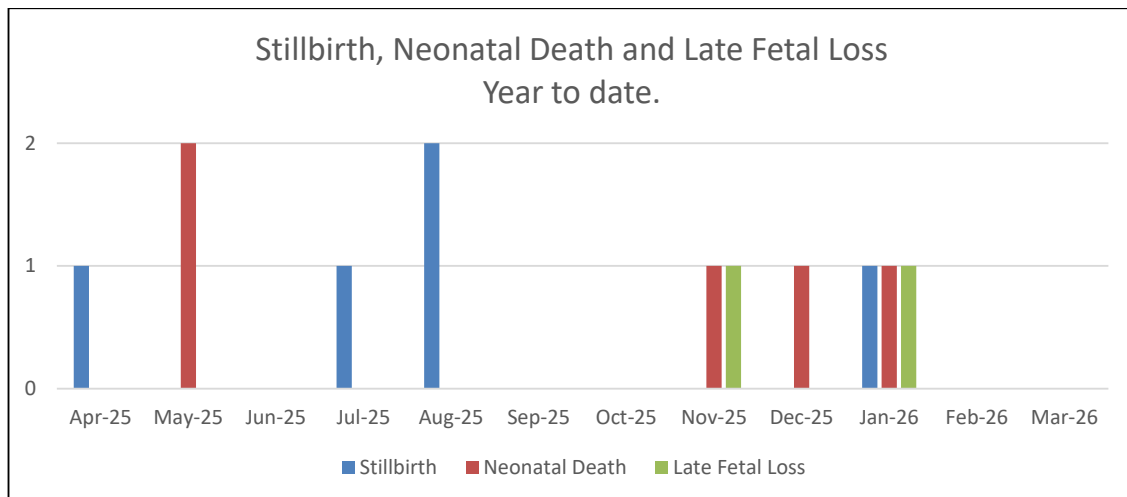
Definitions.

- Stillbirth: when a baby is born dead after 24 completed weeks of pregnancy. It occurs in around 1 in every 200 births in England.
- Early neonatal death: the death of a newborn within the first seven days of life.

Perinatal services have seen an increase in neonatal deaths. Cases that meet criteria have been referred Maternity and Neonatal Safety Investigations (MNSI) for review, a perinatal mortality review tool (PMRT) meeting will also be held. The Trust is also undertaking 2 patient safety incident investigations into cases from May 25

and Jan 26. A case review meeting was held on 19th March with external engagement. Key themes were identified and actions produced to be managed under the Maternity and Neonatal Improvement Support Team (MNIST) action tracker.

The chart below shows the cases of stillbirth, neonatal death and late fetal loss since April 2025. The second chart depicts mortality rates since 2019.



4.2 Current Perinatal mortality cases:

January 2026: 1 baby born at 29+2/40 delivered by Category 1 CS at Torbay, treated for sepsis at birth, transferred to Derriford, died 2 days later. Derriford are leading on the Perinatal Mortality Review Tool (PMRT). The Trust is also investigating this case as a patient safety incident investigation (PSII) under the local maternity category of delays to escalation in care.

January 2026: Baby born at 30+6/40 having been transferred in utero for an uplift in care to St. Michaels, Bristol due to known fetal abnormality. Baby born in St Michaels and transferred to hospice at 15 days of age. St. Michaels to lead on PMRT.

January 2026: Baby stillborn at Torbay at 28+2 weeks gestation. PMRT meeting held on the 7th May 2026 was unable to determine a cause of death. No issues were found with the care of the mother up until delivery of her baby and care issues which would have made no difference to the outcome for the mother were determined by the multi-disciplinary team.

January 2026: Late fetal loss of a baby at 21 weeks who died following amniocentesis which confirmed T21.

There were no perinatal loses in February, March or April 2026.

4.3 Perinatal mortality actions:

- Perinatal services are being supported by the MNIST Action plan. Due to an increased number of incidents 2 insight meetings were held to review themes and trends.
- 2 internal PSII's are underway related to perinatal mortality cases supported with external perinatal expertise from MNIST.
- A thematic review meeting was held on March 19th to review all cases, identify themes and learning. This meeting was supported by MNIST, executive lead for safety, perinatal leaders and the central patient safety team.

5.0 Child Deaths quarter 3 & 4

A child death review must be carried out for all children regardless of the cause of death, both expected and unexpected, including death of a live-born baby, and birth of a baby not attended by a healthcare professional determined to be born alive (it does not include stillbirths, late foetal loss or termination of pregnancy).

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area, or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

In quarter 3 there was 1 expected death of a child who had been under the care of specialist liver units in Birmingham and Bristol, then transferred to an out of area hospice where they sadly died.

No expected or unexpected child deaths in quarter 4.

Delays remain in receiving postmortem reports this is exacerbated for children due to a shortage of paediatric pathologists.

6.0 Medical Examiner service

The Medical Examiners service became statutory on the 9th September 2024. As such, the independent Medical Examiner's Office hosted at TSDFT now scrutinises 100% of the deaths in the hospital and community settings, which are not directly

referred to the coroner. In October 2025 the medical examiners mechanism for reporting deaths transferred to the Trust DCIQ incident reporting system, this will enable improved safety insight and triangulation of data.

On 1st October 2025 the mortality module on the Trust incident reporting system went live to ensure robust capture of ME requests for Structured Judgement Reviews (SJRs). Since implementation in October 2025 to the end of the financial year for 2025/2026, the medical examiners referred thirty-one deaths to the Trust for further review via SJR due to possible care factors impacting upon the outcome or due to concerns raised by bereaved families. The Trust's patient safety team is not currently assured that An SJR is being completed for all appropriate cases. The patient safety team will work with the medical examiner team to provide assurance that all deaths escalated by the medical examiner service have been reviewed.

7.0 Deaths of a patient with a Learning disability or Autism

Q4 Update (2025/26)

Patients with learning disabilities continue to experience significant health inequalities, with life expectancy estimated to be 15–20 years shorter than the general population. The Learning Disabilities Mortality Review (LeDeR) programme requires independent thematic review of deaths to identify learning and drive system-wide improvement across health and care partners.

In addition, all deaths occurring within acute and community hospital settings are subject to independent scrutiny through the Medical Examiner system and, where appropriate, a Structured Judgement Review (SJR) undertaken by Trust GP advisers. This ensures that potential care quality issues are identified at the earliest opportunity.

During Q4 2025/2026:

- A total of 7 deaths of patients with a learning disability were recorded.
- 5 LeDeR referrals were submitted in line with national requirements.
- No cases have, to date, triggered a focused LeDeR review, and no recurring themes have been identified.
- All cases were reviewed by the Medical Examiner, with no concerns raised regarding care or cause of death.

Oversight and handover of this area is currently being transitioned to Natalie Herring, Deputy Chief Nurse, to ensure continued senior clinical leadership and system learning.

8.0 Learning from deaths & structured judgment review

We are currently revising our learning from deaths policy which will be published trustwide later this year. The trust uses the Royal College of Physicians Structured Judgment (SJR) review methodology to review deaths identified by the Medical Examiner service, or which meet local criteria for review. The SJR process may also trigger a further patient safety review.

SJR's form a key part of our Learning from Deaths strategy but there remains work to be done to strengthen this process, to be led by the Medical Director, Deputy Medical Directors and Trust Lead for Mortality. Training resources for SJRs have been developed and Trust clinicians undertaking SJRs are supported to gain access to Datix so that SJRs can be completed. The SJR reviews are completed by the relevant clinical teams, and the outcome data are held centrally on the Datix system.

The quarterly Mortality Surveillance Group (MSG) continues to have clinical engagement and oversight. A monthly mortality huddle is used to drive progress and flag any emerging issues. MSG will continue work to improve coding accuracy and data coding to ensure accuracy of mortality data, and commission focused work to understand areas of increased mortality (following safety intelligence, CUSUM alerts, mortality trends).

9.0 Challenges/Risk

The Coding team is adapting to the new Elixhauser/ Bottle methodology; however, there are limitations around capturing comorbidity/frailty (related to our IT systems), which can potentially lead to an underestimate or "risk of death" and thus an overestimation of our HSMR. There have been significant capacity issues in the trust coding team. This has affected the timeliness and quality of our mortality data. The coding position has improved (due to overtime), all 2025/2026 coding is complete, which should start to show a more positive impact on mortality statistics when it filters through to the data

Accessing Mortality data has been difficult for clinical teams due to poor IT. Poor IT systems and multiple paper-based, manual systems represent areas of risk for the trust in managing patient referrals and records.

It should be noted that with the Epic the above IT issues should be overcome, however the coding department still has capacity issues with five positions currently being advertised, a delay in coding even with Epic will still impact mortality. It is also expected that Epic will increase the number of day cases to be coded, although this is not yet proven.

Uptake of the SJR system has so far been limited. This is due to IT issues and issues around allocation of clinicians to the role within specialties. Work is ongoing to correct this supported by the patient safety team and Director of patient safety.

10.0 Recommendations

Members of the Quality and Peoples committee are asked to:

- to receive and note the mortality data and analysis, including its implications for patient safety and quality.
- discuss the findings and analysis shared and confirm whether further assurance is needed at this stage.
- The Trust is not assured that all cases requiring a structured judgment review are being reviewed using this tool. The SJR module has been transferred to the DCIQ electronic system which will enable enhanced oversight however

medical staff are not yet familiar with this system. Support is required from medical leadership to ensure clinician engagement.

- Mortality coding: Due to staffing capacity there has been a delay in coding mortality data. This data is classified as R69 uncoded date falling outside of 41 diagnosis groups which can negatively affect the accuracy and quality of our mortality data. The coding position has improved, all 2025/2026 coding is complete, which should start to show a more positive impact on mortality statistics when it filters through to the data

Glossary of Terms

HSMR (Hospital Standardised Mortality Ratio) - the case-mix adjusted mortality rate relative to the national average. This now uses the Elixhauser/ Bottle methodology to capture predicted mortality.

The Standardised Hospital Mortality Indicator (SHMI) is the ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital, which resulted in a death either in-hospital or within 30 days post-discharge from the hospital. The expected number of deaths is calculated from a risk-adjusted model with a patient case-mix of age, gender, admission method, year index, Charlson Comorbidity Index and diagnosis grouping. The cumulative risk of dying within the spell for each patient within the selected group gives the number of expected deaths.

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	CoG/Board Policy of Engagement for Serious Concerns				Review of Board Workplan
For Review						
	Patient Story Our Plan for Better Care Strategy Update Operational Plan	Patient Story Our Plan for Better Care ~~Workforce Plan~~ Strategy Update	Patient Story Our Plan for Better Care Strategy Update	Patient Story Our Plan for Better Care SDH Developments Annual Report and Accounts Strategy Update	Patient Story Our Plan for Better Care Strategy Update	Patient Story Our Plan for Better Care Strategy Update
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 Clinical Audit Forward Plan Medicines Management Annual Report Cultural Insights Report End of Life Annual Report National Staff Survey Report	IPQR Working Lives of Resident Doctors NMC Fitness to Practice Cultural Insights Report Annual Revalidation Report Mann 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 2 July 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



02/07/2026 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

- Our Plan for Better Care Report Appendix (item 4.1)
- Perinatal Quality and Safety Report Appendix (item 5.4.1)

Finance and Operations Committee

- Integrated Performance and Quality Report (item 5.3.1)
- Elective Activity Report (item 5.3.1)
- Monthly Finance Report Appendix (item 5.3.2)
- Electronic Patient Record Progress Report (item 5.3.3)

Quality and People Committee

- Medicines Optimisation Report
- End of Life Annual Report
- Cultural Insights Review Group
- Clinical Audit Forward Plan
- 2025 National Staff Survey Results Report (Revised)



Our Plan for Better Care

Torbay and South Devon NHS Foundation Trust
June 2026





Executive Summary



This report provides an update to the Board of Directors at TSDFT on delivery progress against Our Plan for Better Care. It summarises: (a) the monthly assurance position across workstreams, (b) delivery of CIP aligned to relevant workstreams, and (c) the highest risks and issues to delivery, including mitigations that have been reviewed and challenged in month. Detailed workstream updates are provided in the appendices following monthly highlight reporting.



Delivery of Our Plan for Better Care Oversight Group is chaired by the Chief Executive and includes 6 core domains; Living well in our neighbourhoods, Reimagining acute and specialist care, Joined up care, every step of the way, Smart use of technology for better care, Caring skilled people, ready for tomorrow and Enablers. Across these domains, the programme encompasses 15 workstreams. Domain Senior Responsible Officers (SROs) receive a monthly highlight & escalation report from each workstream. These are presented to Oversight Group and form the basis of this report



The Board of Directors will receive a monthly update on delivery of Our Plan for Better Care, focusing on progress, key challenges, and actions to mitigate delivery risks. The Executive Assurance RAG is aligned to existing Board Assurance ratings to ensure consistency and clarity in assessing workstream performance.



RAG definitions are;

Significant Assurance

Satisfactory Assurance

Limited Assurance

No Assurance



Workstream Progress Summary

Domain / Workstream	May 2026	June 2026
1.0 Living Well in our Neighbourhoods		
1.1 Frailty Expansion and Community Bed-Base Care Review		
1.2 Acute Bed-Base Care Review		
1.3 Virtual Ward & Hospital at Home Service		
1.4 Neighbourhood Teams Infrastructure & Support		
1.5 Adult Social Care Transition		
1.6 Innovation & Evaluation Hub		
2.0 Reimagining Acute & Specialist Care		
2.1 Clinical Services Review		
2.2 Improving Productivity		
2.3 Pathology		
3.0 Joined-up Care, Every Step of the Way		
3.1 Pathway Review and Redesign		
4.0 Smart use of technology for better care		
4.1 Digital First incorporating AI		
4.2 Epic Implementation & Benefits, including MY CARE		
5.0 Caring, skilled people ready for tomorrow		
5.1 Workforce Transformation		
5.2 Culture Transformation		
6.0 Strategic Enablers		
6.1 One Devon Shared Services - Finance		

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

Key Updates in Month:

- Frailty Expansion has moved to satisfactory assurance, reflecting positive progress including the development of the 7-day Frailty SDEC business case. Bed-Based Care and Virtual Wards have moved to no assurance due to limited progress within the workstreams to date and identified resource gaps, increasing the likelihood of delays to key deliverables
- In respect to Clinical Service Reviews, a small number of activities are currently running approximately one month behind schedule, which is impacting overall status. Targeted recovery plans are in place and being actively progressed to bring delivery back on track.
- For Epic Implementation & Benefits, the change in assurance reflects the current level of delivery risk associated with the CRB schemes.



The Transformation Programmes Impact to CIP (M2)



Our Plan for Better Care Workstream Dashboard

Workstream	Original Plan	Latest CIP Schemes	Transacted YTD	Transacted Full Year Delivery	Forecast Outturn (Transacted & Forecast)	Forecast Outturn High Delivery Risk	Forecast Outturn Medium Delivery Risk	Forecast Outturn Low Delivery Risk	Variance Between Original & Forecast Outturn
1.1 Frailty expansion & community bed based care review	£ 1,225,995	£ 1,221,000	£ -	£ -	£ 894,616	£ -	£ -	£ 894,616	£ 326,384
1.2 Acute Bed Based Care Review	£ 1,206,000	£ 1,208,480	£ -	£ -	£ 609,524	£ -	£ 409,524	£ 200,000	£ 598,956
1.4 Neighbourhood infrastructure and support	£ 401,000	£ 401,000	£ -	£ -	£ 401,000	£ 80,000	£ 321,000	£ -	£ 0
1.5 Adult Social Care Transition	£ 11,390,000	£ 10,408,003	£ 573,757	£ 930,642	£ 10,352,905	£ 1,898,003	£ -	£ 8,454,902	£ 55,098
2.2 Improving Productivity	£ 1,150,000	£ 1,150,000	£ -	£ -	£ 1,150,000	£ -	£ -	£ 1,150,000	£ 0
4.2 Epic implementation & benefits including MyCare	£ 5,056,312	£ 4,654,497	£ 86,642	£ 908,422	£ 4,650,842	£ 1,643,789	£ -	£ 3,007,053	£ 3,655
5.1 Workforce Transformation	£ 2,896,600	£ 2,896,600	£ -	£ -	£ 2,655,162	£ -	£ -	£ 2,655,162	£ 241,438
5.2 Cultural Transformation	£ 1,574,000	£ 1,574,000	£ -	£ -	£ 1,505,000	£ -	£ -	£ 1,505,000	£ 69,000
Our Plan for Better Care Total	£ 24,899,907	£ 23,513,580	£ 660,399	£ 1,839,064	£ 22,219,049	£ 3,621,792	£ 730,524	£ 17,866,733	£ 1,294,531
Other Non Pay - Procurement	£ 1,915,000	£ 1,925,000	£ 62,449	£ 374,779	£ 1,993,999	£ -	£ -	£ 1,993,999	£ 68,999
Other Non Pay - Medicines Optimisation	£ 2,600,000	£ 2,661,316	£ -	£ -	£ 2,315,853	£ -	£ -	£ 2,315,853	£ 345,463
Other Care Group Schemes	£ 25,004,877	£ 26,319,943	£ 2,691,326	£ 7,424,562	£ 27,890,938	£ 3,431,646	£ 1,315,440	£ 23,143,852	£ 1,570,995
Total	£ 54,419,784	£ 54,419,839	£ 3,414,174	£ 9,638,405	£ 54,419,839	£ 7,053,438	£ 2,045,964	£ 45,320,437	£ 0

The Trust has a challenging **£54.4m** CIP target to achieve in 2026/27, of which *Our Plan for Better Care* has schemes that contributes **£23.5m** (43% of the total plan).

Year to date delivery stands at **£0.7m**, with full year delivery of **£1.8m** and a forecast outturn of **£22.2m**, leaving a variance of **£1.3m** against the latest schemes.

The dashboard opposite summarises the CIP position by workstream.

There remain additional CIP schemes, outside of the remit of OPFBC, including non pay schemes in Procurement and Medicines Optimisation, together with local Care Group schemes.

The forecast outturn of these schemes totals **£32.2m** bringing the total forecast outturn position to **£54.4m** in line with the overall CIP target.



RAID Management

- The PMO continues to strengthen its approach to RAID management, with all high risks (scoring 15+) and issues categorised as critical clearly highlighted within this report to support visibility and proactive oversight (pages 6-8).

RISKS

- During this reporting period, 63 existing risks were reviewed via the OPFBC RAID log and circulated to SROs for validation and confirmation. In addition, **11 new risks were escalated for SRO review and approval**, comprising 5 within Living Well in Our Neighbourhoods, 2 within Reimagining Acute & Specialist Care and 3 within Smart Use of Technology for Better Care. These risks are summarised alongside in the accompanying table.
- 7 risks are currently rated at 15 or above and are included in this report for oversight and agreement ahead of onward Board reporting. This represents a reduction from 18 in the previous period, providing increased assurance and indicating that mitigating actions are beginning to positively impact inherent risk levels.

ASSUMPTIONS

- During this reporting period 54 existing assumptions were recorded on the OPFBC RAID log & shared with SRO's to 'check & confirm'. **2 new assumptions were presented** in month. These are summarised in the table opposite.

ISSUES

- During this reporting period 7 existing issues was recorded on the OPFBC RAID log & shared with SRO's to 'check & confirm'. **1 new issues was presented to SRO's for check and approval**. These are summarised in the table opposite.
- 3 of these issues are currently categorised as 'critical' and are listed in this report for oversight and agreement for onward reporting to Board.

DEPENDENCIES

- During this reporting period 77 existing dependencies were recorded on the OPFBC RAID log & shared with SRO's to 'check & confirm'. These are summarised in the table opposite.

Domain / Workstream	No. of Risks	No. of Assumptions	No. of Issues	No. of Dependencies
1.0 Living Well in our Neighbourhoods	26	21	5	30
1.1 Frailty Expansion and Community Bed-Base Care Review	3	6	1	5
1.2 Acute Bed-Base Care Review	4	1	0	6
1.3 Virtual Ward & Hospital at Home Service	4	3	0	4
1.4 Neighbourhood Teams Infrastructure & Support	7	3	0	6
1.5 Adult Social Care Transition	6	4	3	4
1.6 Innovation & Evaluation Hub	2	4	1	5
2.0 Reimagining Acute & Specialist Care	23	13	1	23
2.1 Clinical Services Review	11	5	0	15
2.2 Improving Productivity	3	2	0	5
2.3 Pathology	9	6	1	3
3.0 Joined-up Care, Every Step of the Way	3	4	2	2
3.1 Pathway Review and Redesign	3	4	2	2
4.0 Smart use of technology for better care	8	9	0	10
4.1 Digital First	2	5	0	6
4.2 Epic Implementation & Benefits, including MY CARE	6	4	0	4
5.0 Caring, skilled people ready for tomorrow	7	5	0	7
5.1 Workforce Transformation	5	3	0	5
5.2 Culture Transformation	2	2	0	2
6.0 Strategic Enablers	7	4	0	4
6.1 One Devon Shared Services – Finance	7	4	0	4
Total	74	56	8	77

Please see Appendix B for the full detailed OPFBC RAID log.



Highest Risks to Delivery (1)

Definitions

Movement in month – Key:

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

Workstream risks with a current risk score of 15+:

7 risks remain rated at 15 or above and are included for oversight and agreement ahead of Board reporting. This is a reduction from 18 in the previous period, providing increased assurance that mitigating actions are having a positive impact. The remaining risks continue to be closely monitored; while mitigations are in place and progressing, workstream leads consider it too early to reduce their scores.

Workstream & Risk Reference	Risk Description	Initial Risk Score	Current Risk Score	Mitigations	Mitigation Owner	Mitigation Status	Target Risk Score	Risk Trend
2.3 Pathology - 059	Risk: Actual expenditure and benefits realisation will no longer align with the timings set out in the FBC. Cause: Implementation timescales slip. Consequence: CDEL and capital spend cannot be recognised in the required financial periods.	20	20	1) Early notification to capital programme of slippage in this financial year. 2) Ongoing review of benefits delivery & mitigations	1) Paul Asprey 2) Paul Asprey	In Progress In Progress	5	↔
1.2 Bed based care review - 008	Risk: Delays or compromise to the delivery of the Acute Bed Base Review. Cause: Seasonal increase in emergency admissions and bed occupancy exceeding safe operational thresholds. Sustained OPEL 3–4 pressures during winter months. Consequence: Delayed completion and assurance of the Acute Bed Base Review. Inability to implement planned bed reconfiguration. Intended transformation benefits are not realised.	16	16	1) Strengthen front-door clinical decision-making. 2) Expand admission avoidance pathways. 3) Patient Flow Management (PFM), maintain a clear escalation framework, using escalation beds as a last resort. 4) Agreed shared priorities across acute, community and wider partnerships.	1) Lee Johns 2) Lee Johns 3) Lee Johns/Craig Owen 4) Lee Johns	Not Started Not Started In Progress In Progress	12	↔
1.2 Bed based care review - 010	Risk: Constrains the scope, timing, and implementation of the Acute Bed Base Review. Cause: Mandate to eliminate corridor care by Sept 2026 (defined as treating patients in non-designated areas (corridors, waiting rooms, ambulances) for 45 minutes or more. Consequence: Acute Bed Base Review recommendations may be delayed, scaled back, or re-sequenced to avoid any perceived risk to corridor care compliance. Reduced ability to progress bed reductions, reconfiguration, or repurposing until corridor care risks are fully mitigated.	16	16	1) Explicitly adopt “corridor-care-free” principles as a non-negotiable constraint within the demand and capacity analysis. 2) Consider testing all scenarios against winter and peak-demand assumptions to ensure robustness. 3) Consider testing all scenarios against winter and peak-demand assumptions to ensure robustness. 4) Communicate clearly with clinicians and wider stakeholders that bed review activity supports, and does not compromise, corridor care elimination.	1) Lee Johns/Shelly Machin 2) Lee Johns 3) Lee Johns 4) Lee Johns	Complete Not Started Not Started Not Started	12	↔
1.5 Adult Social Care - 057	Risk: Inadequate resources are available to plan, manage, and execute the ASC transition effectively. Cause: Insufficient staffing levels (clinical, operational, or project resources) allocated to the ASC transition programme. Consequence: Delays to transition timelines and key milestones. Reduced quality of implementation, leading to operational inefficiencies.	16	16	1) Undertake detailed workforce planning aligned to transition milestones. Ringfence time. 2) Monitor where workstreams are falling behind and escalate. 3) Procure external SMEs.	1) Alan Welch 2) Alan Welch 3) Alan Welch	In Progress In Progress In Progress	8	↔



Highest Risks to Delivery (2)

Definitions

Movement in month – Key:

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



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Workstream risks with a current risk score of 15+:

Workstream & Risk Reference	Risk Description	Initial Risk Score	Current Risk Score	Mitigations	Mitigation Owner	Mitigation Status	Target Risk Score	Risk Trend
2.3 Pathology - 054	Risk: Workforce retention is compromised. Cause: Staff are unwilling to relocate to the new site. Consequence: Leading to staffing shortages, reduced pathology capacity, delays in diagnostic testing, increased costs, and potential risks to service continuity and patient safety.	20	16	1) Early and proactive engagement with affected staff to understand concerns and Management of Change (MoC) plans being developed. 2) Travel impact assessment and mitigation, including support for public transport, parking provision, travel subsidies and minibus provision. 3) Increasing outsourcing / Locum support whilst recruiting to posts that have been vacated. 4) Discussions between Trusts to understand workforce gaps.	1) Tony Lowe	In Progress	8	
					2) Tony Lowe	In Progress		
					3) Tony Lowe	Not Started		
					4) Tony Lowe	Not Started		
2.3 Pathology - 058	Risk: Required inputs are not available when needed, delaying the start or progression of Digital activities. Cause: Prerequisites, dependencies, and required inputs for Digital workstreams are not clearly defined or agreed at the outset. Consequence: Delays to Digital workstreams and overall programme timeline. Inefficient use of Digital resources due to stop/start activity.	16	16	1) Comprehensive prioritisation & risk management process for Pathology Digital Projects agreed and in place. 2) Further work to be completed to align to programme objectives where same resources required for delivery.	1) Ria McCoy/Josh Langdon 2) Ria McCoy/Josh Langdon	Complete	4	
						Not Started		
2.3 Pathology - 060	Risk: Required activities will not be completed in time to support a go-live by the end of March 2027. Cause: Equipment transfer, installation, and verification timelines take longer than allowed for within the programme. Consequence: Failure to achieve go-live by the end of March 2027. Knock-on delays to dependent programme workstreams and operational readiness.	16	16	1) Engage Roche and key suppliers in joint planning sessions to confirm lead times, resource requirements, and critical path activities, ensuring supplier capacity is aligned to programme needs. 2) Implement a detailed readiness checklist (site readiness, utilities, approvals, documentation, training) and actively manage dependencies to prevent avoidable delays on arrival or install.	Tony Lowe	In Progress	4	
						Not Started		



Highest Issues to Delivery

Workstream Issues with a current category of critical

Workstream & Issue Reference	Issue Description	Issue Category	Likely consequence if left untreated	Mitigations
1.5 Adult Social Care - 003	Torbay Council have referred matter to judicial review.	Critical	Decision nullified, additional timescales and costs.	1) Evidence and decision logs. Collate all relevant documents, decisions, and audit trails to support the organisation's position
1.5 Adult Social Care - 004	Torbay Council are raising concerns about Trust engagement.	Critical	Project will stall. Increased staff anxiety.	1) TC-TSD SRO meeting to address any perceived lack of engagement. 2) Joint workstreams and project plan.
2.3 Pathology – 007	The existing TSD Histopathology facility is not fit for purpose (circa 40 years old, Building Condition D), resulting in ongoing staff recruitment and retention challenges and increased operational risk associated with building failure.	Critical	Increases workforce, service continuity, and safety risks. Increased likelihood of building failure leading to unplanned service disruption. Requirement to identify and fund an alternative accommodation solution outside the programme, with associated cost, delay, and reputational impact.	1) Work with TSD and Estates to implement short-term mitigations to reduce safety, workforce, and operational risks in the existing facility while the programme solution is delivered.



Appendices

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 Hub



Torbay and South Devon
NHS Foundation Trust

Delivered

7-day Frailty SDEC service

- ✓ Significant progress has been made in developing the 7-day Frailty SDEC service, with clinical design complete and the business case submitted to TIG (26/05/2026); following review, it has now progressed to regional 'Triple Lock' for approval.
- ✓ Core service model components including cohorts, interfaces, governance, safety frameworks supported by standard operating procedures (SOPs) and a Harbour dashboard reporting pack are established, alongside a quarterly review mechanism.
- ✓ Workforce requirements are clearly defined in the business case, although consultation is required for staff not contracted for 7-day working, and clarity is still needed on the services overarching Care Group governance.
- ✓ Operational processes, communications planning, referral guidance, and digital readiness are largely complete, with outstanding actions including frailty redirection pathways, stakeholder engagement, and EPIC optimisation.
- ✓ Go-live is now projected for November 2026 (or earlier if feasible), with a proposed extension to the delivery timeline.

Xray mobile services

- ✓ Procurement activity for vehicles and equipment is underway and due for completion by June 2026, supported by completed stakeholder engagement, EQIA/DPIA, and financial due diligence of contract (including VAT position).

Community beds redesign

- ✓ Community Bed Reconfiguration Case for Change discussed at EXCO on 21/05/26, strong in-principle support, and—following incorporation of feedback and refinements—is now progressing to Private Board for approval.

Next Steps

- Procurement of the mobile x-ray service for launch in July/August (timelines dependent upon procurement risk of publishing via most suitable provider route. Intention to award contract decision w/c 6th July 2026.

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
27-001	Totnes Hospital Bed Reconfiguration	1,129,995	1,125,000	0	798,616	28.66	28.66	0.00	0.00	
27-001	Totnes bed closure- catering/ food service	96,000	96,000	0	96,000	1.40	1.40	0.00	0.00	

Key Performance Indicator	Baseline	Target	Current Position	Trend
Reduced ambulance conveyance from care homes	Population of KPIs will be prioritised in M3 subject to approval			
10% Reduction in ED attendances with # HIP/NOF				
Reduction in acute hospital admission for patients >65 years				
30% reduction in re-admission rates for patients >65 years				

RAID Group	Score/ Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
		No new RAID in this reporting period.

Assurance	Rating
Executive Sponsor Rating	Satisfactory



1.2 Bed Based Care Review


Torbay and South Devon
NHS Foundation Trust

Delivered

✓

An options appraisal paper for bed reconfiguration is being prepared for submission to the June Executive Committee (ExCo). This draft does not include an option for bed closures. While progress has been made in developing the paper, there remains limited assurance regarding the feasibility of any future bed reductions due to increasing demand, reliance on escalation areas (as a cost pressure), and ongoing work to eliminate corridor care.

✓

Work on the remaining deliverables will commence once there is an ExCo decision about the Acute Bed-based care review paper. Further analysis and engagement will be required to confirm deliverable plans and assess feasibility, particularly in relation to service capacity and system-wide impacts.

✓

Work to eliminate corridor care is in progress, with a trust-wide meeting scheduled for 18/05/2026 to support this objective.

Next Steps

•

Complete draft options appraisal paper for submission and approval at EQIA Panel and Executive Committee.

•

Develop the quantifiable metrics (baseline, target and current position) used to evaluate that the project is meeting objectives.

Key Performance Indicator		Baseline	Target	Current Position	Trend
Bed occupancy		Population of KPIs will be prioritised in M3 subject to approval			
Length of stay improvement					
Length of stay improvement					

RAID Group	Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
		No new RAID in this reporting period.

Assurance	Rating
Executive Sponsor Rating	No

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
27-062	Dawlish MIU Closure	250,000	252,480	0	200,000	4.36	2.40	0.00	4.36	
27-072	Acute Bed-base care review	956,000	956,000	0	409,524	32.48	32.48	0.00	32.48	



1.3 Virtual Ward & Hospital at Home Service



Delivered
✓ No material progress has been made against workstream deliverables this month, primarily due to capacity constraints.
Next Steps
- End-to-end Virtual Ward pathway agreed and implemented, including referral route into Virtual Wards - Develop Central Hub staffing model and posts confirmed - Develop Communication pack and hold stakeholder briefing sessions - Develop training materials - Start to progress establishing a single Virtual Ward budget - Develop the quantifiable metrics (baseline, target and current position) used to evaluate that the project is meeting objectives. - Confirm and allocate necessary operational and clinical resources to support the next phase of virtual ward expansion, including engagement of ops managers and clinical leads.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Increased VW capacity – 80 beds	Population of KPIs will be prioritised in M3 subject to approval			
Reduced cost per VW patient				
Improved clinical outcome e.g. Los				

RAID Group	Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
		No new RAID identified during this reporting period.

Assurance	Rating
Executive Sponsor Rating	No

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
To be confirmed in discussion with Finance Business Partner.										



1.4 Neighbourhood Teams Infrastructure & Support



Delivered
✓ Metrics pack agreed with Health Innovation South West (HISW) shared accountability for system outcomes include: • Reducing non-elective admissions • Improving urgent and emergency care performance • Reducing unnecessary outpatient activity • Improving discharge flow and reducing delays ✓ INT Programme Group meetings agreed to progress with steering/project groups aligned to governance and delivery of TSDFT signature moves focussing on Frailty, Cardiovascular, Diabetes and End of Life. ✓ Business case approvals awaited at triple lock for Community Bed Based Review & Frailty Expansion. Mobile X-ray Service to be discussed at TIG on 17/6 with parallel procurement publication from 5th June 2026. ✓ Early clinical engagement for sub-specialty involvement.

Next Steps
• Develop outcomes framework and quantifiable metrics (baseline, target and current position) to evaluate the project is meeting objectives e.g. key targets in national framework as well as interdependencies across primary care/LCP/ICB to be mapped to ensure partner plans aligned/map data flows. • Sub-specialty virtual ward expansion stakeholder meetings take place to initiate phase 1 of delivery. • Programme governance structure outlined. • OD/workforce development approach to be outlined. • Establish resource/knowledge repository to demonstrate system changes impacting population. • Co-creation session with NEDS for Board Seminar 24/7/2026. • Confirm baseline, target and data source for KPIs. • Finalise outcomes framework and benefits methodology. • Map interdependencies with Primary Care, LCP, ICB and Digital Integration. • Mobile Xray service decision approval at TIG 17/6/2026.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Flat growth rate across UEC demand (current forecast 6.5%)	National Framework baseline assumptions: >10% improved health outcomes <10% reduction in outpatient activity >10% identified as approaching End Of Life <10% reduction in admitted bed days Contributed to <25% diversion rate from secondary care for people with diabetes.			
Reduction in Type 1 ED Attendances (baseline 4k increase 24/25-25/26)				
Reduction in ambulance conveyance to ED.				
Further KPIs TBC following wider evaluation (see next period).				
RAID Group	Score/Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)		
NEW Assumption		Acute clinicians will work with neighbourhood teams to co-design and deliver pathways across the full patient journey, including admission avoidance (crisis) and urgent care, Inpatient care where required, discharge, rehabilitation and follow-up. This requires joint clinical ownership and a move away from organisational handoffs toward continuous, coordinated care.		
NEW Dependency	With external parties	Clarify ICB position and leadership expectations.		
Assurance		Rating		
Executive Sponsor Rating		Limited		

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
	Rationalisation of Estate- Teignmouth hospital	321,000	321,000	0	321,000	1.48	1.48	0.00	0.00	
	Impact of Integrated Neighbourhood Coordination	80,000	80,000	0	80,000	0.00	0.00	0.00	0.00	



1.5 Adult Social Care



Torbay and South Devon
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Delivered
Delivery remains at an early stage, with progress still affected by dependencies, unresolved scope questions and capacity constraints. Planning, Coordination and Governance ✓ Transition Working Group (TWG) has been established and meets fortnightly and first Oversight Group meeting has now taken place, providing senior review of the programme position, key risks, and workstream escalations. ✓ Meetings have taken place with workstream leads to review involvement in activities contained in the Torbay Council project plan and build the TSD delivery plan, including identification of Council-only, joint and TSD-specific tasks. Workforce & HR ✓ Workforce workstream is now mobilised with regular meetings established with Council counterparts, helping align plans and progress TUPE-related work Finance ✓ Joint finance group has been established and has already convened twice, strengthening financial oversight and enabling coordinated decision-making ✓ Better Care Fund, Client debt, year-end handling of transactions after 31 March, legacy financial issues and clarity on financial and contracting baselines highlighted during meeting with workstream leads ✓ Need for stronger finance resourcing identified Operations (including Customer Services) ✓ CHC and Intermediate Care remain closely linked to IT systems and joint admin arrangements, with additional staffing support identified but still needing to be worked up into a clear model. Legal and Governance ✓ Work continues on Memorandum of Understanding Data & Analytics ✓ Milestone plan completed on 29/05/2026 IT and Infrastructure ✓ Work continues on Liquid Logic implementation Engagement and Communications ✓ FAQ and intranet arrangements have also progressed, and routes that were previously feeding back to the Council have been further clarified.

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's (FYE)	Forecast Outturn £000's	26/27 Original WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
7 schemes	£6,200	£8,500	£931	£8,455	0.00	5.00	0.00	0.00	
1 scheme	£5,190	£1,980	0	£1,898	0.00	0.00	0.00	0.00	

Key Performance Indicator		Baseline	Target	Current Position	Trend
Following approval, reporting against the KPIs outlined on slide 16 will commence in the next reporting period.					
RAID Group	Score/ Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)			
NEW Risk	9	Cause: Unclear TUPE scope and complexity. Consequence: Delays, inaccuracies, legal issues, and higher costs.. Mitigations: 1. Undertake exercise to identify TUPE scope early. 2. Secure specialist Expertise. 3. Develop clear TUPE plan.			
NEW Risk	9	Cause: Unclear debt ownership across partners Consequence: Financial disputes and delays, affecting affordability and delivery. Mitigations: 1. Clarify debt position early. 2. Agree ownership principles. 3. Legal and Finance review and agree Formal agreement document.			
NEW Issue	Concerning	Cause: Vacancy in Property Management means Estates not resourced to provide consistent workstream leadership and delivery Mitigations: 1. Interim cover will be provided by R. Callcut.			
Next Steps					
• Finalise Terms of Reference and Delivery Plan • Write back to Anna Coles setting out the Trust position on transfer scope, including areas agreed in principle, areas not accepted as out of scope and staff groups that still require further due diligence • Further development of KPIs • Hold the planned half-day operational workshop to define the post-transition health model for referral handling, hospital discharge, coordination, and associated health functions • Validate staff list and continue TUPE assessment work, including preparation for the planned formal consultation launch on 01/08/2026. • Clarify staff base assumptions, equipment arrangements, NHS mail, and wider system access issues. • Continue staff and stakeholder communications as well as conversation relating to NHS Pension Scheme					



1.5 Adult Social Care – Proposed KPIs



Area of Work	KPI	Numerator	Denominator
Human Resources and Staffing	% Staff confirmed in scope	No Staff confirmed as being in scope	No initial staff identified (minus those confirmed as out of scope)
	% Staff awaiting a decision as to whether they are in scope	No Staff awaiting a decision as to whether they are in scope	No initial staff identified (minus those confirmed as out of scope)
	% Outcome letters issued	No Outcome Letters issued	No staff confirmed as being in scope
	% Staff Transferred under TUPE	No Staff Transferred under TUPE	No staff confirmed as being in scope
	% post transfer Payroll or Contractual issues resolved	No Post transfer Payroll or Contractual issues resolved	No Post transfer Payroll or Contractual issues raised
Estates	% Lease documents gathered	No Lease documents gathered	No buildings confirmed as being in scope
	% Lease documents reviewed	No Lease documents reviewed	No buildings confirmed as being in scope
	% Compliance Checks completed	No compliance checks completed	No buildings confirmed as being in scope (excluding those not required)
Contracts and Commissioning	% ASC Contracts reviewed	No ASC Contracts reviewed	No ASC Contracts
	% NHS Contracts reviewed	No NHS Contracts reviewed	No NHS Contracts
Finance	% Balance Lines prepared	Balance Lines prepared	Balance Lines
	% Balance Lines prepared (£)	£ Balance Lines prepared	£ Balance Lines
	% Debt Cases with agreed ownership (No)	No Debt Cases with agreed ownership	No Debt Cases
	% Debt Cases with agreed ownership (£)	£ Debt Cases with agreed ownership	£ Debt Cases
	% Court of Protection Orders reviewed	No Court of Protection Orders reviewed	No Court of Protection Orders
Operations	% Pathways mapped	No Pathways mapped	No Pathways in scope
	% Customer Service Scripts updated	No Customer Service Scripts updated	No Customer Service Scripts
	% Leaflets updated	No Leaflets updated	No Leaflets in scope
Data and Analytics	% Statutory Returns and Reports catalogued	No Statutory Returns and Reports catalogued	No Statutory Returns and Reports
IT and Infrastructure	% Liquid Logic Implementation Milestones complete	No Liquid Logic Implementation Milestones complete	No Liquid Logic Implementation Milestones
Communications and Engagement	% Engagement Events completed	No Engagement Events completed	No Engagement Events
	% FAQs with responses	No FAQs with responses	No FAQs
Legal and Governance	% Legal Queries closed	No Legal Queries closed	No Legal Queries raised



1.6 Innovation & Evaluation Hub


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NHS Foundation Trust

Delivered					Key Performance Indicator	Baseline	Target	Current Position	Trend
✓ The Innovation Steering Group (ISG) has been established, with the inaugural meeting on 11 June 2026. A draft Terms of Reference, including scope and membership, has been developed to support effective mobilisation and engagement. ✓ A draft Hub operating model has been developed and is ready for initial review; the SRO is currently finalising the target audience and next steps for circulation and review. ✓ Review of the DISG Gateway process has been completed, with updates drafted to reflect dual internal and external entry pathways; the revised approach will be presented at the ISG meeting on 11 June. ✓ A draft Hub designation paper is in development and has been shared with the SRO for initial review; subject to feedback, it is scheduled for presentation to ISG for ratification in July. ✓ A structured baseline assessment of all 28 active pipeline projects against ISG Gateway maturity criteria has been completed in June, alongside full project triage with agreed classifications (deploy, pause, stop) confirmed; work to define benefits is now underway, with a draft paper targeted for July ISG for ratification. ✓ Following initial scoping discussions in April, the partnership with HIN South West has progressed to formalisation and is currently with partners for completion; a similar position has been reached with NHSE Regional following a meeting between the Regional Director, CEO and SRO in May. ✓ In addition to the initial £10k secured, a further circa £2m grant is being agreed with the European Space Agency, with timelines for access to funding to be confirmed. ✓ Options appraisal for the proposed structure is nearing completion and will be submitted to the SRO to inform and support decision-making on restructure.					KPI 1 — % of innovation pipeline actively progressing	• 39% of pipeline actively progressing (11 of 28 projects). • 61% stalled at prototype stage.	• Target: 60% or more of pipeline actively progressing by Q4 2026/27.	Pipeline triage complete (June 2026); all 28 projects classified. Active/stalled split to be formally confirmed at July ISG.	New
					KPI 2 — Number of jointly delivered or co-funded HIN SW projects	• 0 jointly delivered or co-funded projects.	• Minimum 1 co-funded or jointly delivered project initiated by Q3 2026/27.	Not yet initiated. Dependent on partnership agreement completion.	New
					KPI 3— Innovation-to-IT pipeline SLA: in place (Y/N)	• No innovation-to-IT pipeline SLA in place.	• SLA agreed and operational by Q4 2026/27.	Not yet established. Dependent on Implementation Lead appointment and IT Services engagement. Options appraisal for structure nearing completion.	New
					KPI 4— Average time from ISG Gateway 3 approval to BAU deployment (days, per project)	• Not yet established. No formal tracking of Gateway 3-to-BAU time in place.	• Baseline established and average time tracked monthly from Q3 2026/27 once SLA is operational.	Not yet trackable. Will be established alongside the innovation-to-IT SLA.	New

Next Steps		
• Complete the draft Hub designation paper and finalise for review at the July ISG meeting. • Progress benefits definition, mapping, and alignment with Epic where applicable. • Develop a benefits dashboard to enable effective oversight and visibility at future ISG meetings.		

RAID Group	Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
		No new RAID in this reporting period.
Assurance		Rating
Executive Sponsor Rating		Satisfactory

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
No CIP savings expected to be delivered in 2026/27										

2.0 Reimagining Acute & Specialist Care

Senior Responsible Owner – Nicola McMinn, CNO, Sam Wadham Sharpe, COO & 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



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ Good progress has been made in advancing analytical capability and strengthening clinical engagement across priority productivity workstreams. During the month, the workstream lead met with lead clinicians to align on programme objectives and confirm their critical role in driving engagement and delivery.
- ✓ Evaluation criteria, including hurdle criteria, have been developed in alignment with workstream objectives and the Trust strategy. Reviewed by SROs, and decision made to close this action as any strategic changes will be managed by ICB.
- ✓ Analytical work with Midlands CSU is underway, with multiple investigations and modelling activities in progress. These are expected to complete within a three-month timeframe.
- ✓ An external diagnostic review for Trauma and Orthopaedics, led by Ruth Griffiths, is progressing well. Clinical pathways are currently being mapped and key issues identified. Early findings indicate significant opportunities for improvement, with further work underway to develop recommendations by the end of June.
- ✓ A proposal has been developed outlining Associate Clinical Director leadership for Paediatrics and Maternity.

Next Steps

- The Chief Operations Officer (COO) will identify and secure external clinical support for Emergency Medicine.
- Trauma and Orthopaedics review to continue by external clinical specialist.
- Plans with Paediatrics and Maternity Associate Clinical Director leading the work to be confirmed.
- Workstream governance meeting membership will be updated to include on workstream leads and SROs to focus on escalations and decisions. This is due to feedback from clinical leads that their time is more efficient when used to engage directly with the teams.

Key Performance Indicator	Baseline	Target	Current Position	Trend
No. of CSR's completed	N/a	6	0	
No. of service improvements identified (per CSR speciality)	N/a	2 x 6	0	
No. of improvement plans in delivery	N/a	12	0	
<i>Please note - delivery impact KPIs to be identified following reviews</i>				

RAID Group	Score/Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
		No new RAID in this reporting period.

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
No CIP savings expected to be delivered in 2026/27										



2.2 Productivity Including Best Practice

Delivered

- ✓ Progress has been made in mobilising analytical capability and strengthening alignment across key productivity workstreams, although this has been limited due to ongoing resource challenges and as these are expected to persist, securing additional support from the finance team is necessary.
- ✓ Midlands CSU support is in place, with mobilisation underway and stakeholder engagement initiated. Demand and capacity modelling using the New Hospital Programme (NHP) model is in progress. Service Line Reporting (SLR) data has been shared to highlight areas for further review, and analytical work using national datasets has commenced.
- ✓ The finance team has refined the mapping of Cost Improvement Programme (CIP) schemes to productivity themes, improving alignment and transparency. At the same time, challenge and scrutiny from the ICB is increasing, reinforcing the need for stronger, more robust data to support progress reporting and decision-making.
- ✓ Interdependencies with the Clinical Service Review are being actively managed by the workstream lead to ensure alignment and learning and opportunities are shared across the workstreams.
- ✓ Detailed learning from the Trauma and Orthopaedics diagnostics workshop will prove useful, informing the wider productivity workstream, particularly in identifying opportunities to improve theatre utilisation.
- ✓ Workstream governance and delivery structures continue to mature, with dedicated groups now being established for key cross-cutting themes such as theatres, outpatients, and inpatient flow (left shift – movement of healthcare resources, out of acute hospitals and into community care setting)
- ✓ Overall, the programme is mobilised and progressing. Addressing current resource constraints and strengthening analytical capacity will be essential to maintain momentum, respond to increasing stakeholder expectations, and deliver sustainable productivity improvements.

Next Steps

- Continued advance analytical capability development.
- Midlands CSU analytical support ongoing.
- Maintain governance and external engagement.

Key Performance Indicator

Baseline

Target

Current Position

Trend

Following approval, reporting against the KPIs outlined on slide 24 will commence in the next reporting period.

RAID Group

Score/ Category

Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)

No new RAID in this reporting period.

Assurance

Rating

Executive Sponsor Rating

Limited

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
27-022	Same Day Cancellations in Theatres	150,000	150,000	0	150,000	0.00	0.00	0	0	
27-081	Finance – NHSE Variable Contract		500,000	0	1,000,000		0.00	0	0	
	Finance – NHSE Variable Contract	1,000,000	500,000	0	0	0.00	0.00	0	0	



2.2 Productivity Including Best Practice – Proposed KPIs



Key Performance Indicator	Baseline	Target	Current Position	Trend
Outpatients				
• % of clinic templates meeting GIRFT UQ				
• % of follow up pathways adhering to GIRFT standards				
• % patients discharged at first appointment				
• % DNA				
• First to follow up ratios	<i>To be populated from M3 subject to approval</i>			
• % activity undertaken as virtual				
• % activity re-directed through SPOA				
• % room utilisation in c these half sessions we seem to have				
• % follow up overdue backlog reduction				
Theatre				
• % theatre capacity used (fallow sessions) broken down by specialty				
• Theatre utilisations (knife to skin or needle to skin)				
• % HVLC lists adhering to GIRFT standards				
• % cancellations on the day (non clinical)				
• Compliance with 6-4-2 protocol				
Diagnostics				
• % direct to test pathways in place and used				
• Number of tests per inpatients (radiology and pathology)				
• % risk stratified pathways in place				
• Reporting turnaround times				



2.3 Pathology



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ Progress has been made in strengthening governance and delivery oversight, with fortnightly Steering Group meetings and structured workstream reporting now supporting effective coordination and timely escalation.
- ✓ Clinical and operational design has progressed, with significant advancement in microbiology. Key developments include the design of Acute Service Laboratory (ASL) and Clinical Service Laboratories (CSL) models, incorporating considerations for turnaround times, transport logistics, technology requirements, workforce implications, and business continuity.
- ✓ Activity has also commenced to prioritise Full Business Case (FBC) content and enable a more agile, responsive workstream structure, including focused logistics, CSL, and ASL discussions through both formal and ad hoc sessions.
- ✓ Despite this progress, delivery remains under pressure due to the demanding timetable, dependencies on estates, workforce constraints, and limited availability of key clinical and leadership input, all of which continue to present risks to pace and momentum.
- ✓ Overall, while governance, design, and prioritisation activity are progressing well, sustained focus and targeted mitigation of key risks will be critical to maintaining trajectory and achieving planned milestones.

Next Steps

- Progress the FBC refresh at pace, using extraordinary meetings where needed, to complete by mid-August and secure Board approval by end-September.
- Continue formal and ad hoc meetings to prioritise FBC content and support logistics and logistics CSL and ASL model development.
- Review the workforce model developed by the Heads of Pathology with Finance support.
- Confirm the available capital position for fit-out and whether Histopathology estates work can proceed at risk ahead of joint FBC approval.
- Confirm whether Histopathology timelines can align with Blood Sciences and Microbiology, (RDUH dates relate to building handover rather than operational go-live).
- Clarify whether EDF would raise any issues with enabling works taking place across three floors concurrently.
- Continue clinical model development, workforce planning, and staff and stakeholder communications activity.

Key Performance Indicator	Baseline	Target	Current Position	Trend
No of TSD agreed clinical strategies (Histopathology; Microbiology; Blood science)	N/a	3	0	
% of enabling milestones completed for workforce changes	N/a		Not reportable under Q3/4	
% of enabling milestones completed for Estates	N/a		Not reportable under Q4	

RAID Group	Score/Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
NEW Risk	16	Cause: Insufficient pace across workstreams. Consequence: Delivery timescales are at risk if pace is not increased across workstreams to meet the mid August Full Business Case (FBC) deadline and end September approvals timetable Mitigations: Governance to be agile and condensed through extraordinary meetings and loosening joint chair arrangements.
NEW Risk	15	Cause: Insufficient transport plans. Consequence: operational risk affecting turnaround times, resilience, and the balance between Acute Service Laboratories (ASL) and Clinical Service Laboratories (CSL) activity. Mitigations: Clinical modelling is being shared with logistics workstream for viability and costing of options.
NEW Assumption	N/A	Capital is assumed to be broadly available, subject to final confirmation for some elements including Histopathology fit-out.

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
No CIP savings expected to be delivered in 2026/27										

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 & Redesign


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ Agreement has been reached that the Non-Ambulatory Fragility Fracture pathway to sit under orthogeriatrics, recognising the complex medical needs of this cohort. Clinical leadership will be provided by 2 Consultant Clinical Leads as joint leads, ensuring coordinated, high-quality care across the pathway. ✓ 11 of 13 GIRFT pathway assessments were completed in May, with evidence collated to support delivery assurance. Overall performance is strong, with an average of 81% of pathway components rated green with a range of 48%–100%. Variation remains in areas requiring standardisation (e.g. referral criteria, decision tools, MDT oversight), with the most significant gap in non-ambulatory fragility fractures beyond femur cases. In other specialties, gaps largely reflect local pathway adaptations rather than absence of care. ✓ Work will now commence on engaging clinical team in identifying clear plans to address identified gaps.

Next Steps
• Completion of the remaining GIRFT assessments for wisdom teeth removal and laparoscopic cholecystectomy. • Confirm a named Oral and Maxillofacial Medical Lead to ensure clear clinical leadership and accountability for the wisdom teeth pathway. • Commence engagement with clinical teams on outcomes of GIRFT non-compliant pathways and establishing clear plans to address identified gaps.

Key Performance Indicator	Baseline	Target	Current Position	Trend
% of identified clinical pathways reviewed against GIRFT	N/A	100% (13)	85% (11)	⬆️
% Current pathways compliant with GIRFT Standard	N/A	100% (13)	8% (1)	⬆️
% of change plans developed to ensure GIRFT standard met	N/A	100%	Not yet due	
% of change plans implemented	N/A	100%	Not yet due	
% redesigned pathways compliant with GIRFT standard	N/A	95%	Not yet due	
Develop dashboard to reflect % of patients that follow GIRFT pathway		85%		

RAID Group	Score/ Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
		No new RAID in this reporting period.

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
No CIP savings expected to be delivered in 2026/27										

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 AI



Delivered
✓ Initial scoping discussions for AI appointment intelligence requirements have been held with the COO, Head of PMO, and key stakeholders, with agreement to proceed. Detailed scope is now being finalised, with alignment to Epic critical. ✓ 1,000 Copilot licences have been received from Microsoft (June 2026) and are being held pending allocation through an agreed assessment process to ensure prioritisation aligns with organisational needs. Discussions with Microsoft are ongoing to explore additional licences. ✓ Engagement with partner organisations, including Healthwatch, is ongoing to support NHS App adoption, with a focus on enabling partners to deliver activities such as training and onboarding. ✓ Four digital volunteers have been recruited to provide broader digital support and will be upskilled for NHS App deployment; two are now actively supporting delivery. ✓ Horizon scanning is currently being undertaken on an informal basis, with plans for Innovation Steering Group to lead and formalise this process. Supporting infrastructure is now in place, including a generic inbox and intranet page, which will be used to enable and streamline horizon scanning activities. ✓ Initial discussions with library services have taken place regarding support for literature reviews on specific technologies, with agreement in place to engage their expertise as required in future.

Next Steps
• Complete detailed scoping for AI appointment intelligence requirements with IT Services and outpatient transformation leads, including mapping Epic integration dependencies. • Baseline delivery for consultation modality choice (virtual, telephone, in-person) scheduled to commence from July).

Key Performance Indicator	Baseline	Target	Current Position	Trend
Number of Co-Pilot licences issued				
% of clinical staff using digital dictation				
% of staff completing digital skills programme	To be populated from M3 subject to approval			
No of alternative applications in use where EPIC is the primary platform				
MyCare adoption rate				
Average documentation time per consultation (baseline and follow-up)				

RAID Group	Score/ Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
		No new RAID in this reporting period.

Assurance	Rating
Executive Sponsor Rating	Satisfactory

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
CIP scheme to be developed in conjunction with PMO										



4.2 Epic Implementation & Benefits including MY CARE

Delivered

- ✓ Tracking of stabilisation continues across all Care Groups, with the Post-Live Stabilisation Assessment completed in May providing the identification of all areas of concern and a clear understanding of next steps in most areas. This has enabled a clearer, more structured approach to addressing outstanding concerns.
- ✓ Performance recovery presents a mixed picture with Referral to Treatment (RTT) performance ahead of plan and Cancer tracking behind plan. Targeted help for struggling specialties is in place and is supporting recovery planning and delivery.
- ✓ Benefits realisation is now fully integrated within the Programme Management Office (PMO) with benefit owners identified and are developing their delivery plans. Work is underway to improve visibility of net new emerging benefits including accessing benefits earlier and planning for leveraging MyCare to create self-booking platforms and the reduction in reliance on paper notes is being actively pursued.
- ✓ We are sharing a full record of Lessons Learnt with the University Hospital Plymouth (UHP) team and will continue to support them in readiness for their go-live on 23/07/2026. This is helping to mitigate risk and strengthen implementation confidence.

Next Steps

- Finalise BAU resource plan for 1 Devon
- Launch benefit realisation delivery activities
- Finalise activity recovery plans
- Complete alignment of early staffing benefits to VR programme

Key Performance Indicator	Baseline	Target	Current Position	Trend
MyCare adoption rate	N/a	50,000 end Yr1	19,000	↑
Value of Project Outline Documents (POD's) approved vs business case	N/a	£4,916k	£3,315k	↑
Epic CRB Forecast against plan	N/a	£4,654k	£4,651k	N/a – First month
Patient safety metric due to poor record keeping – TBC				
Counting/coding metric - TBC				
<i>* Work is ongoing to develop output KPI dashboard</i>				

RAID Group	Score/ Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
NEW Risk	8	Risk: Risk of double counting benefits captured in other CIP schemes Mitigations: 1. Ensure all benefits are moved from the EPR Benefits Register to the established PMO management process
NEW Risk	12	Risk: Time delay between the submission of the EPR business case and current position Mitigations: 1. Rebaselining of benefits and associated value
NEW Risk	12	Risk: Proximity of the UHP go-live limits the amount of available resource within the workstream Mitigations: 1. Service desk tickets provide an escalation route to prioritise workstream efforts within TSD

Assurance	Rating
Executive Sponsor Rating	Limited

CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's (FYE)	Forecast Outturn £000's	26/27 Original WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
10 schemes	£406	£3,010	£908	£3,007	18.70	50.69	1.00	19.00	
8 schemes	£0	£1,645	£0	£1,644	0.00	2.07	0.00	0.00	
2 schemes	£4,650	£0	£0	£0	0.00	0.00	0.00	0.00	No RAG status yet

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

Delivered

- ✓ Formal consultation for One Devon Shared Service Pension & Payroll service commenced on 8th May with TUPE remaining scheduled for 1 July. The Co-Design Phase is underway with payroll representatives identified to support development of the Target Operating Model.
- ✓ The Operational Management Review is progressing with the consultation paper now drafted and ready for presentation to the Partnership Forum on 10th June. The first informal engagement session took place on 1 June with phase 1 of formal consultation now expected to begin in July.
- ✓ The Corporate Review is underway with Strategy and Planning presenting their Consultation document at the Partnership Forum on 10th June and formal consultation launch on 15th June with a plan to transition to the new structures in August.
- ✓ In respect to People Digital, Offboarding for leavers has progressed, with testing complete and a play period scheduled for w/c 8 June. For onboarding, the Candidate Portal and Manager Hub integration remain on hold due to national IT issues requiring resolution by One Devon People Digital. Wave 3 enhancement activity is underway, with early sprints focused on strengthening the EVA platform, expanding community access and improving user experience.
- ✓ TSDFT has extended the HIVE LMS contract for 12 months due to concerns and risks with the One Devon LMS, enabling a safer transition.

Next Steps

- Payroll & Pensions Shared Service: Continue formal consultation (8 May – 12 June), including 1:1 meetings and engagement activity; Complete TUPE readiness activities ahead of 1 July transfer.
- Management Progress: Corporate Services consultation to confirm timeline for all areas; Launch Operational Review consultation (July).
- People Digital Programme: Address technical issues impacting Wave 2 delivery, Mitigate resourcing challenges linked to the LMS, Begin early implementation planning, including workforce mapping and transition approach.

Key Performance Indicator	Baseline	Target	Current Position	Trend
CIP Workforce Reductions	N/A	56.36 WTE	Consultation process yet to conclude	
People Digital CIP Target	N/A	7.95 WTE	0 WTE	
Voluntary Redundancy Uptake	N/A	56.36WTE	74.70WTE (offered)	↑
Successful TUPE transfer of Payroll & Pension team	N/A	01/07/2026	On Schedule	↔
* Ongoing work to define broader organisational impact measures for People Digital				

RAID Group	Score/Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
		No new RAID in this reporting period.

Assurance	Rating
Executive Sponsor Rating	Satisfactory

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
27-019	People Digital Wave 2	496,600	496,600	0	354,662	7.9	7.9	0	7.9	
27-077 & 27-078	Corporate & Operational Management Review	2,400,000	2,400,000	0	2,300,500	56.36	56.36	0	0	



5.2 Cultural Transformation



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ Overall progress remains on track, with all deliverables progressing in line with plan, though some elements continue to depend on external decisions and national timelines.
- ✓ The wellbeing programme business case has been refreshed with finance input and scheduled for approval at Trust Investment Group (TIG) on 17 June. Mapping and gap analysis continue, with next steps dependent on the TIG decision.
- ✓ Learning Academy proposal was approved by Board on 22 May; work now ready to progress and will guide the People & Education restructure.
- ✓ Phase 1 (senior leadership) of the People & Education Remodel is reaching final stage with staff alignment and appointments underway. Phase 2 preparatory work to begin in June.
- ✓ Restorative Just and Learning Culture (RJLC) policy group progressing work, with Attendance Policy as the initial focus. Training and communications needs are being identified alongside policy work.
- ✓ Internal provision for Leadership & Management Development has been reviewed and gaps identified; further development paused pending publication of the national framework.

Next Steps

- **Wellbeing:** Trust Investment Group decision on business case; complete gap analysis and begin design of revised wellbeing offer (subject to approval).
- **Just & Learning:** Continue Attendance Policy redesign; finalise training and communications approach.
- **Learning Academy:** Progress detailed design and implementation planning following Board approval, aligned to restructure.
- **Leadership:** Continue preparatory alignment work, pending publication of national framework.
- **P&E Remodel:** Complete Phase 1 implementation; commence Phase 2 engagement and design activity.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Workstream Performance				
% policy due for review completed & published	N/A	5	0	
Number of staff accessing wellbeing offer	N/A	All who require	Not yet active	
Number of staff accessing renewed Leadership & Management Development Programme	N/A	All leaders	Not yet active	
Organisational Impact				
Reduction in sickness absence	Population of KPIs will be prioritised in M3 subject to approval			
Staff engagement: Recommendation as a place to work				
Staff Survey response rate				
Number of formal ER cases				
Identify WRES/WDES indicator to directly improve				
Identify Speak Up indicator to directly improve				

RAID Group	Score/ Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
		No new RAID identified during this reporting period.
Assurance		Rating
Executive Sponsor Rating		Satisfactory

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
27-020	Education & Training - Cost Reduction	174,000	174,000	0	105,000	2.73	2.70	0	3	
27-035	Temporary Staffing	1,400,000	1,400,000	0	1,400,000	4.14	4.14	0	0	

6.0 Strategic Enablers

Senior Responsible Owner – James Corrigan, CFO

Securing the essential foundations for transformation



6.1 One Devon Shared Services - Finance


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ Progress this period reflects steady movement across design, data, and readiness activity, alongside continued engagement with SBS. Several dependencies remain outside TSD control, particularly relating to system build and SBS responsiveness, which continue to influence the pace of delivery. ✓ The Chart of Accounts was completed at the end of May, with data cleansing across Accounts Payable and Accounts Receivable finalised; this now supports the system configuration. ✓ An initial draft of the SBS Personas was submitted at the end of May, with work ongoing to review and update these ahead of a second submission; this continues to support the system configuration by defining required staff access. ✓ Accounting and Reporting Solution Design reviews took place throughout May, with TSD targeting sign off in June. This supports preparation for later configuration and testing stages. ✓ Review and completion of Accounts Receivable templates is progressing with SBS and the Treasury team. Other data templates and uploads are being completed by the TSD system team, this supports data readiness for later stages of system configuration and testing. ✓ The Unit4 upgrade was successfully completed during the week commencing 25 May 2026, which can now move into the next phase. ✓ SBS have provided an initial plan outlining the tasks required for successful system implementation. However, key detail is missing. TSD Finance are awaiting an updated version from SBS to enable further progress. The consequence of this has delayed completion of the below; • The SBS Oracle Fusion system is not yet built for Providers and is expected by July. Staff are currently unable to view the system, delaying procedure development and staff training. • TSD continue to experience issues with the timeliness and quality of SBS responses, and the guidance provided remains unsatisfactory. Clarity on the critical path remains dependent on SBS engagement.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Completion of critical path milestone	N/A	14	3 complete, 11 green	↑
Testing status	N/A	67%	60%	N/A – New KPI
One Devon Shared Service Programme KPI's	N/A	29	2 complete, 24 green, 3 amber	↑

RAID Group	Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
		No new RAID identified during this reporting period.

Next Steps
• Accounting and Reporting Solution Design sign off in June.

Assurance	Rating
Executive Sponsor Rating	Satisfactory

CIP Scheme Ref	CIP Scheme Name	26/27 Original Plan £000's	26/27 Latest Schemes £000's	Transacted £000's	Forecast Outturn £000's	26/27 Original Plan WTE	26/27 Latest Schemes WTE	Transacted WTE	Forecast Outturn WTE	Delivery RAG
No CIP savings expected to be delivered in 2026/27										



Torbay and South Devon NHS FT MATERNITY BOARD REPORT

MARCH 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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Saving Babies Lives Care Bundle V3	Error! Bookmark not defined.
RAG Rating	Error! Bookmark not defined.
Narrative by exception.....	Error! Bookmark not defined.
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RAG Rating	Error! Bookmark not defined.
Single Delivery Plan Measuring Success: Regulation (CNST)	Error! Bookmark not defined.
Narrative by Exception	Error! Bookmark not defined.
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Appendix	Error! Bookmark not defined.

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	Families consistently praised the staff support, describing midwives, nurses and SCBU teams as kind, reassuring and highly professional. They valued the quality of care for both mother and baby, including clear communication and feeling involved in decisions. The environment, comfort and practical help, from feeding support to cleanliness and food, also contributed to very positive experiences.	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	Themes noticed with concerns not being taken seriously and language used between staff and patients. Emerging theme around difficulties when transporting women to be with their babies when their care has been transferred to another unit.	Investigation ongoing.	Respond to concerns and identify if changes to practice necessary. Plan to revisit transfer process.	May-2026
3) Devon Maternity & Neonatal Voice (MNVP) projects/ additional comments	DMNVP to be included at all levels to support improvements to maternity services.	DMNVP to be working in partnership with all leads for service development	DMNVP Strategic lead is present one day a month to work alongside the PLT. The DMNVP Trust lead and neonatal Leads present one day a month to meet with staff and service users.	Ongoing

			Quarterly reporting of engagement and feedback from the DMNVP now in place. (Summary included below)	
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
Safety Champion walkaround March 2026	The Safety Champions walkaround on 26 March 2026 identified predominantly positive service-user feedback, with opportunities to strengthen communication during induction and when delays occur, as uncertainty was described as anxiety-provoking. The birth partner experience and ward environment were discussed.	Hearing the voices of fathers in the perinatal journey	Improve real time communication with families and involve the MNVP in service-user-led refurbishment of the waterbirth room.	

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2.2 Additional Service User Feedback-

MNVP ENGAGEMENT — TORBAY	OVERVIEW & MATERNITY FEEDBACK	NEONATAL OVERVIEW & KEY THEMES	SCBU RECOMMENDED ACTIONS FOR TORBAY
3 Monthly Catch-Ups 3 PMRTs Attended 2 Safety Walkarounds ★ Community Outreach This Quarter 23 participants engaged · 12 service users heard from · Totnes & Paignton focus groups · Feed & Nurture groups TRUST ENGAGEMENT ✓ Discharge focus groups: Totnes & Paignton ✓ Feed & Nurture groups at Paignton Family Hub ✓ 2 Monthly SCBU meetings with Neonatal Teams ✓ Neonatal Lead: 3 visits to Torbay SCBU ✓ MSSP Review & Reset meeting (January) ✓ Fully embedded in QUAD & MNIST meetings ✓ 2 Safety Champion walkarounds with NEDs ✓ Devon Pelvic Health survey collaboration ✓ 3 cross-site PMRTs attended ✓ Senior Lead: monthly onsite visits committed ⚠ Partners Staying Overnight Frequently raised by families. Senior leadership are taking steps & MNVP continues to advocate. Bereavement Feedback Pathway launches April 2026	Consistent Torbay Strength Staff are consistently described as supportive, <u>friendly</u> and kind across all settings. This is Torbay's most reliable and valued asset. Service user feedback echoes what senior teams are sharing at quorate level. MATERNITY — WHAT WAS POSITIVE? ✓ Friendly, welcoming & professional staff ✓ Clear explanations of treatment ✓ Clean and comfortable hospital stay ✓ Made to feel comfortable throughout ✓ Community midwife Emma (Mulberry team) praised ✓ Partner present & ward leave supported ✓ Compassionate and reassuring staff ✓ First induction experience described as great MATERNITY — WHAT COULD IMPROVE? ■ Waiting times (acknowledged as unavoidable) ■ Communication on next steps during labour ■ Clearer plan when contractions increase <i>“Communication has <u>generally been</u> fantastic — keeping me informed every step of the way — but I <u>wasn't</u> sure of the next step when contractions became more consistent.”</i> Maternity service user, Torbay	SUMMARY Neonatal feedback from Torbay SCBU reflects the experience of a level 1 unit under significant resource pressure. Staff are consistently described as kind, supportive and doing their best — but capacity limitations mean families are not always able to access the holistic, <u>developmental</u> and emotional support they need. Two distinct voices emerge: one experiencing exceptional care from a well-staffed unit perspective, and another highlighting the stark difference experienced when transferring from a larger unit. <i>“Everyone so supportive and amazing and doing the best they can — just understaffed and <u>that's</u> not their fault.”</i> THREE HEADLINE THEMES ◆ Staffing capacity — root cause of most issues ■ Family Integrated Care & parental autonomy ⓘ Communication, information & daily planning WHAT IS WORKING WELL? ✓ Staff warmth and dedication praised ✓ Above and beyond care to keep families in Devon ✓ Empowering parents to do baby cares ✓ Building parental confidence and reducing anxiety	⚠ MNVP Questions for Torbay SCBU ▶ How can psychological support for SCBU families be improved — what is the current referral criteria? ▶ How can parents be given more autonomy through Family Integrated Care? ▶ Can MNVP support with FIC resources, communications and leafleting? ⚠ Psychological Support — Referral Barrier Prematurity alone does not qualify for hospital psychologist referral. Only diagnosed conditions do — all other families must go through their GP. This is inequitable and a barrier to timely support. MNVP is investigating. ★ Staff Culture & Recognition Staff commitment is exceptional. Recognition of above-and-beyond care should be celebrated. MNVP supports continued culture improvement work with Senior Teams. ■ Staffing Capacity Root cause of most SCBU concerns. Families are clear this is systemic, not individual. Staffing levels need urgent attention to allow holistic developmental care. ◆ Family Integrated Care Parents want to be active participants in baby cares. MNVP can co-produce resources and training support to embed FIC principles across Torbay SCBU. ⓘ Communication & Daily Planning 'Now and next' daily plans, consistent shift introductions and waiting for partners before complex conversations would transform family experience.

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. Staff report needing additional support with psychological safety at work	This came from feedback gathered during listening events and from feedback after incidents	This can result in burnout and trauma leading to sickness absence and challenges with retention. This can impact on the ability to provide safe patient care	Clinical psychology team are offering 1.1 sessions with staff on a six-weekly basis. Director of Midwifery is working to develop a psychological safety strategy	
2) 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. Psychological strategy being developed as described above	

Safety Champions meetings - Table 1-

Table 1

Date	Attendees	Feedback
March 2026	Board Safety champion- NED. Maternity Safety Champion, MNVP Devon Senior lead,	John Macpherson Ward Feedback from a recently delivered service user and their birth partner was overwhelmingly positive, particularly when compared with their previous birth experience; however, opportunities for improvement were identified in relation to communication. Specific themes included the need for clearer explanations about the induction process and improved communication when delays occur, as uncertainty and lack of updates were described as anxiety-provoking. The birth partner also highlighted the emotional impact of not being able to remain on the ward after birth despite space constraints. During the walkaround, estates improvements nearing completion were reviewed, with a particular focus on the waterbirth room, and a request was made for MNVP involvement in shaping refurbishment plans and supporting a potential name change to reflect service-user preferences. Agreed actions focused on strengthening communication with women and families regarding care decisions, delays and changes, and engaging the MNVP to consult service users on the proposed labour ward environment improvements

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.	0	
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).	0	
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).	0	
Delay of more than 30 minutes in providing pain relief.	0	
Delay of 30 minutes or more between presentation and triage.	0	

Full clinical examination not conducted when presenting in labour	1	A short period of high acuity was noted, no incident reported as risk mitigated on shift by staff.
Delay of two hours or more between admission for induction and beginning of process.	0	
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).	0	
Any occasion when one midwife cannot provide continuous one-to-one care and support to a woman during established labour.	0	
Labour Ward Coordinator (LWC) is not supernumerary	0 – not providing 1:1 care 2 – providing 1:1 care	These two episodes were for a short period one out of hours and one at the end of the working day. Both resolved with extra staff arriving to support. Acuity can raise quickly, safety is maintained by LWC's limiting any times having to provide 1:1 care to the absolute minimum and escalating.
Retention Issues	0	No concerns.
Obstetric cover on Labour Ward	Quarterly audits are performed on consultant attendance when called for clinical support. Presented and discussed at consultant monthly meeting	Rota covered.

Gaps in obstetric rota	All rotas covered.	Further absence has resulted in consultants being required to cover at short notice increasing the required number of on calls and intensity of work however this is reducing in frequency. Further recruitment this period of 2 replacement posts and 1 WTE new post.
Neonatal unit staffing Nursing -	There is a requirement for a minimum of 1 Qualified in Speciality (QIS) Nurse per shift to support stabilisation of pre- term / term unplanned admissions. QIS as % of registered workforce is 57 % (BAPM min 70%) Improvement in sickness absence - we continue to ensure minimum safe staffing numbers and QIS cover. Lack of suitable resource (QIS/neonatal experience) via NHSP.	2 staff members mid-way through QIS training and beginning work-based placements. EOI received from 2 staff members for 26/27 cohort. Successfully recruited 1WTE B6 QIS & 1.92 WTE B5 – onboarding to starting May/June 26. EQIA submitted to convert B6 vacancy to B5 – suitable candidate interviewed to put in development post to fast-track QIS. 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.

Medical staffing	Meets BAPM standards for level 1 special care unit. Revised BAPM medical staffing standards released in Nov 25 which will have future implications for the organisation meeting medical staffing requirements	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 %
March 2026	84	90	86	74
April 2026	79	94	100	77

*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. Throughout March and April, 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 was 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 slight increase in the annual birthrate for the financial year 2025-2026, there also continues to be 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. The service has been considering how they address the establishment uplift, however, with the current CIP challenges, this would appear unachievable at this level and the issue has, therefore, been escalated through the care group. Compliance with the required Birthrate Plus establishment is mandated within the maternity incentive scheme. An inability to comply with the establishment required is likely to impact on the ability to demonstrate full compliance with the scheme this year.

3.3 Multidisciplinary Training Compliance- KM

TRAINING COMPLIANCE	PROMPT	Fetal Monitoring	Safeguarding
All Staff	81%	82%	87%
Midwives	82%	82%	94%
Maternity Support Workers	74%	NA	90%
Obstetric Resident Drs	73%	60%	40%
Obstetric Consultants	64%	73%	85%
Anaesthetists	87%	NA	NA

The slide outlines progress and gaps in maternity mandatory education across multiple domains. EPIC training has had a significant impact on training compliance rates; as highlighted above, this has been highlighted as a risk and is captured on the risk register. Additional training dates and mop-up sessions have been arranged. Fetal monitoring training shows 82% 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. The Trust have agreed to fund study leave for anaesthetists attending the PROMPT training, which is already having a significant positive impact on update and attendance

Learners in Practice – feedback

In April 2026 the maternity service received a summary and comparison of the Midwifery National Education and Training Survey (NETS) results for 2024 and 2025. Overall, the data showed consistent strengths in induction, supervision and wellbeing access, alongside concerns regarding psychological safety for learners, particularly in relation to staff behaviours and confidence in raising concerns. Unfortunately, there was a limited response rate of 5 Student Midwives who completed the survey in both 2024 and 2025. It should also be noted that the student midwives have been supported by a Practice Education Facilitator Midwife, who has been in post since the end of 2024, however, due to another member of the team having a prolonged period of unexpected leave, the Practice Education Facilitator Midwife had to step out of this role for 6 months. She has now returned to her post in January 2026 and will, therefore, be able to focus on support for the student midwives within the service.

Key strengths

- Induction - 100% of midwifery students rated induction as good or excellent in both 2024 and 2025.
- Supervision - 100% reported supervision as adequate or good/excellent across both years.
- Wellbeing - Awareness and confidence in accessing wellbeing support improved from 80% in 2024 to 100% in 2025.
- Placement recommendation - Increased to 100% of students recommending the placement in 2025.

Key concerns

- Bullying and harassment - Reports of witnessing bullying and harassment by staff increased significantly from 20% in 2024 to 75% in 2025. Additionally, 20% of students reported feeling personally bullied or harassed in 2025.
- Discrimination - Discrimination remains a concern across both years, shifting from patient related in 2024 to staff-related in 2025, with students reporting that incidents were not appropriately addressed.
- Raising concerns - Whilst 100% of students in 2025 reported knowing how to raise concerns, 75% stated they did not feel able to do so or did not report their experiences, indicating a lack of psychological safety.
- Sexual safety - 20% of students continued to report witnessing unwanted, harmful or sexual behaviours by patients or staff, consistent across both years.

Actions

- Current discussions on provision of more support for student midwives at the “Student Council” and how obtaining feedback from them on how we can be support them to feel safer to raise concerns.
- Offer to meet with cohorts or individual students if they have any concerns. Practice Education Facilitator Midwife to email out to all students, due to the established relationship that she has with them.
- Ensure all students know who their assigned PMA (Professional Midwifery Advocate) is and know that they can see any PMA not just their named one to discuss any concerns and obtain support.
- Ensure all student midwives know who the Freedom to Speak Up guardian is and how to contact them.
- Consider group sessions for students which include psychological safety run by Practice Education Facilitator Midwife
- Consider offering PNA (Professional Nurse Advocate) support (the PMAs are already in conversations with PNAs regarding this) if the student midwives feel they would prefer to obtain support outside the maternity service.
- Invite all students to the maternity virtual mandatory study day which has a session on psychological safety and civility in the workplace (run by the PMA's)
- Lead PMA to email out to all students an individual invite to meet with her (introducing her new role and allowing time for individuals to raise any concerns)
- Explore how student midwives can be encouraged to complete the NETS survey so that there is an increased response rate, with improved validity of data.

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-

BAPM & NHSE Neonatal Service Specifications – Level 1 Special Care Baby Unit provides care for babies from 32 weeks' gestation who do not require ongoing high dependency or intensive care.

In this reporting period there was one baby delivered at Torbay and South Devon at less than 27 weeks' gestation – 23+4 weeks; mother presented in spontaneous labour out of hours. Baby was intubated and stabilised before being transferred to a level 3 unit. The perinatal governance team are currently reviewing this case as it sits outside of agreed neonatal pathway, to identify any learning and positive practice.

One baby delivered at 31+0 weeks and was not transferred out to a tertiary neonatal unit; this was due to a lack of suitable cots across the southwest and with agreement from the network. Mutual clinical decision between the network and local neonatal team to support care at Torbay; the baby was weaned off respiratory support at 12 hours of age and was stable enough for ongoing care to be supported locally.

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:**
 - Obstetric leadership and capacity
 - Culture and leadership
 - 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:	March 2026		
MIA(s):	Suzanne Cunningham Erum Khan	Level of support:	Targeted		
Site visits in past month:	March 12 th , 18 th & 19 th	Support start date:	01/01/2026	Support end date:	01/07/2026
Achievements and progress of milestones					
- Obstetric interviews and two successful recruitments for one new post and one replacement. - RCOG Obstetric leadership role descriptors allocated. SOP agreed and the gap identified. For the Trust to assure themselves this is sufficient ensure objectives to be agreed with individuals and review achievements in 6 month. - SOP for huddles ward rounds and huddles completed and published – for audit over next 3 months. - Perinatal Leadership Team now joined by Devon MNVP Lead on a monthly basis. - HOM role job matched but appeal in process. Process for appointment agreed and ready to go live. - Perinatal Learning Review- MDT review commence and Thematic review commenced. Themes and early learning agreed. MatNeoIST supported. - Lessons learnt* systems and processes to be incorporated into Perinatal Learning Review - 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. Psychological Safety Training now incorporated into Induction and mandatory training					
Escalations					
Process for DOM appointments					

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. There will also be an Insights Visit in June facilitated by the SW regional team to review improvement work and progress, 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.

CQC MUST DO actions	Achievements	Action for Improvement
Maternity Triage	• Dedicated phone line in place. Net call now installed and working well. • Consistent documentation process embedded in the electronic record includes a standardised risk assessment mechanism. • Allocated midwife to answer the phone line, day and night. • Reconfiguration of staffing establishment to increase Triage team complete, staff in place and service now running 8-8 in the Day Assessment Unit. • Monitoring via audit process • Estates work completed. • All staffing appointed to and opening hours increased.	• Feedback from Recent shadowing by director of midwifery: What we're working on • Improving consistency of telephone triage, including use of Netcall across 24 hours • Standardising how triage calls and reasons for admission are recorded in Epic to support patient flow / categorisation, audit and learning • Improving visibility between triage and DAU to better prioritise and manage risk • Introducing acuity coding on the triage whiteboard to support situational awareness • Reviewing the staffing model, including capacity at peak times and weekends • Clarifying obstetric availability, • Strengthening training and pathways for BSOTS

		Next steps • Practical changes (e.g. whiteboard acuity coding) are already in progress. • Further work is underway on pathways, digital processes and workforce planning • Antenatal Clinic Manager is going to RDUH to further shadow and review. • We have dedicated project management support to progress this work.
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.	• 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. • Currently on risk register with score of 15 (down from 20. Reviewed on a monthly basis.

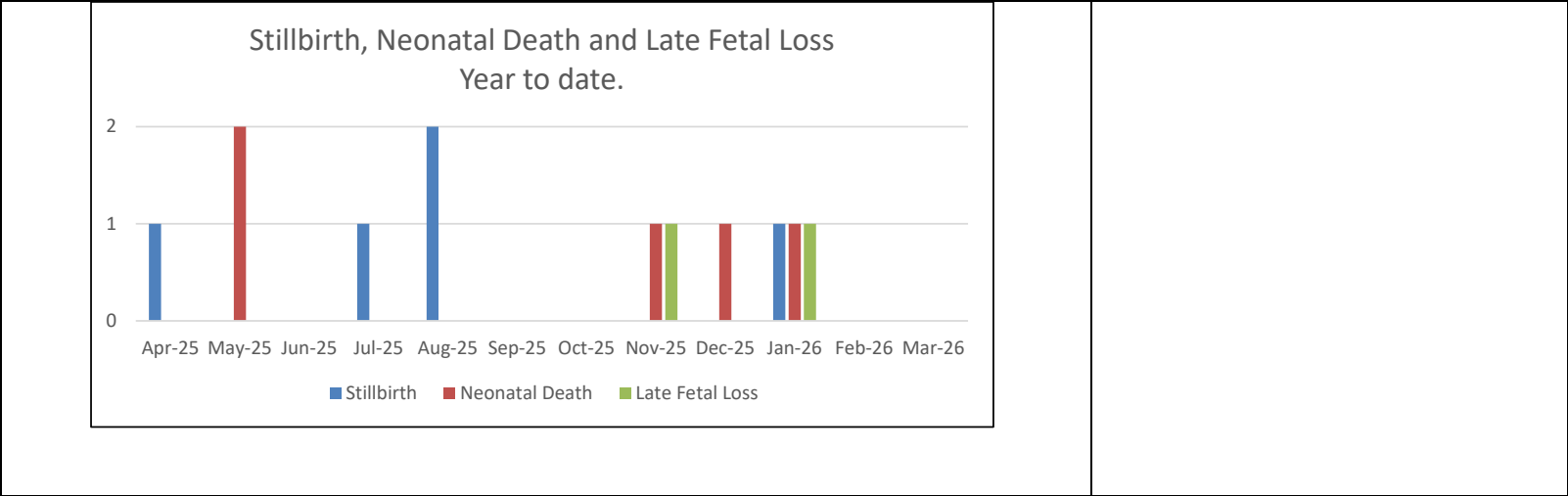
Fetal Monitoring oversight	• Audit of “fresh eyes” – now quarterly. • Full day fetal monitoring training for all midwives and doctors commenced in 2024 and is ongoing. This includes an assessment – which is currently being completed on K2. • Action Closed on action tracker	
Use of Electronic MEOWS system	• Increased surveillance and support of system to improve the completion. • New digital midwife now in place to ensure work can continue in this area. • QI project complete, no on regular audit cycle • Action Closed on action tracker	
Medical staffing	• Business case to increase the number of FTE consultants progressed via Trust and ICB processes. Recruitment of 2 FTE completed and now working within the trust. • Action closed on action tracker	
Provision of Emergency Equipment	• Replacement CTG's and resuscitaires in place; staff trained to use.	• Department recognises that there is no suitable dedicated area to store resuscitation equipment on postnatal ward. This is under consultation with estates to create a bespoke space. Resucitaire is stored in ward corridor.

Medical staffing – safeguarding children training compliance	- Improvement in compliance figures. Practice educator collaborating with clinical director to support attendance. - Safeguarding support in place within unit as part of day to day working. - Bespoke, local safeguarding input as part of induction	Safeguarding Children level 3. An additional e learning module for doctors is being considered to improve safeguarding compliance. Consultants currently at 85%. Residents at 40%.
Governance oversight and assurance	Matron for Quality and Patient Safety now in role.	- Governance forms part of the MNIST. - 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 almost finalised - Alteration in the floor to board reporting to support oversight to be initiated.

4.5 Patient Safety

4.5.1 Perinatal Morbidity and Mortality Summary for the period

	March 2026 No Perinatal mortality in March.



4.5.2 Patient Safety Incidents

PATIENT SAFETY Incidents (PSI)	Number	Key themes/ trends/ escalations
Serious Incidents	1 in total	March 2026 1 x Severe – DCIQ 35055 – Severe – Woman developed immune Anti D antibody between pregnancies, unknown sensitising event.
Moderate Incidents	1 in total	March 2026: 1 Moderate Incidents reported. 1 Moderate – DCIQ 35495 – Moderate – Forceps Delivery @ 37/40, developed haematoma, return to theatre.

PATIENT SAFETY	Number	Key themes/ trends/ escalations
New referrals to MNSI	0	
Findings of final MNSI reports returned (themes only)	0	No reports by MNSI were received in March 2026.
Findings of cases reviewed under PMRT. (themes only)	0	One PMRT report was completed cases were reviewed in this period. • 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 completed 25. February 2026. The MDT determined the cause of death was chorioamnionitis leading to premature labour. No care issues were identified by the MDT team that would have made a difference to the outcome for the woman or her baby. No PMRT MDT meetings were held in this period.

		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 held 7th May 2026 – external participants present, Report due by 11th July 2026. Will be met once PMRT MDT meeting held. No PMRT Reviews led by other trusts for babies that delivered in Torbay. 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
30963	White British	2
32804	White British	5
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 abuse in her pregnancy	Discuss at Mandatory Training around lessons learnt from incidents to communicate the importance of asking about DV at any contact where the woman attends alone send information via Clinical Updates WhatsApp group and email. –	Clinical Governance Coordinator	Completed

			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	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	Inpatient Matron and Clinical Governance Coordinator(s)	30.04.2026

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

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

		from the staff involved at the time of the event.	practice for those involved in reflective practice.		
Datix No: 26398	Fetal Growth monitoring	It was overlooked that due the woman's bicornate uterus she did not need to be measured at 28 weeks.	Reminder to go out to all staff that a uterine anomaly should be treated as a risk factor for preterm birth and care should be consultant led.	Outpatient Matron	Completed
Datix No: 30963	Record Keeping	This mother's progress in labour was not monitored on a partogram.	The bereavement midwives undertake an annual update on bereavement care and findings from the PMRT. Use of the partogram will be included and the audit of use of the partogram to be undertaken and getting feedback from the midwifery team as to why it has not been used. Audit of use of Partogram. Should be resolved by EPIC EPR.	Bereavement Midwives	Ongoing

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

Q4 scorecard review

Claims Scorecard April 2015 – March 2025 (new scorecard due)

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



Torbay and South Devon
NHS Foundation Trust

Maternity Incentive Scheme – SA C

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

Complaints and Concerns Q4 2026

3 complaints around staff attitude and consent during intrapartum care.
3 complaints around antenatal care – including transfers
1 complaint regarding OASI following forceps delivery
1 complaint regarding issues in the PN period following a retained placenta.

Themes Q4

- Management of OASI
- Return to theatre
- Preterm Births <32 weeks in level one unit.

Incidents (moderate or above) Q4

Immune Anti D from unknown sensitising event (1)
Stillborn baby (1)
Neonatal death (1)
Hypoxia (1)
Forceps – Haematoma (1)
Caesarean Section – Haematoma (1)
Preterm birth in wrong location (6)

Learning Q4

- Ongoing audit of 3rd and 4th degree tears (OASI)
- Improvement in rate of 3rd and 4th degree tears, likely impact is the introduction of training.
- Thematic review completed of preterm births ,32 weeks in level one unit. Key themes around deprivation and low predictive rate of screening for preterm birth at booking.

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 and this has now been ratified by the LMNS.

4.7 Perinatal Leadership Team (PLT) – Culture and Leadership

A perinatal leadership team is deemed to be the best way to improve collaboration and develop psychologically safe cultures within the perinatal teams. The team consists of the director of midwifery head of midwifery, obstetric lead consultant, operational lead, neonatal lead and MNVP representative. The PLT as a team, meets regularly with an invite extended to the maternity improvement advisors and the clinical lead. Now that the capacity within the Maternity and Neonatal Voices Partnership (MNVP) has increased they will also be able to attend these meetings from now on. The senior lead for Devon MNVP has also begun to work alongside the PLT on site monthly. Bimonthly meetings also occur with the PLT and the safety champions including the Board level champions and Maternity and Neonatal Voices Partnership (MNVP) lead. There has been collaboration with the Trust MNVP lead with attendance at Quality meetings, PMRT meetings and Perinatal Improvement Board meeting in March 2026.

Topics addressed and activities of PLT included.

- Safety Champion walkaround discussed
- Improvement Work: supporting the areas of focus as described in 4.3
- Drove and assured key aspects of the Perinatal Improvement Programme (communications, KPIs, culture, workforce, governance).
- Provided leadership oversight to case reviews, system safety learning, and service-level governance. T
- 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 March 2026, the trust did not receive 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. The team is also planning a tabletop exercise to test the SOP in practice.

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. On 25th March 2026, it was confirmed by NHS Resolution that we had met all 10 safety actions for Year 7 of MIS.

With the Perinatal Compliance Lead in post, they continue to support with the assurance and oversight required for perinatal services and they continue to work with the team to enable ongoing compliance.

MIS Year 8 will formally launch on 1st April 2026 with the national webinar being held on 23rd April 2026 to highlight the changes and areas of focus for the upcoming year. There are already some big changes announced to this year's programme. One being the reduction in the number of safety actions from 10 (1-10) to 6 (A-F). There is also a planned greater emphasis on outcomes and board oversight for this year.

Trusts are encouraged to begin early preparation which has been ongoing. Resources and discussions continue through the MIS Futures NHS workspace and webinars.

Year 8 will 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 has been conducted in March 2026, 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. Recommendations will be presented to the team in mid-May 2026 with a meeting planned to action plan with the PLT in early June. This will then be presented back to the committee in the next report.

6.0 Conclusion.

This report provides a comprehensive overview of the safety, quality, and governance arrangements within maternity and neonatal services for March 2026. There is clear evidence of sustained focus on national priorities, including compliance with the Perinatal Quality Oversight Model, the Three-Year Delivery Plan, and the Maternity Incentive Scheme.

The service continues to demonstrate positive progress across several domains, including:

- No perinatal mortality recorded within the reporting period
- Continued compliance with all ten CNST/MIS safety actions for Year 7
- Strengthened governance arrangements and oversight through the Perinatal Leadership Team and executive-led improvement structures
- Ongoing delivery of Saving Babies Lives Care Bundle elements, with most areas compliant or on track

There is also clear evidence of learning and improvement, particularly through PMRT processes, safety investigations, and thematic reviews, with increased focus on communication, documentation, and escalation.

However, the report highlights ongoing risks and areas requiring continued oversight, including:

- Workforce capacity gaps, particularly neonatal QIS staffing and midwifery establishment deficit
- Training compliance challenges, influenced by operational pressures and EPIC implementation
- Cultural and psychological safety concerns, including staff and learner feedback indicating variable confidence in speaking up
- Ongoing external support through the Maternity and Neonatal Improvement Support Team, reflecting the need for continued improvement in leadership, governance, and culture

Integrated Performance Focus Report (IPR)



Torbay and South Devon
NHS Foundation Trust

June 2026: Reporting period May 2026 (Month 2)

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Working with you, for you

Oversight Framework - Introduction

National Oversight Framework:

Quarterly assessments against the framework reflecting performance in Q4 2025/26 has been published. The overarching score and national ranking across the six domains for the Trust in Q4 is Segmentation 4 (from Segmentation 3 in Q3) and ranked 102 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 metrics have been reviewed in this report alongside existing Operational Plan commitments to ensure alignment of metrics and performance trajectories. Where the operational plan trajectories are not being met these are reviewed through the monthly Care Group Review meetings and Executive Oversight group. In the Performance section of this IQPR focus report, exception reports have been created where these metrics are not being met reflecting the review and risks discussed through the Governance meetings.

System performance governance and reporting:

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

- Regional performance review meetings with Region and TSD executives
- System Improvement Assurance Group (SIAG) meeting with Region, Devon ICB and provider CEOs.

Internal performance oversight:

The Trust continues to oversee its performance through weekly performance oversight structures and monthly through the Care Group Quality and Performance Assurance Frameworks.

Urgent and Emergency Care Performance Summary

Overview of Month 2 Performance

Month 2 performance shows continued pressure across urgent and emergency care pathways, with only marginal improvement from April with ED 4-hour performance at 64.7% vs 72% trajectory. Demand remains consistently high, with over 11,000 attendances across services in May and ED attendances increasing month-on-month. Performance is constrained by flow issues across the Trust particularly on admitted pathways.

UEC demand (230+ patients/day in ED) exceeding capacity remains the core risk driver with an increasing trend 12-hour delays, long ED stays (24/48 hours) and ambulance handover delays impacting both patient experience and safety. High-risk areas include mental health patients experiencing prolonged stays and stroke pathway underperformance.

Actions already underway include:

- ED workforce recruitment and new workforce model implementation ED refurbishment programme improving estate and layout
- Stroke improvement actions (capture Stroke, pathway redesign, external support)
- Ambulance and flow management improvements (handover focus, escalation monitoring)
- Care coordination models aligned with system partners
- EPIC optimisation workstreams underway

Further Actions to Be Taken

- Improve mental health pathway flow and escalation management
- Address ED data reliability and validation issues
- Increase capacity to meet sustained demand (beds, staffing, flow)
- Strengthen EPIC system responsiveness and functionality
- Reduce agency reliance and stabilise workforce
- A corridor care working group has been established with a programme of work timetabled in June. A Trust wide event is taking place on 23rd June with action plans to be agreed and key responsible leads identified with the view to eliminate corridor care

For June, the Trust is forecasting continued pressure on ED performance with high demand expected to persist. Some improvement is expected from workforce stabilisation and flow improvement actions, however, overall position is likely to remain below trajectory.

The July forecast is a gradual improvement due to ED rebuild progress, workforce recruitment gains, and improved pathways across stroke and patient flow. There is a risk to deliver required performance with seasonal increase in attendances across the Emergency Department, Urgent Treatment Centres, and Minor Injury Units.

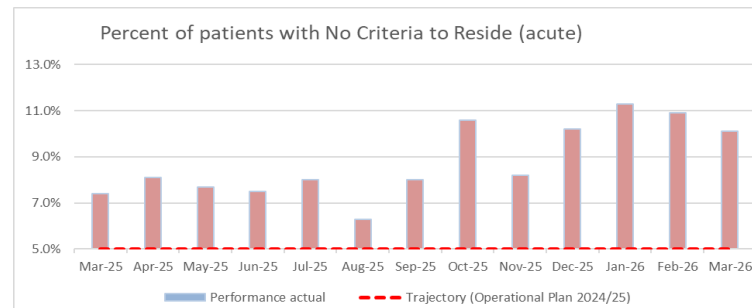
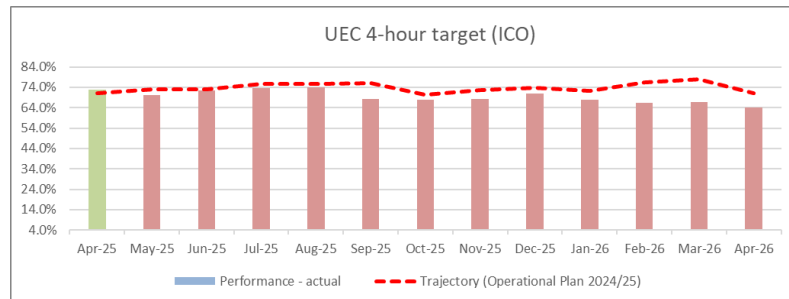
National Oversight Framework– Urgent and Emergency Care Performance Summary

Trajectories have been agreed as part of the 2026/27 Operational Plan submission; monthly performance RAG ratings are based on these trajectories. Data in bold is nationally reported data.

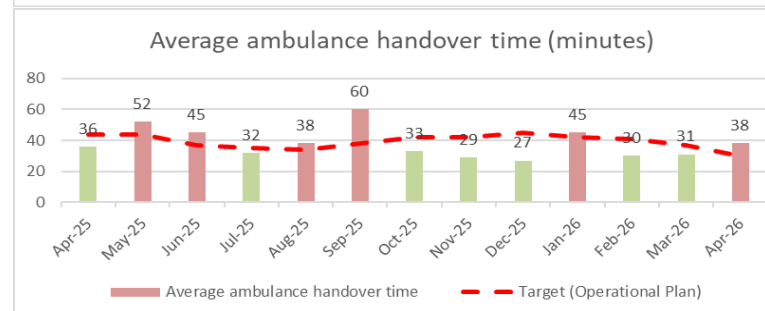
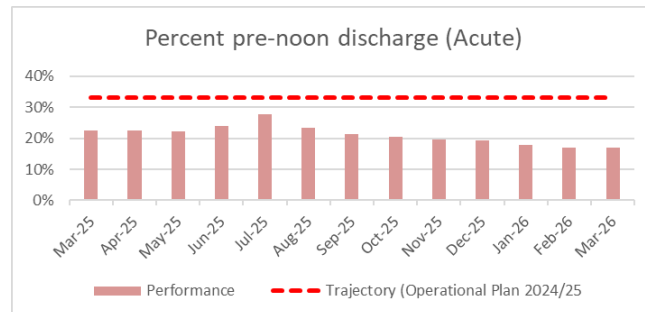
INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

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Data RAG rated against monthly Operational Plan trajectory Bold number = national data	Target March 2027	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			1530	1159	725	943	1823	810	624	559	1283	621	755	952	1390	
Ambulance handovers - time lost over 15 mins - Plan														641	676	623
Average handover time (mins) - Actual	30 mins		52	45	32	38	60	33	29	27	45	30	31	38	47	
Average handover time (mins) - Plan	30 mins		44	37	35	34	38	42	42	45	42	41	37	30	30	30
Total average time in ED (hours/minutes) - Actual	Reduction		05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	06:10	06:06	06:07		
Total average time in ED (hours/minutes) - Plan																
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Actual	0		688	494	457	426	655	585	549	520	918	740	734	676	839	
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan														394	655	469
Percentage of patients waiting over 12 hours in ED - Actual			9.8%	7.4%	6.5%	6.1%	9.7%	8.5%	8.3%	7.5%	13.6%	12.1%	10.6%	9.8%	11.7%	
Percentage of patients waiting over 12 hours in ED - Plan					6.3%	5.6%	8.2%	9.9%	8.4%	7.2%	7.0%	7.0%	6.1%			
UEC 4-hour target (RAG against local trajectory to national target) - Actual	82%		70.1%	72.2%	73.5%	74.1%	68.3%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.2%	64.7%	
UEC 4-hour target (RAG against local trajectory to national target) - Plan	82%		73.0%	73.0%	76.0%	76.0%	76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%
% patient discharges pre-noon - Actual	33%		22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	
% patient discharges pre-noon - Plan	33%		33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Percentage of inpatients with No Criteria to Reside (acute) - Actual	<5%		7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	
Percentage of inpatients with No Criteria to Reside (acute) - Plan	<5%		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%



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 includes data up to week ending 31 May 2026. The Trust did not meet the Operational Plan trajectories for A&E 4-hour performance. Ambulance handover delays over 45 minutes have increased with the recent weekly ranking of 120 out of 123 trusts from rank of 115 last month.



Organisation

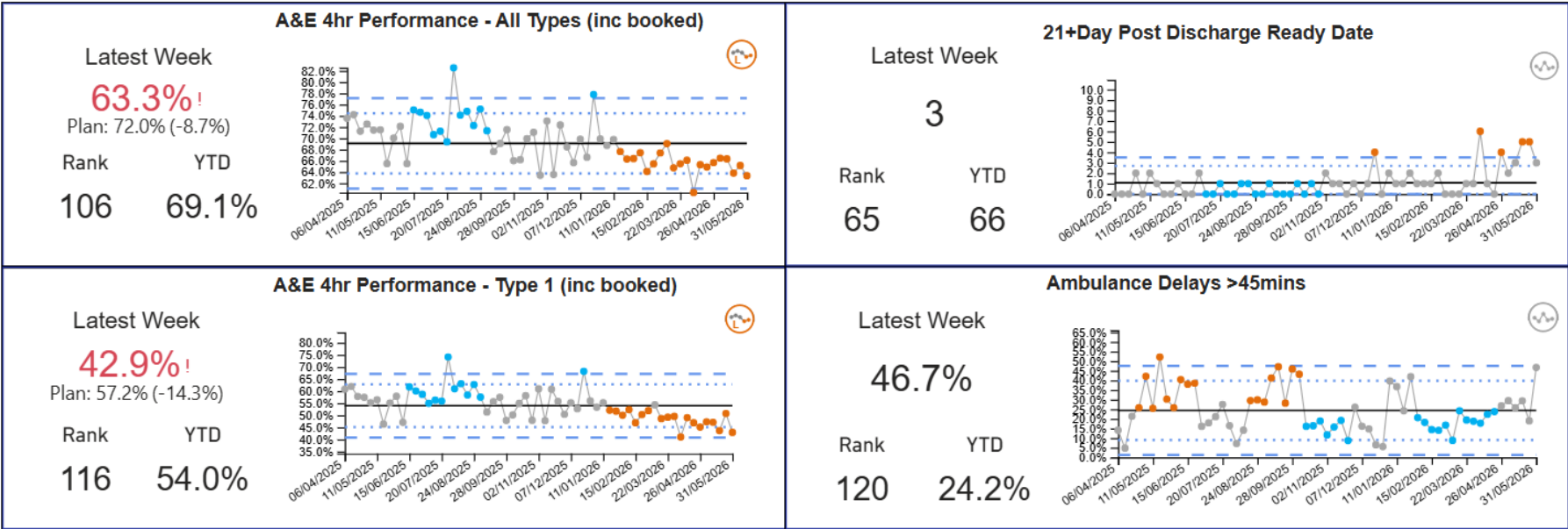
Torbay and South Devon

Metric Focus: UEC

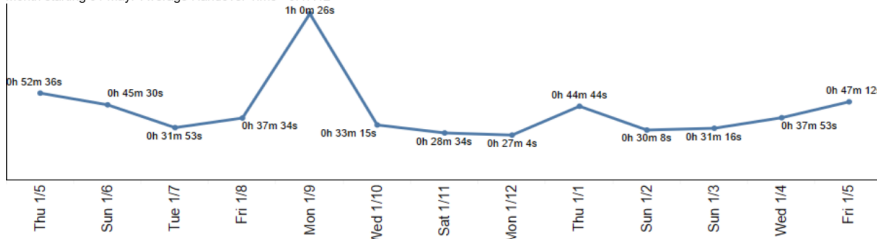
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31 May 2026

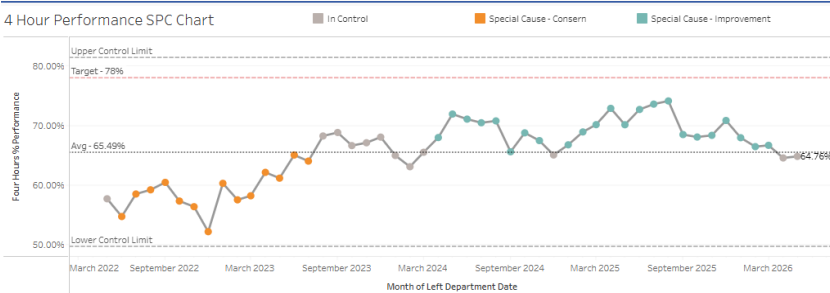
✓ Above plan
! Below plan



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

Performance	Operational update																																																																																		
The total number of ambulance conveyances to the ED in May was 2,556; this is a 6.4% increase on handovers from May 2025 and 4.6% increase on April 2026. April's average ambulance handover was 47mins 12secs. The number of handovers over 45mins has increased from 562 in April to 751 in May. Average handover time – rolling 30 day (as 1 June 2026) Rolling 30-day position as at 01 June 2026 <i>click on a bar to highlight site on the trend chart</i> <table><tr><th>Ambulance Trust</th><th>Site Name</th><th>Time</th></tr><tr><td>South Western</td><td>Royal Cornwall Hospital (triliske)</td><td>1:25:06</td></tr><tr><td>South Western</td><td>Derriford Hospital</td><td>1:17:58</td></tr><tr><td>South Western</td><td>Royal United Hospital</td><td>1:14:02</td></tr><tr><td>South Western</td><td>The Great Western Hospital</td><td>1:00:00</td></tr><tr><td>South Western</td><td>Torbay Hospital</td><td>0:49:24</td></tr><tr><td>South East Coast</td><td>University Hospital Lewisham</td><td>0:43:30</td></tr><tr><td>South East Coast</td><td>Chelsea & Westminster Hospital</td><td>0:41:10</td></tr><tr><td>South East Coast</td><td>Queens Hospital</td><td>0:38:08</td></tr><tr><td>South East Coast</td><td>St Thomas' Hospital (camhs Ment.</td><td>0:34:32</td></tr><tr><td>South Western</td><td>Royal Bournemouth Hospital</td><td>0:33:53</td></tr><tr><td>South Central</td><td>Royal Bournemouth Hospital</td><td>0:33:51</td></tr><tr><td>South Western</td><td>Salisbury Health Care NHS Trust</td><td>0:32:49</td></tr><tr><td>South Western</td><td>Poole Hospital</td><td>0:31:35</td></tr><tr><td>South East Coast</td><td>A & Conquest</td><td>0:29:11</td></tr><tr><td>South Western</td><td>Yeovil District Hospital</td><td>0:27:25</td></tr><tr><td>South East Coast</td><td>Princess Royal University Hospital</td><td>0:27:03</td></tr><tr><td>South Western</td><td>North Devon District Hospital</td><td>0:27:00</td></tr></table>	Ambulance Trust	Site Name	Time	South Western	Royal Cornwall Hospital (triliske)	1:25:06	South Western	Derriford Hospital	1:17:58	South Western	Royal United Hospital	1:14:02	South Western	The Great Western Hospital	1:00:00	South Western	Torbay Hospital	0:49:24	South East Coast	University Hospital Lewisham	0:43:30	South East Coast	Chelsea & Westminster Hospital	0:41:10	South East Coast	Queens Hospital	0:38:08	South East Coast	St Thomas' Hospital (camhs Ment.	0:34:32	South Western	Royal Bournemouth Hospital	0:33:53	South Central	Royal Bournemouth Hospital	0:33:51	South Western	Salisbury Health Care NHS Trust	0:32:49	South Western	Poole Hospital	0:31:35	South East Coast	A & Conquest	0:29:11	South Western	Yeovil District Hospital	0:27:25	South East Coast	Princess Royal University Hospital	0:27:03	South Western	North Devon District Hospital	0:27:00	There is a 3-fold worsening position in ambulances being held over 2hrs, jumping from 38 in April to 123 in May 2026. This is a direct patient safety risk with associated impact on them and the associated holding of crews. From a patient quality impact, it is not the type of care that the team would aspire to and creating moral injury and undue strain across the SWAST and TSDFT multidisciplinary teams especially after such positive inroads in performance and outcomes. Average ambulance handover time Thursday 1 May 2025 - Sunday 31 May 2026 - Monthly data Month starting 01 May: Average Handover Time - 0:47:12  <table><tr><th>Date</th><th>Time</th></tr><tr><td>Thu 1/5</td><td>0h 52m 36s</td></tr><tr><td>Sun 1/6</td><td>0h 45m 30s</td></tr><tr><td>Tue 1/7</td><td>0h 31m 53s</td></tr><tr><td>Fri 1/8</td><td>0h 37m 34s</td></tr><tr><td>Mon 1/9</td><td>1h 0m 26s</td></tr><tr><td>Wed 1/10</td><td>0h 33m 15s</td></tr><tr><td>Sat 1/11</td><td>0h 28m 34s</td></tr><tr><td>Mon 1/12</td><td>0h 27m 4s</td></tr><tr><td>Thu 1/1</td><td>0h 44m 44s</td></tr><tr><td>Sun 1/2</td><td>0h 30m 8s</td></tr><tr><td>Sun 1/3</td><td>0h 31m 16s</td></tr><tr><td>Wed 1/4</td><td>0h 37m 53s</td></tr><tr><td>Fri 1/5</td><td>0h 47m 12s</td></tr></table>	Date	Time	Thu 1/5	0h 52m 36s	Sun 1/6	0h 45m 30s	Tue 1/7	0h 31m 53s	Fri 1/8	0h 37m 34s	Mon 1/9	1h 0m 26s	Wed 1/10	0h 33m 15s	Sat 1/11	0h 28m 34s	Mon 1/12	0h 27m 4s	Thu 1/1	0h 44m 44s	Sun 1/2	0h 30m 8s	Sun 1/3	0h 31m 16s	Wed 1/4	0h 37m 53s	Fri 1/5	0h 47m 12s
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Actions to complete next month • The ED team continue with building upon their Apr-Oct 2026 Stabilisation and Improvement Plan to support the ongoing support of the THP, the new national drive to eradicate Corridor Care and the embedment of Epic. • The organisation, chaired and sponsored by Joe Teape the CEO, is undertaking a Trust wide Corridor Care Launch Event on Tuesday 23/06/26.	Risks/issues • Financial balance: 7.5% CIP for UEC + short notice but protracted escalation. • 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
	May 2025	May 2026	4hr performance for the month stands at 64.7% against a trajectory of 72%, meaning a deterioration in performance and 7.3% below trajectory. The ICO had 11,148 attendances in May, the Emergency Department recorded 7,115 attendances. June's month-to-date is showing a slightly improved position of 66.7%. • May 2026 recorded the 2nd highest attendance in the last 6 months averaging 230+pt/day • Higher attendance levels are noted on a Monday which is mirrored across the CUC services. • 60% needed Majors level care and 4% in Resus. • There was minimal improvement from a 4-hour monthly performance, but a reduction in resus performance and a grossly strained admitted pathway performance of 13.2%, which directly correlates to flow across all pathways and assessment areas. • 33.22% of those attending the ED were via SWAST ambulance disposition. • The final phase of the ED refurbishment and rebuild is still ongoing with 1 x cubicle at a time being closed and out of use.
MIU/UTC attendances	3995	3993	
MIU/UTC performance	99.6%	99.7%	
ED (type 1) attendances	7280	7115	
ED (type 1) performance	54.0%	46.4%	
ICO attendances	11235	11148	
ICO performance	70.1%	64.7%	
ED/UTC/MIU ATTENDANCE ANALYSIS 4HR TARGET 			
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 have a 6-month stabilisation plan in place to support year, the embedding of the new ED footprint and workforce, and to working with a fully electronic patient management system and processes. An initial 6- month plan has been implemented with the ED team, which will closely be followed by the AIM team. The organisation, chaired and sponsored by Joe Teape the CEO, is undertaking a Trust wide Corridor Care Launch Event on Tues 23/06/26			• Financial position of the Care Group and organisation and the impact on temporary versus substantive staffing, plus escalation. • Ongoing Winter pressures with associated IPCC issues for staff and patients. • Impact of Industrial Action on the senior workforce- next due 15/06/26. • 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

7

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

Performance	Operational update
Performance Analysis: The percent of pre-noon discharge for May is currently not available due to the implementation of Epic; data is being collated by the Business Intelligence Team. The Discharge Monitor Dashboard within EPIC does give a view of the previous day's discharges and those before noon and 5PM by ward. It is noted that due to the change of IT system baselines will need to be validated and reset. The latest report showing 14% by noon and 68% by 5PM.	Early patient discharge continues to be challenging with a significant impact on patient flow across the Trust. Early discharges have been low, with most discharges occurring much later in the day. This delay has increased pressure on escalation areas and led to a rise in out-of-hours transfers to G&A beds.
Actions to complete next month	Risks/issues
• Focus and drive on discharge planning and morning flow • Targeted work on wards that are outliers with Expected Date of Discharge accuracy • Review ward processes with EPIC and changes, new processes that have been introduced and sharing best practice • Include pre-noon discharge as part of the corridor care programme of work.	We continue to not meet the 33% pre-noon target for acute wards.

Exception report: Corridor Care

Performance						Operational update
The Trust has experienced an increased number of patients waiting longer than 45 minutes in the corridor or a non-clinical space.						On the 18th May, the Interim Chief Operating Officer led the first session of the senior leadership group tasked with eliminating corridor care within the Trust. The group in question contained senior clinical and operational leaders from across the Trust and jointly agreed the prioritisation of eliminating corridor care, a wider Trust engagement and planning event will take place on the 16th June where the plans and impacts will be co-designed with teams who will each have an influence on eliminating corridor care. It is acknowledged that increased corridor care is a negative consequence of failures within other elements of our 'unscheduled healthcare pathways' rather than being an issue on its own. We have therefore decided to ensure that all of the work around the UEC improvement plan, UEC demand management plan, Corridor Care and the first 72 hours plan (which is a national mandate) are combined into the same programme of work as delivery in these areas will be key to both improving our UEC performance, and eliminating corridor care.
	Jan 2025	Feb 2026	Mar 2026	April 2026	May 2026	
Corridor Care	1130	1040	813	1017	1014	
Actions to complete next month						Risks/issues

Planned Care Performance Summary

RTT

Month 2 shows activity recovery following EPIC go-live disruption, with activity stabilising but still below required trajectory. RTT performance at 60.4% remains below the May trajectory of 62.4% and March 2027 target of 73.8% indicating a large improvement requirement over the remainder of the year.

The deterioration in 65-week waits is driven by non-admitted pathway growth in T&O, Ophthalmology, and ENT due to EPIC implementation.

Actions in progress include insourcing and additional capacity across Ophthalmology, ENT, Urology, T&O, Dermatology, UGI, OMFS and deep-dive reviews at specialty-level, Workforce recovery: Gradual increase in consultant clinic templates (e.g. T&O at 80%); Operational improvements: Super clinics (e.g. T&O 120 patients planned for outpatients in July) and Weekend theatre lists; Validation activity: Dedicated validation team addressing duplicate RTT pathways and waiting list entries, plus the reintroduction of non-clinical validation text service; EPIC optimisation: Workflow fixes, booking improvements, sub-specialty grouping for booking and PTL management; 65-week specific actions: Insourced ENT clinics (~160 pts/month), T&O weekend operating lists, and Ophthalmology insourcing (three days per week over 6 weeks will clear all new waiting patients).

The June forecast shows continued pressure on performance and backlog growth particularly for non-admitted pathways and follow-up demand. The 65-week position is expected to remain elevated (123 patients - provisional). July forecast is expected to improve (112 patients - provisional) due to full utilisation of insourcing and additional clinics to target non-admitted cohort of patients, increased consultant capacity in T&O. Meeting the performance targets is dependent on Epic optimisation and stabilisation, adherence to plan for additional capacity and the theatre build completion.

Cancer

The Trust did not meet the cancer standards in May with 28-day performance at 49.3% (trajectory 57.0%) and 62-day performance at 50.4% (trajectory 55-60%). Dermatology capacity remains the largest contributor with approximately one third of the FDS activity. A loss of ~500 slots in April created a backlog, despite added capacity, backlog persists into June. The Trust is forecasting non-compliance of the 28-day cancer standard in June despite a waiting time improvement to 27 days.

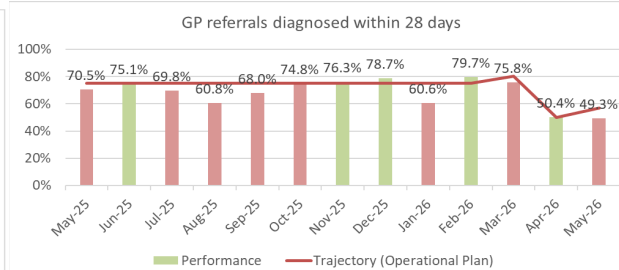
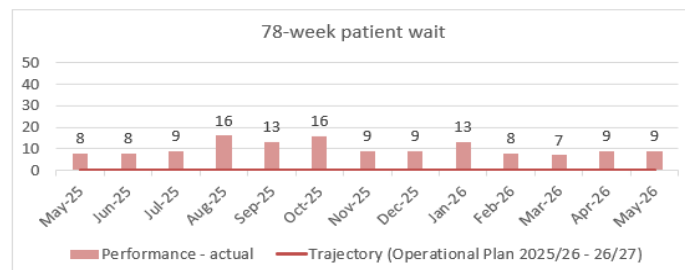
Improvement will be seen in July due to insourcing for dermatology (dermatology FDS forecast to 52%) and a waiting time reduction to ~22 days.

The national standards is not expected to be met until September 2026.

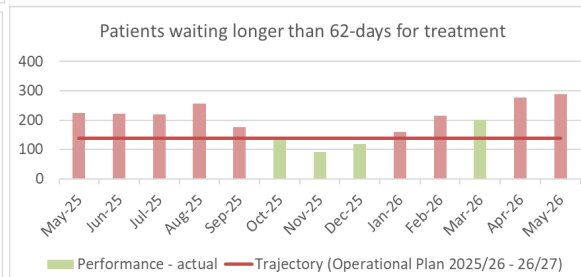
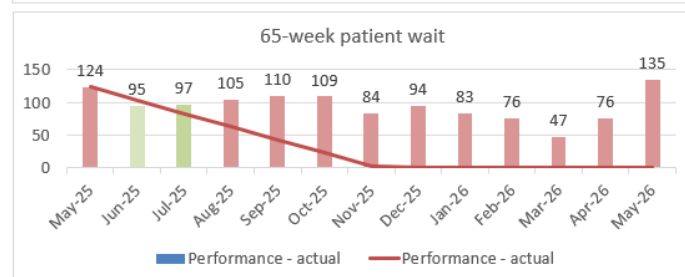
The 62-day standard will see an improvement in June and July driven by clearing April backlog but will still be below the national standard.

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

Torabay and South Devon NHS Foundation Trust																
INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS																
Data RAG rated against monthly Operational Plan trajectory Bold number = national data	Target March 2027	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Elective recovery																
RTT 78 week wait incomplete pathway - Actual	0		8	8	9	16	13	16	9	9	13	8	7	9	9	
RTT 78 week wait incomplete pathway - Plan	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT 65 week wait incomplete pathway - Actual	0		126	95	97	105	110	109	84	94	83	76	47	76	135	
RTT 65 week wait incomplete pathway - Plan	0		124	103	83	63	43	23	3	0	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual	0		805	740	615	618	615	647	607	663	604	607	600	799	993	
RTT 52 week wait incomplete pathway - Plan	0		887	833	780	728	673	586	505	449	383	327	268	571	546	522
RTT % Incomplete pathways <18 wks - Actual	73.83%		65.6%	68.2%	69.7%	69.5%	70.4%	69.3%	68.7%	67.5%	67.0%	66.8%	66.4%	62.8%	60.4%	
RTT % Incomplete pathways <18 wks - Plan	73.83%		62.8%	63.1%	63.5%	63.8%	64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	62.8%	62.4%	62.4%
RTT Wait for first appointment <18 weeks - Actual	74.0%		71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%	66.5%	
RTT Wait for first appointment <18 weeks - Plan	74.0%		65.7%	66.2%	66.7%	67.2%	67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%	66.3%
Cancer: 28-day FDS patients diagnosed - Actual	80.88%		70.5%	75.6%	70.1%	62.3%	67.3%	75.7%	76.2%	78.3%	60.6%	79.7%	75.7%	50.4%	49.3%	
Cancer: 28-day FDS patients diagnosed - Revised forecast	80.88%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	50.0%	57.0%	52.0%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual	80.75%		69.6%	63.7%	57.8%	64.5%	63.2%	70.4%	71.1%	79.8%	75.2%	67.1%	60.1%	57.4%	50.4%	
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.75%		74.0%	77.0%	75.7%	75.2%	75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	60.0%	55-60%	70.0%
Cancer: No of patients waiting >62 days to start treatment - Actual			225	223	220	257	176	132	91	119	159	214	201	276	288	
Cancer: No of patients waiting >62 days to start treatment - Plan																
Cancer: % of patients >62 days to start treatment - Actual			8.9%	7.9%	7.8%	9.2%	7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%	8.6%	
Cancer: % of patients >62 days to start treatment - Plan																
Diagnostics - proportion waiting over 6 weeks - Actual	15%		32.1%	33.9%	36.7%	37.1%	36.8%	29.4%	28.4%	30.4%	35.8%	30.6%	37.4%	41.6%	34.2%	
Diagnostics - proportion waiting over 6 weeks - Plan	15%							5.0%	4.0%	3.0%	3.0%	3.0%	3.0%	30.6%	29.2%	27.7%



RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

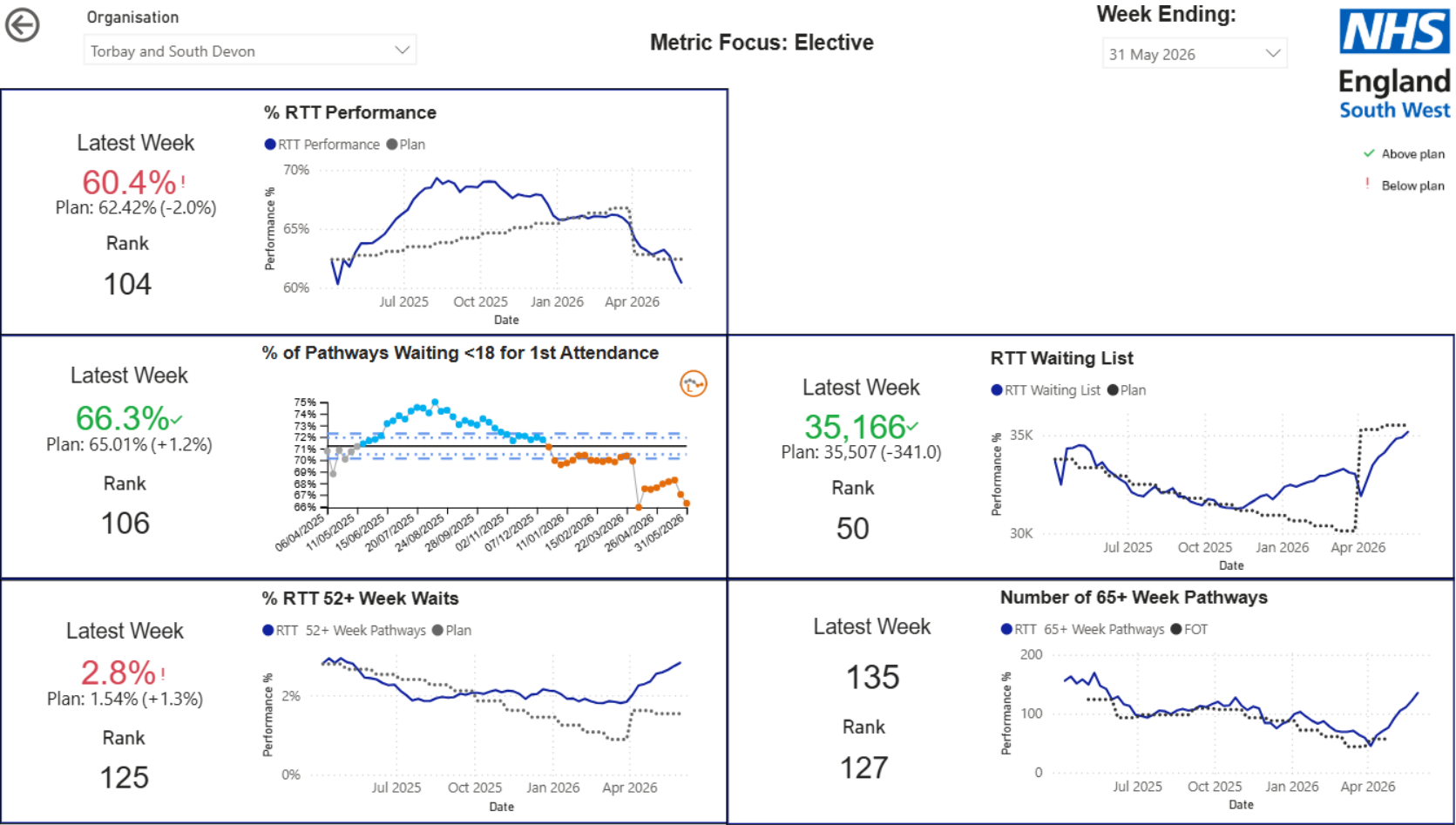


Elective Care Performance Summary - NHS England monitoring report

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

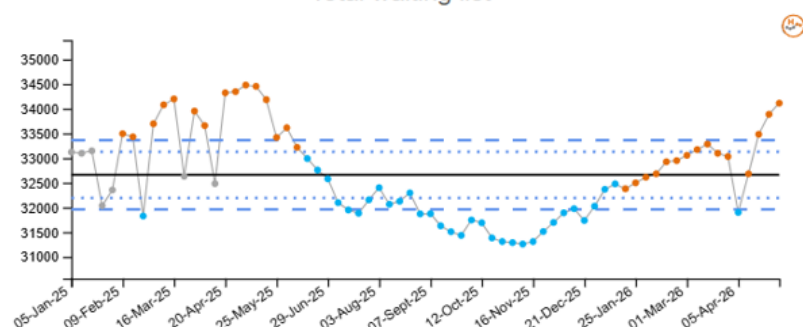
The published reports showing latest performance and trust ranking (134 Trusts) against the RTT waiting time metrics. Submitted operational planning trajectories confirm the good performance seen to date this year. At present on plan for RTT waiting list size and wait to first activity. However, challenges continue around 18-week, 52-week, and 65-week position.



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

The implementation of Epic has impacted on activity levels which is reflected in the long waits seen.

	May 2025	May 2026
78 weeks	8	9
65 weeks	126	135
52 weeks	805	993

TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST**Total waiting list****Operational update**

78 week: At the end of May (provisional figures) there are 9 breaches (All T&O)

65 week: In May (provisional figures) there were 135 breaches – with the majority sitting within T&O (63) and Ophthalmology (49).

Ongoing weekly cadence of breach review and action planning.

Total waiting list size: In April, the total waiting list has increased from 33,478 end of April to 35,177 on 31st May following the new Electronic Patient Record go live on 3rd April. This increase was expected and is staying within plan. For the first 6 week of go live teams have run at reduced capacity to allow more time to learn the new system. Teams will be supported to ensure a return to full capacity. This should then stabilise the overall waiting list as we turn attention to catching up lost activity and implement productivity improvements.

Actions to complete next month

- Stabilisation of EPIC
- Continued insourcing in key areas, exploration of additional organisations.
- Theatre recovery programme and outpatient programme refresh.
- Recruiting agreed posts and implement insourcing as part of business planning. Approve case in June at Trust Investment Group.
- Recovery plans to be signed off in June.

Risks/issues

- Trauma and cancer impacting long-wait elective capacity.
- Admin pressures impacting additional insourcing and/or bookings.
- Lost operational capacity due to estate failure e.g. theatre breakdown, MRI breakdown.
- Risk of delays to recruitment against agreed posts to deliver additional capacity and transition away from insourcing.
- Sickness in key areas such as Ophthalmology, Colorectal and ENT.
- Epic stabilisation and achieving Epic pre-go-live capacity.

Exception report: RTT First Outpatient – Elective Recovery

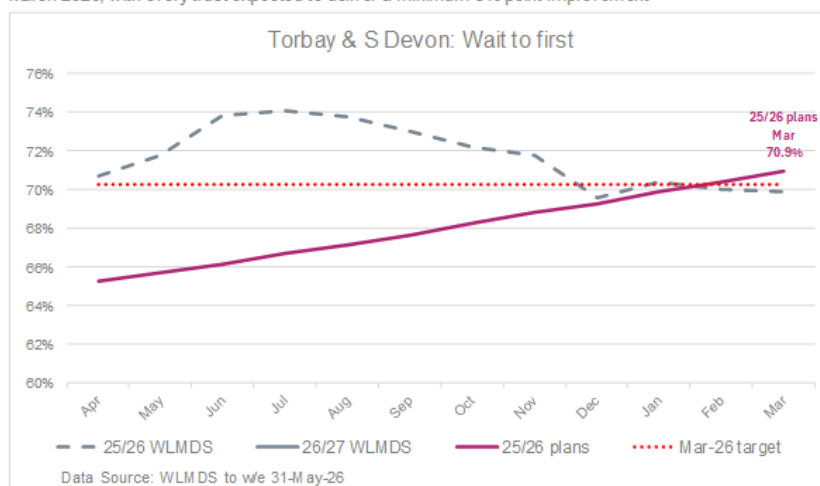
The Outpatient Improvement Group, which is still being set up, will maintain productivity oversight and drive forward improvements to ensure capacity is optimised and Getting it Right First Time (GIRFT) benchmarks are used to inform plans.

The Trust achieved 66.5% in May against the May trajectory of 66.0% of patients being seen at first outpatient appointment in under 18 weeks from referral.

The implementation of EPIC has reduced overall activity levels whilst teams have completed the transition and gained experience on using the new systems. Clinic capacity has not restored to pre-go-live levels in May; teams have been identified for additional Epic support to stabilise and recover performance.

Weekly activity stabilisation meetings are held with teams to review progress to identify any technical or training concerns that need to be supported. Formal recovery plan in place across Cancer, RTT, and Diagnostics.

Improve the percentage of patients waiting no longer than 18 weeks for first activity to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement



Baseline
Nov-24
65.3%

WLMDS
w/e 31-May-26
66.3%

Target
Mar-26
70.3%

Torbay & S Devon: Wait to first by specialty

Specialty	0-18 weeks	First activity	Wait to first	% point change	
				Baseline	Target
Elderly Medicine	107	214	50.0%	-15.3%	-20.3%
ENT	1,346	2,624	51.3%	-14.0%	-19.0%
Oral Surgery	1,054	1,886	55.9%	-9.4%	-14.4%
Urology	759	1,334	56.9%	-8.4%	-13.4%
Ophthalmology	2,055	3,598	57.1%	-8.2%	-13.2%
Trauma & Orthopaedics	724	1,178	61.5%	-3.8%	-8.8%
Rheumatology	409	660	62.0%	-3.3%	-8.3%
Neurology	655	1,002	65.4%	0.1%	-4.9%
Other - Medical Services	1,061	1,589	66.8%	1.5%	-3.5%
Cardiology	1,047	1,401	74.7%	9.5%	4.5%
Dermatology	2,017	2,685	75.1%	9.9%	4.9%
Respiratory Medicine	649	798	81.3%	16.1%	11.1%
Other - Surgical Services	1,018	1,204	84.6%	19.3%	14.3%
Gynaecology	582	679	85.7%	20.4%	15.4%
Gastroenterology	685	764	89.7%	24.4%	19.4%
General Medicine	12	13	92.3%	27.0%	22.0%
Plastic Surgery	38	41	92.7%	27.4%	22.4%
Other - Other Services	241	250	96.4%	31.1%	26.1%
Cardiothoracic Surgery	1	1	100.0%	34.7%	29.7%
General Surgery	6	6	100.0%	34.7%	29.7%
Other	2	2	100.0%	34.7%	29.7%
Other - Paediatric Services	186	186	100.0%	34.7%	29.7%
	-	-			
	-	-			
Total pathways	14,654	22,115	66.3%	1.0%	-4.0%

Data Source: WLMDS for w/e 31-May-26
Baseline is the WLMDS w/e 01-Dec-24

Below baseline Above target

Exception report: Cancer Waiting Time Standards

Performance				Actions to complete next month
	April 2026	May 2026*	June 2026**	
28-day FDS	48%	49%	62% (forecast)	- Dermatology: Additional insourcing and locum capacity is expected to support recovery from late June/early July. Contracts and activity profiles to be finalised. - Gynaecology: Focus is on Epic support for clinicians and increasing colposcopy/outpatient capacity. - Urology: Recovery is centred on Epic support for new and returning locums and improving follow-up booking workflows to release nursing time. - On 11th June, Cancer Services met with Epic to look at further EPR improvements to support the reduction in PTL size. Although mainly clinically activity driven, there are administrative resource/training challenges contributing the growth.
31-day treatment	92%	90%	94% (forecast)	
62-day cancer RTT	59%	55-60%	70% (forecast)	
62-day backlog	276 (8.3%)	317 (9.5%)	311 (9.0%)	
*as at 16 June 2026 (not fully validated). Note: data under development/review due to EPR Go Live ** Forecast figures Faster Diagnosis Standard (FDS): FDS performance has remained stable in April and May, there is a recovery being seen in June with the current forecast at 62%. The reduction in activity is the primary driver of the current cancer performance, but is recovering well. Dermatology is forecast to be 27% compliant in May, but this recovers to 44% in June.. Additional activity into June/July is being booked with external insourcing due to start in July. 62-day backlog: There are currently 3,443 open cancer pathways 311 (9%) over 62-days, this behind the national position of 7.8%. 62-day Cancer Referral to Treatment (Target 80%): May's forecast is 55-60%, which represents increased waiting times across multiple modalities and specialisms. The focus on activity stabilisation and recovering waiting times is a priority which will lead to improved 62-day waiting times.				Risks/issues
				New trajectory submitted to NHS E in May, need to maintain activity recovery to achieve desired trajectories.

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	M9	↓	Safer Staffing - ICO – Daytime (90% - 110%)		
SHMI	M9		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		↑
Medication incidents resulting in mod or more severe harm		↓	Fracture Neck Of Femur - Time to Theatre <36 hours (>90%) - one month in arrears	M1	↑
Falls per 1000 bed days		↑	Maternity: 1:1 care in labour		
Number of Healthcare Assoc Infection: MRSA		↔	Maternity: Admission to SCBU (full term)		
Number of Healthcare Assoc Infection: E-Coli		↑	Maternity: Stillbirths and perinatal deaths		
Number of Healthcare Assoc Infection: MSSA		↓	Maternity: Smoking at time of delivery		
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)		↓	Maternity: 3rd and 4th degree tears		
Formal complaints		↑	Maternity: PPH>1500mls		
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

There were 3 safety incidents in May associated with corridor care- all were no harm.

Incidents: Discharge/ transfer of care

30 incidents related to 'Discharge' were reported in the last month. As an emerging theme this is likely to form a new PSIRF Local Priority.

Mortality surveillance

The latest HMSR+ for September 24 to August 25 is **107.6** (101.0 – 114.6) and statistically higher than expected. This represents a 4-point increase in HMSR+. The Trust is 1 of 9 trusts that have an HMSR+ that is statistically higher than expected (out of 13). There is ongoing monitoring

Stroke care

May saw a further deterioration in performance on the standard of admission to the stroke unit within 4hr to 24.4% . The UEC care group have been asked to submit an update of their action plan following the letter from the National Clinical Director for Stroke last year

Areas of stable or improving performance

Maternity

In May there were no neonatal death or stillbirths. The Trust central safety team thematic review of recent cases is underway.

Infection Control

Rates of MSSA and e-coli are within or marginally above target thresholds. The IPC team is strengthening oversight of lapses and will work with NHS SW on a regional project re MSSA.

Feedback and engagement

New complaints and contacts are now acknowledged within 1 week. There is ongoing work to address the previous backlog of incomplete investigations

Safer Staffing

April 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 decreased but are not outside recent variance.

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 April 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 align with the implementation of the Electronic Patient Record EPIC. The trajectory for closure is by the end of June 2026.

MHRA Inspection Action Plan

It was acknowledged that the format of the MHRA actions are in line with MHRA reporting requirements (letter format) and not a traditional action plan. This is difficult to establish progress and completion. It has been requested that for future EROG meetings that this reports in an action plan format.

Adult Social Care CQC Action Plan

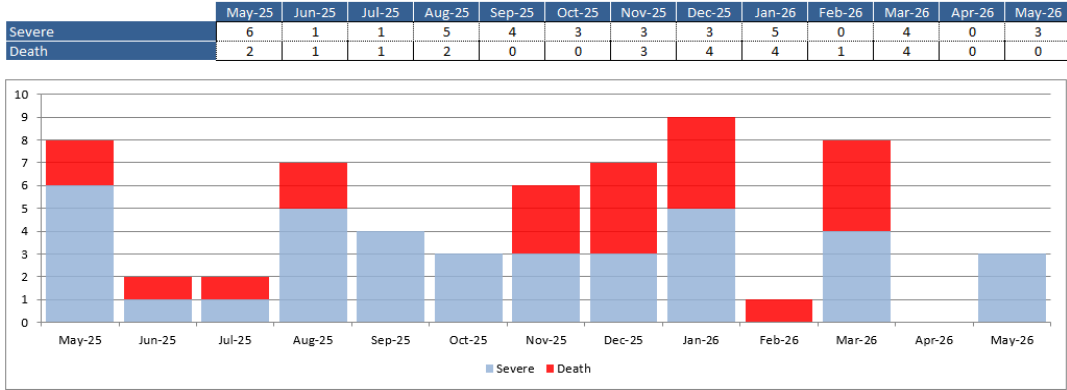
All actions currently on track or not due. Next update due September 2026.

Areas to note and escalate.

➤ None

Quality and Safety exception reports – Reported incidents

Reported Incidents - Severe and Death



Patient Safety Incidents reported as severe harm or death

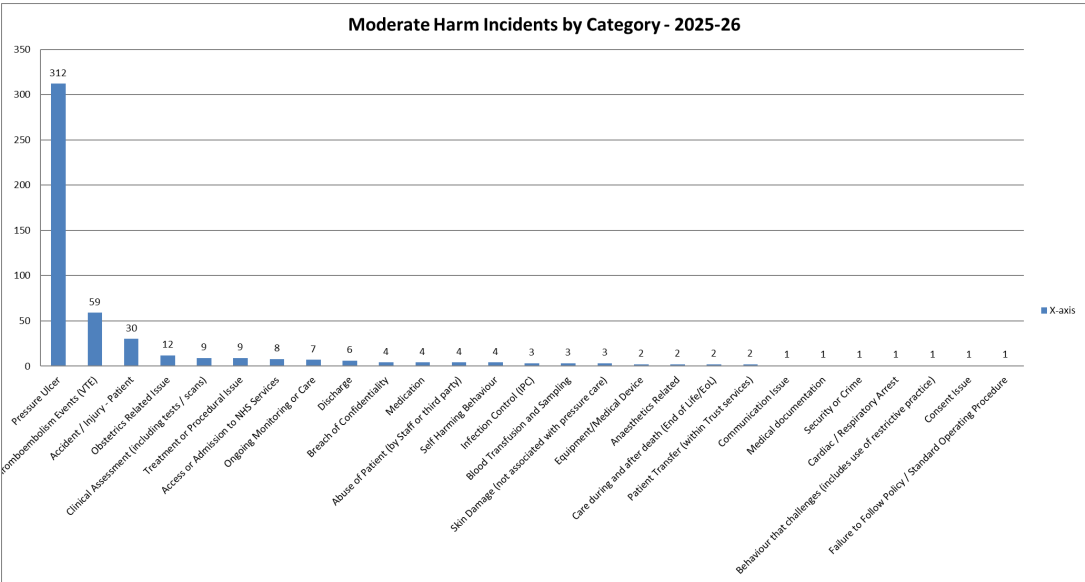
There were 3 incidents of severe harm and no reported incidents of death in May 2026.

[Severe] Postnatal readmission to ICU on a background of multiple sclerosis

[Severe] Fall with possible fracture on a background of recent hip surgery for fractured neck of femur

[Severe] SHOT positive Kleihaur maternity incident, repeat bloods not taken/sent/received.

Moderate Harm Incidents by Category - 2025-26



Patient Safety Incidents reported as moderate harm

Over the year 2025/26, pressure ulcers accounted for 63% of all incidents categorised as moderate harm and are the single largest group of moderate patient harm incidents. This trend continues into 2026/27 with May 2026 data indicating that 53% of moderate harm patient safety incidents reported that month relate to pressure ulcers.

Patient Safety Incident Response Framework (PSIRF)

There are 9 patient safety incident investigations (PSIIs) underway [no change].

5 PSIIs meet national priorities and 3 meet local priorities with another local priority PSII on hold pending the outcome of a thematic review.

Areas to note & escalate.

- Patient safety incidents associated with Corridor Care are monitored; 3 no-harm incidents were reported in May.
- Over 50% of all Incidents reported with moderate harm are categorised as being related to pressure ulcers
- 30 Discharge [26]/Transfer [4] incidents were reported during May 2026. All were low or no harm/near-miss with the exception of 1 moderate harm incident for Discharge, and 1 moderate harm for Transfer. The new PSIRF local priority: *Patient harm associated with inappropriate discharge or transfer of care*, will ensure a continued focus on discharge and transfer incident activity and learning

Quality and Safety exception reports – Hospital Standardised Mortality Ratio HSMR

Mortality data for the period of Dec 2024- Nov 2025

A Dr Foster report was presented to Mortality Surveillance Group on 14th May 2026. There is a high volume of R69 (uncoded) data for December 25 discharges.

HSMR+: Regional Peers (Acute non-specialist) - The Trust is 1 of 9 trusts that have an HSMR+ that is statistically higher than expected (out of 13).

SHMI – Nov 2024 to Oct 2025 : The new published SHMI value is 96.44 and statistically 'as expected'



- The latest HSMR+ for September 24 to August 25 is **107.6** (101.0 – 114.6) and statistically higher than expected. This represents a change in banding compared to the last report produced in January 26 and a 4-point increase in HSMR+.
- The HSMR+ for non-elective admissions for the current 12-month period is **107.8** and statistically higher than expected. This represents a change in banding compared to the previous report in January 26. The crude mortality rate for the current 12-month period is 5.9% (National = 5.8%, Region = 5.6%). Overall, the non-elective rolling 12-month trend for HSMR+ has been declining but sees a slight upturn over the last four periods, the current 12 months being statistically higher than expected.
- The HSMR for elective admissions is 106.8 and remains within the expected range. The rolling 12-month trend shows a general downward trajectory over the last nine periods.
- Emergency weekend HSMR+ remains statistically higher than expected. Emergency weekday HSMR+ remains within the expected range

Compared to the dashboard in the previous report there are four new CUSUM alerts that were not present in the last reported period:

- Congestive heart failure, non-hypertensive – Alert in August 25 (74 observed deaths vs 51.9 expected)
- Diseases of white blood cells – Alert in February 25 (1 observed death vs 0.2 expected)
- Genitourinary symptoms and ill-defined conditions – Alert in January 25 (3 observed deaths vs 1.2 expected)
- Other upper respiratory infections – Alert in September 25 (3 observed deaths vs 0.4 expected)

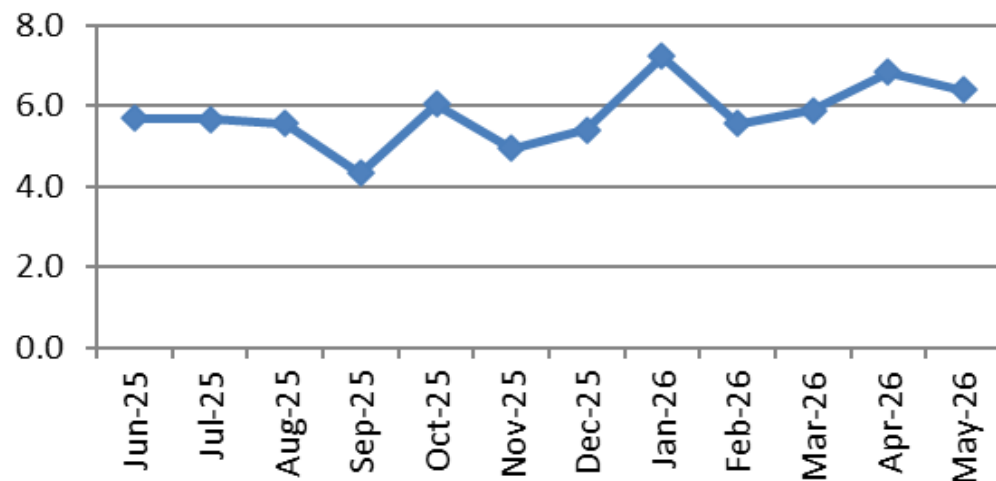
There are two new groups with a Relative Risk that is statistically higher than expected, that were not apparent in the previous report.

- Coronary atherosclerosis and other heart disease (10 observed deaths vs 4.1 expected)
- Other upper respiratory infections (3 observed deaths vs 0.4 expected)

Areas to note and escalate: MSG to continue to monitor

Quality and Safety exception reports – fractured neck of femur and falls

**FALL - Falls per 1,000 OBDs (All Bed Based)
Trustwide**



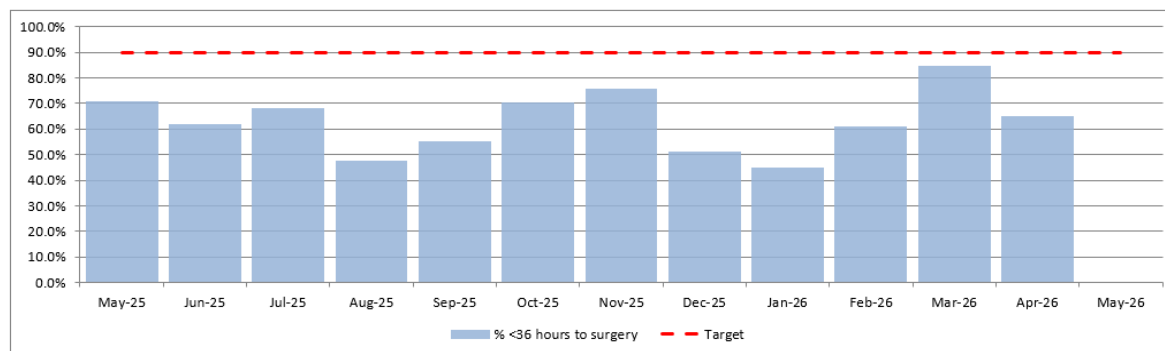
Falls

In the month of May there has been a decrease in the number of falls sustained whilst in our care, within expected variance.

An appropriate level of investigations are assigned.

Fractured neck of femur - <36 hours to surgery

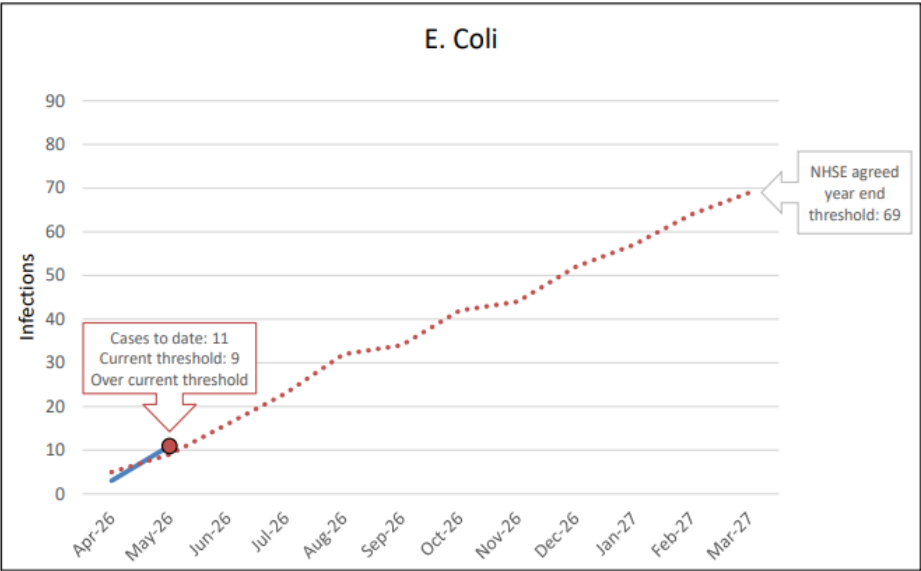
	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
% <36 hours to surgery	70.7%	61.8%	68.1%	47.4%	55.0%	70.3%	75.8%	51.0%	45.0%	60.9%	84.8%	65.0%	N/A
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Fractured Neck of Femur (one month in arrears – Month 2 data not yet available on National Hip Fracture Database).

May 26 data shows 40 hip fractures plus 6 other femoral fractures admitted. This will include the complex periprosthetic fractures. Average time to theatre for the hip fractures was 47 hours. This time to theatre includes 4 very long wait patients due to late presentation and waiting medical Optimisation. If we exclude these 4 patients time to theatre is 33 hours.

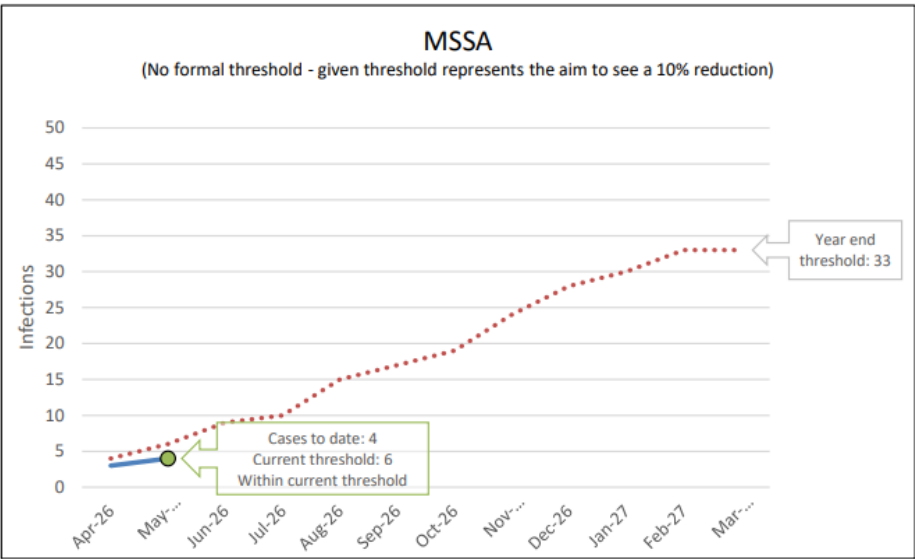
Quality and Safety exception report - Infection control



Escherichia coli (E. coli)

UKHSA historically require a 10% reduction in all blood borne bacteria from the previous year's infections. However, as this has not yet been confirmed, the IPC lead has predicted 26/27 targets to be within the range of 69 E.coli blood borne bacteria by March 31, 2027. This will be revised, if required, when official targets are published.

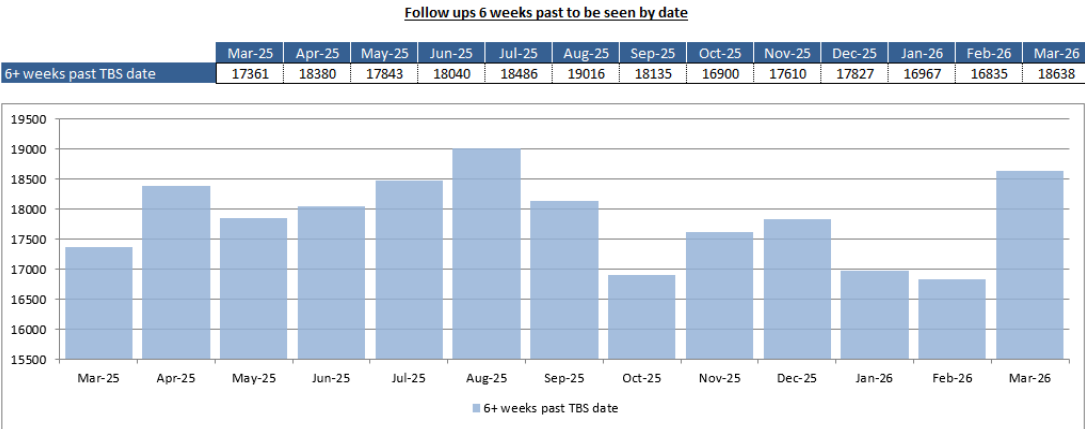
To date there have been 11 E.coli infections detected which is two above the predicted rate (9) for May 2026. Having been reviewed by the Microbiologist and IPC team two Hospital Onset Healthcare Associate (HOHA) bacteraemia's require further investigation with one Community Onset Healthcare Associated (COHA) requiring further review. If further actions are required, this will be escalated via the Care Group IGG and IPCG routes.



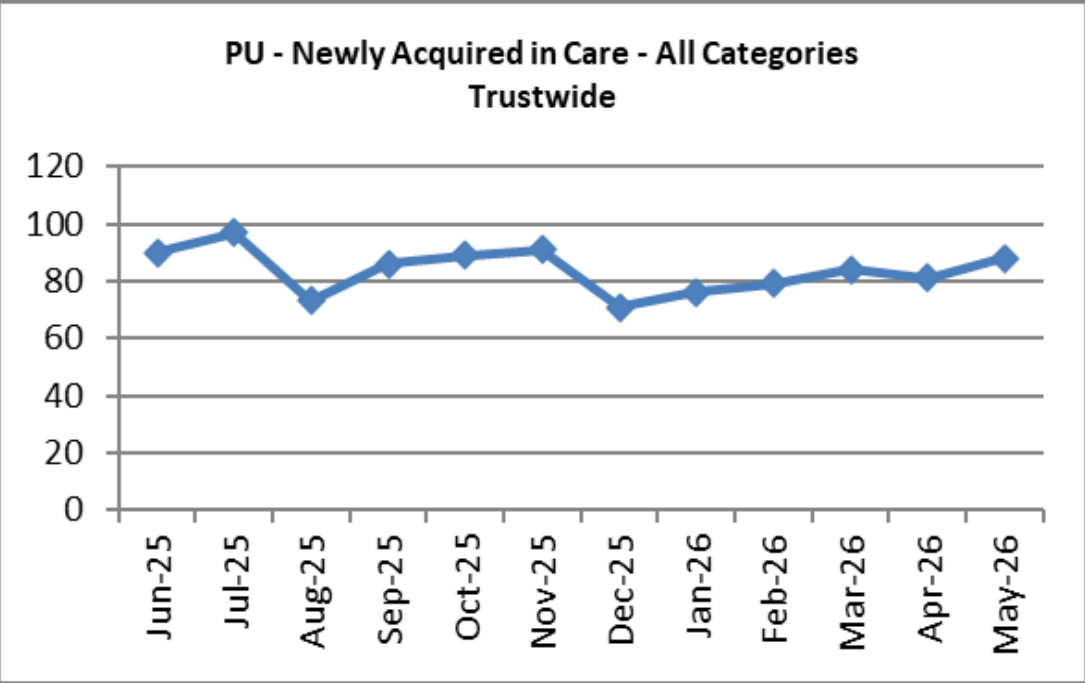
MSSA (Methicillin-Sensitive Staphylococcus aureus)

UKHSA historically require a 10% reduction in all blood borne bacteria from the previous year's infections. However, as this has not yet been confirmed, the IPC lead has predicted 26/27 targets to be within the range of 33 blood borne bacteria by March 31, 2027. This will be revised, if required, when official targets are published. To date there have been 4 MSSA infections which is within the threshold of 6, none of which have required any further investigation following Microbiology and IPC review.

Quality and Safety exception reports – follow-ups past to be seen by date/ pressure ulcer



Follow-ups past 6 weeks to be seen
Due to the launch of EPIC no data currently available to report on.

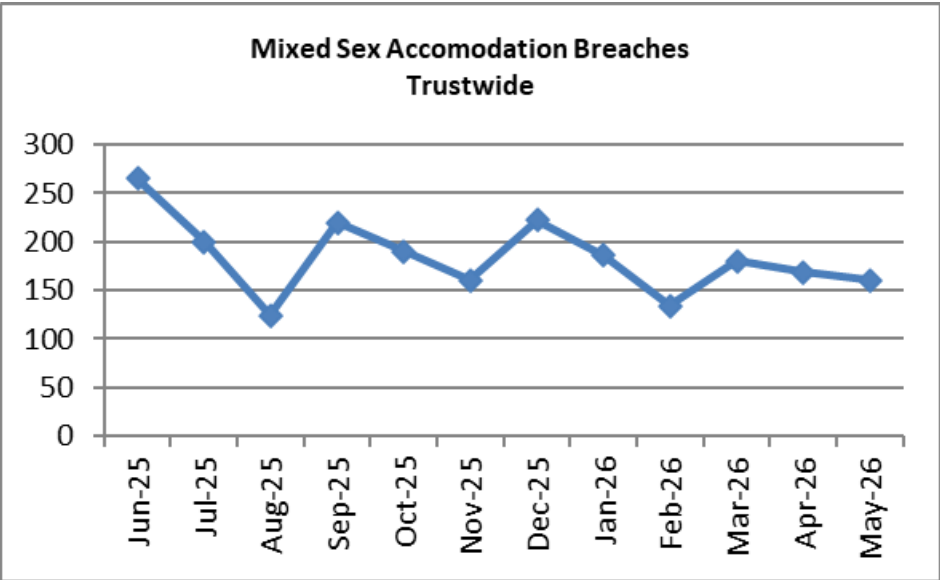


Pressure ulcer

Incidents of pressure ulcers acquired in our care shows a fairly stable picture. The Tissue Viability Team are working with Matrons to raise awareness of education and along with this Purpose-T training is now mandated. Shared learning takes place monthly through the PUP meetings.

Trustwide compliance with pressure ulcer assessment within 4 hours currently sits at 89.6% in April 26, which is static.

Quality and Safety exception report – 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.

Quality and Safety exception report – TSDFT stroke standards

Data for previous month only available from 15th of current month and may be subject to change. Source: SSNAP DIY tool.

NB: These are incomplete data due to the transition to Capture Stroke.

Time critical Stroke Standards	Natl. average Jan-Mar 26													
		May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Number of patients (N)		62	54	50	58	53	57	44	51	56	40	61	48	42*
% Scanned within 20 minutes updated target	32.7%	29.0%	43.1%	24.5%	29.3%	39.6%	27.3%	22.7%	36.5%	37.5%	27.5%	37.70%	31.90%	34.90%
% Admitted to Stroke Unit within 4 hours	48.9%	37%	47.30%	28%	46.40%	50%	49.1%	34.1%	52.90%	34%	38%	49.10%	17.80%	24.40%
Median time to reach the stroke unit (hours:mins)	03:55	05:31	04:16	06:17	04:18	03:40	03:45	06:55	03:43	05:55	09:09	04:01	08:50	07:45
% of patients spending 90% of their time on the Stroke Unit	81.2% (Team)	77.40%	75.90%	78.90%	81%	81%	88.9%	65.9%	74.50%	60.70%	71.80%	73.30%	64.30%	52.40%
% Patients given formal swallow assessment within 24 hours	54.9%	8.1%	8.5%	7.5%	5.2%	5.70%	5.50%	40.00%	58.40%	69.60%	71.90%	73.50%	63.60%	26.30%
% (No.) Patients that received Thrombolysis	13.4%	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)	18.8% (9)	16.3% (6)
Median time between clock start and thrombolysis (hours:minutes) New target	00:55mins	01:17	01:08	01:07	01:17	01:27	00:58	00:57	00:53	01:10	00:48	00:58	00:56	01:00
*incomplete data for May														

Capture Stroke (CS) went live on 18th May. Teams are still familiarising themselves with new processes and the requirement to complete data entry as close as possible to "real time". The performance co-ordinator is completing a backlog of data entry onto CS and SSNAP; this means that data above are not complete.

Unfortunately, results are not encouraging. For the second consecutive month for the proportion of patients reaching the stroke unit within 4 hours decreased; only 24.4% reached the unit in 4 hours which is 11 patients. Proportions of patients receiving a swallow assessment within 24 hours, spending 90% of their time a dedicated stroke unit and receiving thrombolysis dropped.

Stroke Actions:

1. Ongoing breach analysis work
2. Using Samuel tool (thrombolysis predictor) to review a sample of non-thrombolysed patients to look for missed opportunities
3. Progress launch of new hyper-acute pathway SOP
4. Progress project initiation documents for 3 key areas of work

Other work

Work sponsored by PASP has started to look at out DIDO (door-in-door-out) pathway for thrombectomy patients. This consists of detailed mapping of the arrival to CT pathway meeting with key stakeholders to identify improvements.

Work has started across the region – Devon, Cornwall, Somerset, Avon, Gloucester and Wiltshire to look at feasibility of an out of hours reperfusion rota.

Risks

No additional capacity to undertake improvement work

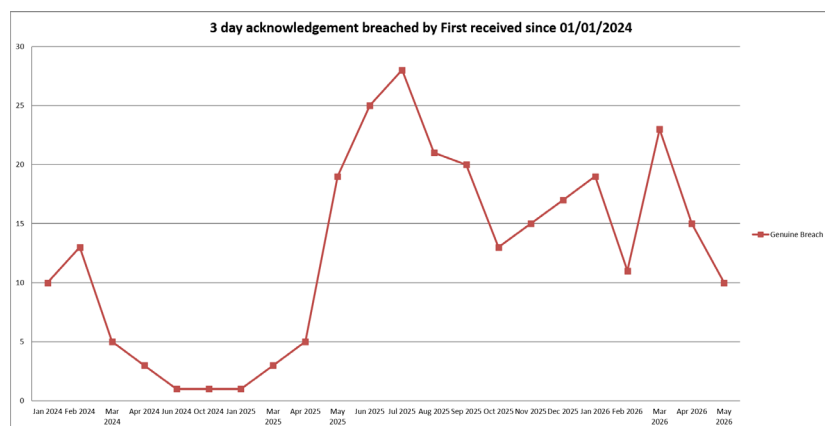
Quality and Safety exception report – Feedback and engagement

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 fluctuating. As of 01/06/2026 Feedback mailbox contained contacts dating less than one week since being received. Efforts now focus on data quality and maintaining this position through annual leave and absence.



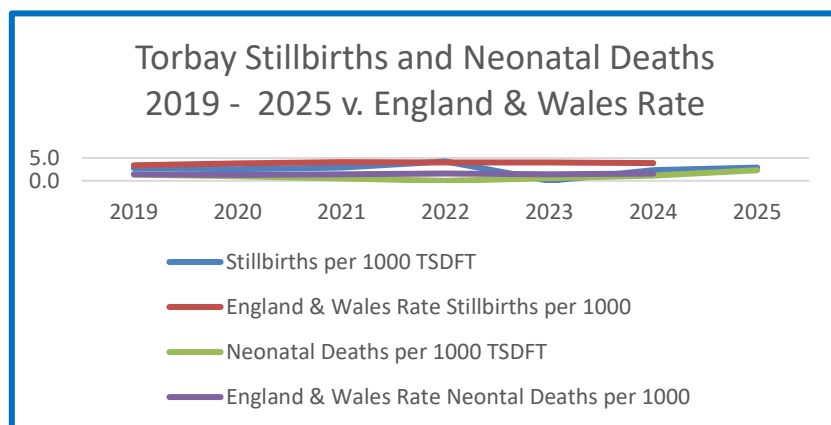
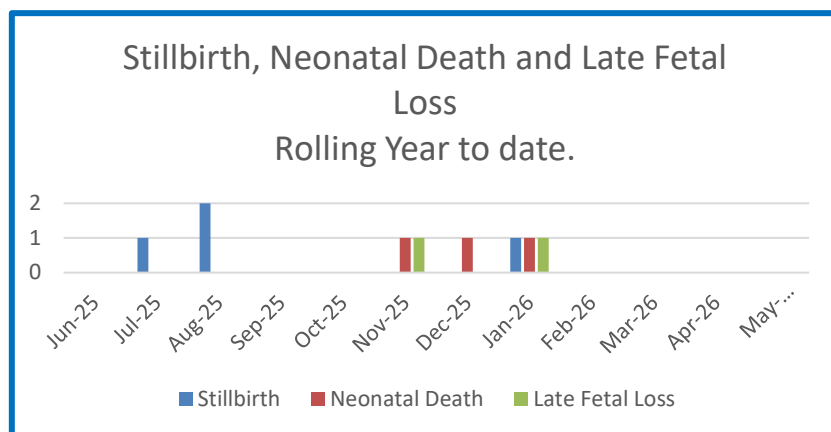
The six-month complaint response standard data is collated upon closure. It is expected due to the backlog in processing complaints this will have an impact but the data is not yet available as complaints are still under investigation.

Current actions in progress to improve efficiencies:

- Ongoing DCIQ development
- Review of persistent and vexatious complainant process and alignment across the peninsula – working with the ICB.
- Awaiting dates to pilot online and telephone translation services
- Friends and Family Test opinions appraisal with consideration to in-house MS Form solution to be piloted. There are concerns with current digital solution (Formic) with insufficient access and being unable to export data for monthly FFT submissions to NHS England.

Quality and Safety- Perinatal Clinical Quality Oversight June 2026 (May 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:

- **July 2025** – 1 x Stillbirth at 36+1 weeks gestation
- **August 2025** – 2 x Stillbirths - 1 x stillborn baby at 39+3 weeks gestation to White British woman. 1 x stillborn baby at 26 weeks' gestation to a woman who was White Other.
- **November 2025** - 1 x Late Fetal Loss - Spontaneous Labourer with probable infection at 22 weeks gestation. 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.
- **Dec 2025** – Neonatal Death 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 amniocentesis

Incidents moderate and above = 2

37906 – Moderate – Large PPH following Cat 1 LSCS – Baby resuscitated and transferred to level 3 unit for cooling.

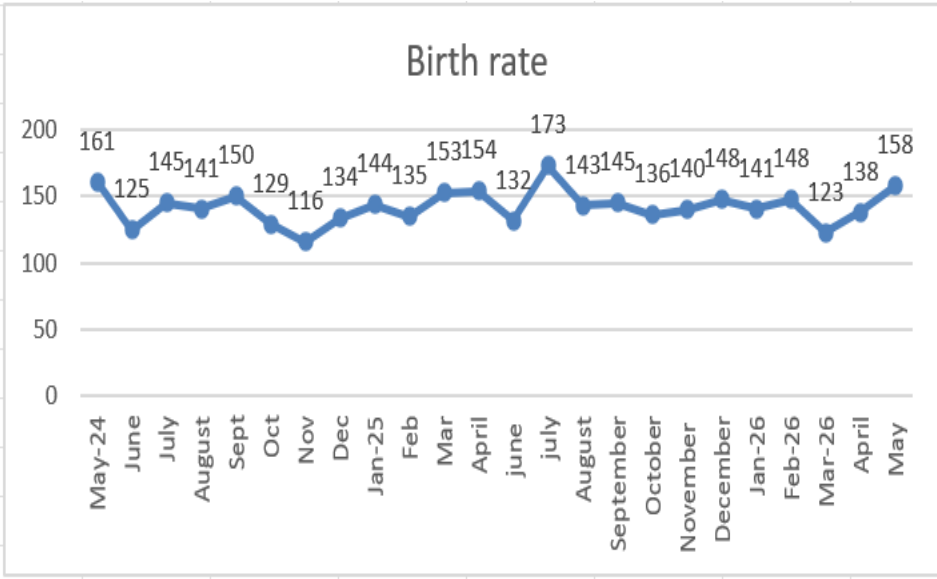
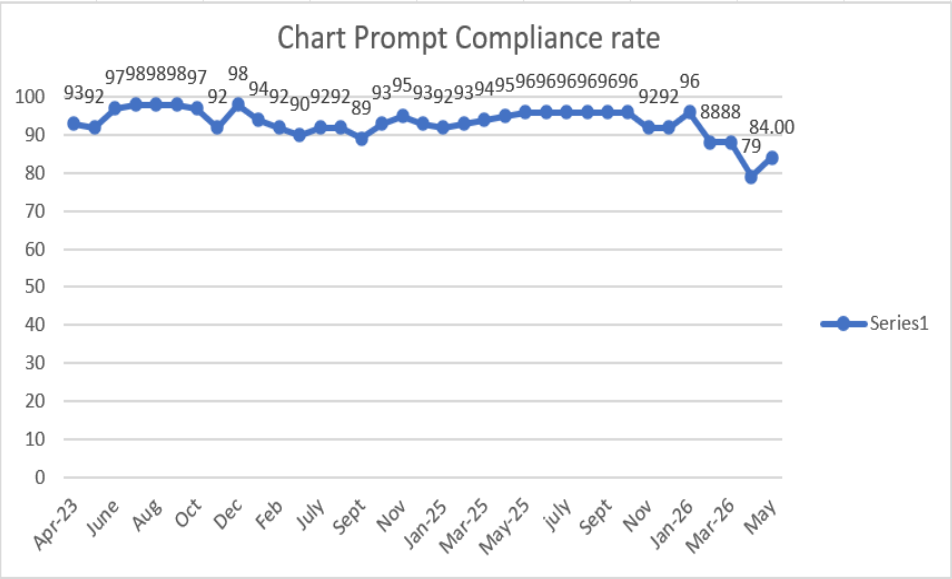
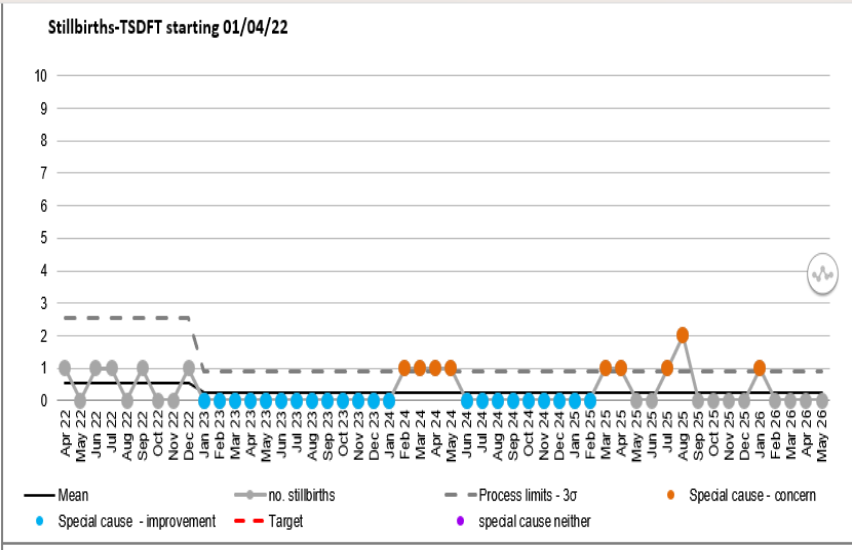
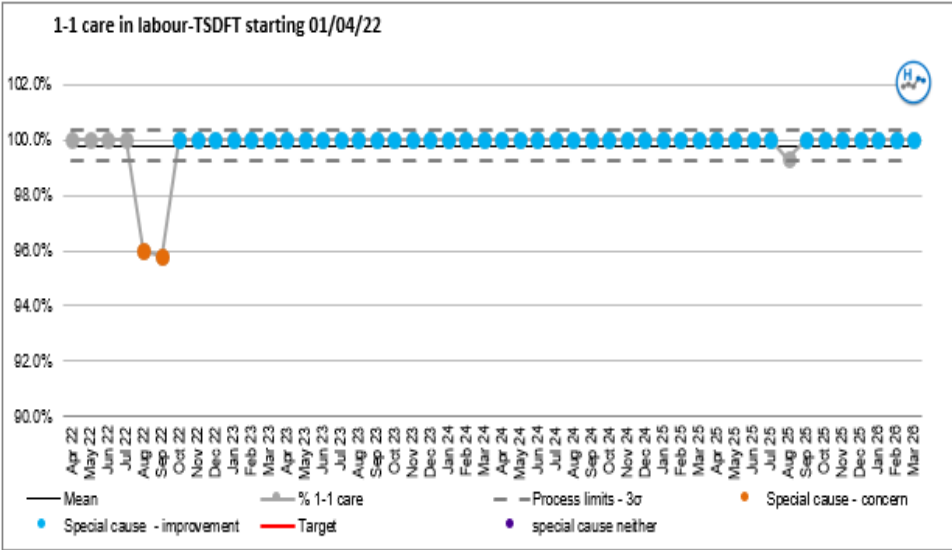
37990 – Moderate - Ongoing issues with obstetric scanning capacity, unable to fulfil requests to meet time requirements

MNSI – None

CQC – None

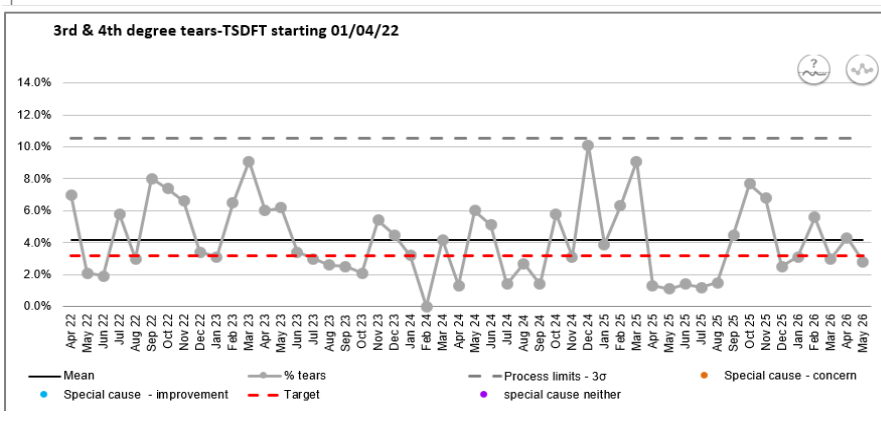
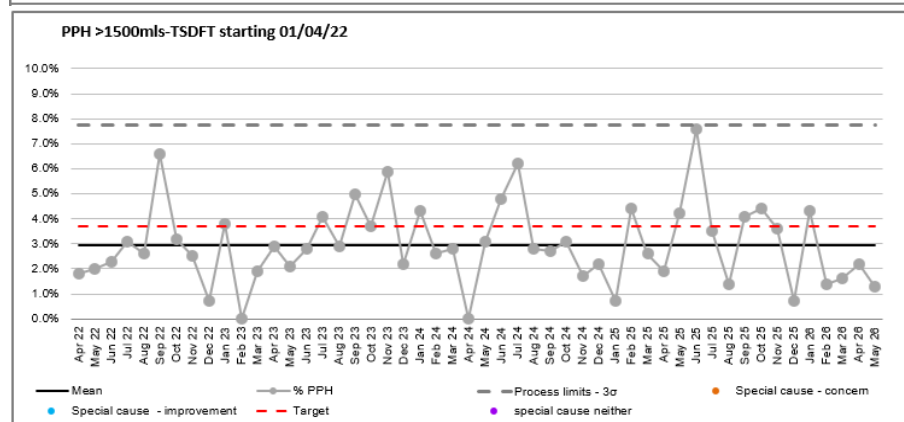
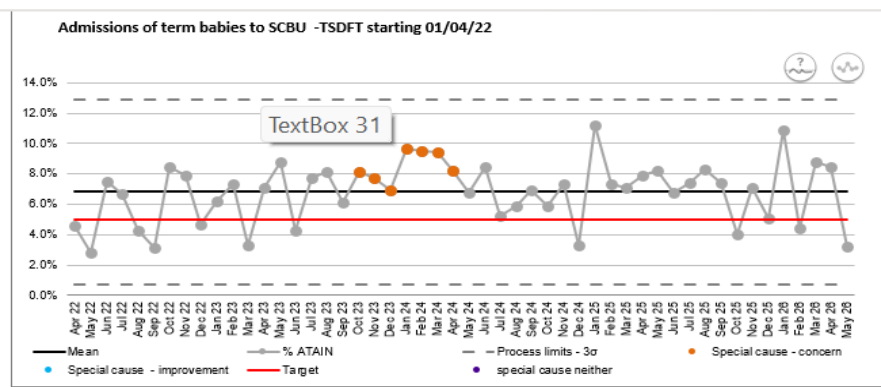
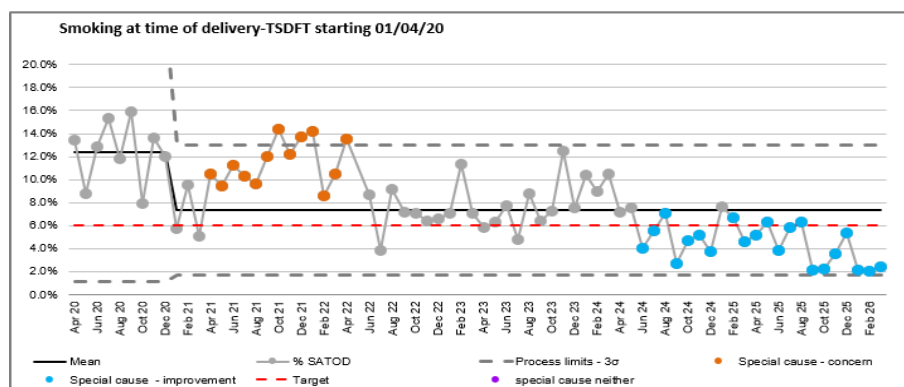
Coroner referral – None

Quality and Safety - Metrics relating to the provision of quality maternity care- May 2026



Quality and Safety - Metrics relating to the provision of quality maternity care - May 2026

- There were 158 births in May 2026.
- Unable to pull data this month for smoking at time of delivery due to alterations in reporting due to Epic launch. This is being resolved ready for ongoing reporting,
- Decrease in the number of 3rd/4th degree from 4.3% in April to 2.8% in May; national target average is 3.2%. Annual figure for 2025/26 = 3.6% marginally above the national average. Ongoing support, education, and audit oversight by pelvic health midwife.
- Decrease in the incidence of PPH>1500mls from 2.2% in April to 1.3% in May. Quarterly average at 3.43% below the national target of 3.7%; annual rate for 2025/26 below the national average at 3.2%.
- A significant decrease in term baby admissions to SCBU to 3.4%. National target is 5% or less (annual figure for 25/25 was 7.2%) QI work in place to reduce rate - Screen and Treat at bedside.



Quality and Safety – Safer Staffing – Dashboard April 2026 (one month in arrears). CHPPD May 2026

Inpatient Wards (All)

Staffing Metrics					
Beds		Establ. Beds		518	
		Bed Occ.		89.4%	
Staffing Fill Rates	Days	RN / Midwives		94.3%	
		Care Staff		94.0%	
	Nights	RN / Midwives		98.0%	
		Care Staff		106.8%	
Actual Staffing Split	Days	% RN / Midwives Hours		55.4%	
		% Care Staff Hours		44.6%	
	Nights	% RN / Midwives Hours		54.5%	
		% Care Staff Hours		45.5%	
Care Hours Per Patient Day (CHPPD)	Days	RN / Midwives	Planned	2.6	
			Actual	2.4	
		Care Staff	Planned	2.1	
			Actual	1.9	
	Overall Day		Planned	4.6	
			Actual	4.4	
		Nights	RN / Midwives	Planned	2.0
				Actual	1.9
	Care Staff		Planned	1.5	
			Actual	1.6	
	Overall Night		Planned	3.5	
			Actual	3.5	
HR Metrics		Sickness Rate	(Mar-26)	5.8%	
		Turnover Rate		9.9%	
		Vacancy Rate		2.4%	
Temporary Staffing		Prop. Bank Hours		9.0%	
		Prop. Agency Hours		4.8%	
Patient Sensitive Indicators					
Safety	Red Flags Raised	EToC Red Flags		0	
		All Red Flags		7	
	Mod. Harm Incs and Above			5	
	PUs G2+ Acq. in Our Care			0	
	Falls	No Harm		46	
		Harm		42	
	Medicine Errors			21	
	% Obs Taken on Time		(Mar-26)	91.5%	
Feedback	Patient Complaints			2	
	FFT	% Positive Resp.	(Jul-25)	98.9%	
		Number of Resp.	(Jul-25)	265	

Emergency Care (ED Only)

Staffing Metrics					
Number of Attendances				6,839	
Staffing Fill Rates	Days	RN / Midwives		99.9%	
		Care Staff		105.6%	
	Nights	RN / Midwives		99.2%	
		Care Staff		58.2%	
Actual Staffing Split	Days	% RN / Midwives Hours		60.7%	
		% Care Staff Hours		39.3%	
	Nights	% RN / Midwives Hours		73.6%	
		% Care Staff Hours		26.4%	
HR Metrics	Sickness Rate		(Mar-26)	9.4%	
	Turnover Rate			9.3%	
	Vacancy Rate			-4.0%	
Temporary Staffing	Prop. Bank Hours			12.3%	
	Prop. Bank Hours			12.3%	
Patient Sensitive Indicators					
Number of Unplanned Reattendances				249	
Service Delivery Times	% Waiting > 4 Hrs			54.5%	
	% Waiting > 12 Hrs			9.9%	
	Avg. Triage Time (mins)			27	
	Amb. Handovers < 30 mins			49.8%	
Safety	All Red Flags			0	
	Mod. Harm Incs and Above			5	
	Medicine Errors			4	
	PUs G2+ Acquired in Our Care			0	
	Falls	No Harm			2
		Harm			2
	Sepsis	% Overall Sepsis 6 Compliance			77.0%
		% Antibiotics within 1 Hour			100.0%
Feedback	Patient Complaints			0	
	FFT	% Positive Resp.		(Jul-25)	100.0%
		Number of Resp.		(Jul-25)	28

CHPPD data May 26

Organisational CHPPD	Planned Total	Planned RN	Planned NA	Planned HCA	Actual Total	Actual RN	Actual NA	Actual HCA
Total Planned Beds / Day	522							
Days in month	31							

Quality and Safety – Safer Staffing – Dashboard April 2026

The Trust overall actual CHPPD is 7.62 this is slightly over the planned target of 7.42. The actual CHPPD for RN/Midwives in April 26 is 4.16 minimally over the planned of 4.13. The overall actual CHPPD for HCSW is 3.40. This is over the planned target of 3.27. Variance from planned was primarily associated with supporting service resilience through the management of annual leave, sickness absence, and temporary vacancy cover.

April's data stays within the NHSE suggested tolerance of 80-120% and within the TSDFT tolerance of 90-110% fill rates. RN numbers have still been stagnant and are at the lower end for the days with an average of 90.6.% fill rate during the day . The average registered fill rate for nights has improved by 2.3%. Care staff fill rates on day shifts has decreased by 0.1% to 94%. The care staff fill rate for nights is 103.9% this is a decrease of 2.9% from March 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. Where HCSW fill rates have reduced, the Trust continues to strengthen workforce pipelines through collaborative working with NHSP, including the development of 3-month trainee HCSW posts to support short-term sickness and maternity leave cover while encouraging progression into substantive roles. Focused recruitment activity is still in place within high-pressure areas such as ED, where vacancy levels stay elevated. Alongside this, the Trust has continued to reduce reliance on temporary staffing through a reduction in agency usage and the successful migration of 29 agency staff into NHSP roles, supporting greater workforce stability and continuity of care.

Organisational absence is still at 5.8% and continues to be stable as a workforce metric. Turnover is currently 9.8%, being a slight improvement of 0.1% compared to March 2026. Focused recruitment campaigns and work to streamline onboarding processes have supported improved workforce stability across Nursing services, although onboarding timelines have increased by an average of 10 days per month, taking average time to hire closer to 60 days rather than the previous 50-day position.

Higher levels of sickness absence continue to be seen within some high-pressure clinical services, particularly areas such as ED where vacancy rates stay elevated. Despite these operational pressures, turnover within these services has still been stable, with some areas proving a slight reduction in turnover rates. In response, the Trust continues to prioritise focused recruitment activity, strengthen support with the Resourcing Team to reduce recruitment timelines and improve time to start, while continuing collaborative work with the People Directorate to support staff wellbeing, workforce resilience, and overall staff experience

The current proportion of temporary workforce utilisation is 12.8% for bank staffing, being an increase of 3.8% from March 2026. Agency utilisation has also increased from 4.8% to 5.4% during the same period, reflecting continued operational pressures and the requirement to keep safe staffing levels in response to workforce challenges, including increased sickness absence.

The Trust continues to focus on reducing reliance on agency staffing through strengthened workforce pipeline initiatives and the migration of agency workers into NHSP roles to improve workforce stability and continuity of care. Added governance measures have also been strengthened, with Directors of Nursing overseeing approval processes for both agency and overtime usage to provide assurance that all workforce mitigations, redeployment options, and safer staffing measures have been fully considered prior to escalation to temporary staffing solutions

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Community and Social Care Indicators - Summary of key metrics

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

Opiate users - % successful completions of treatment (quarterly - 1 quarter in arrears)		
DOLS - Deprivation of Liberty Standard		
Intermediate Care - No. urgent referrals		
Community Hospital - Admissions (non-stroke)		
Community Hospital average Length of Stay (days)		
Community Hospital patient discharges pre-noon		
Urgent Community Response 2 hours	Month 1	↓
Permanent admissions (18-64) to care homes per 100k population (ASCOF) (14)		
Permanent admissions (65+) to care homes per 100k population (ASCOF) (450)	Month 1	↑
Proportion of clients receiving direct payments (ASCOF) (25%)	Month 1	↓
% reablement episodes not followed by long term SC support (83%)		↑

Due to the EPR implementation the above metrics for Month 2 are being established and data quality reviewed.

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. May data reflects the introduction of the new electronic patient record (Epic) implementation, with on-going validation and data quality checks over the coming weeks. In addition, services previously reported under Children's and Family Health Devon formally transferred to Devon Partnership Trust and are no longer included in this report.

In May, 111 people are reported as waiting over 52 weeks for an appointment (from 113 in April) with 67 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 support 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 (snapshot on 1st June 2026)

(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	NHS England 78% target < 18 weeks
(A): Podiatry and podiatric surgery	681	161	0	0	842	81%
(A): Rehabilitation services (integrated and uni-disciplinary) (physio, OT, speech and language)	455	9	0	0	464	98%
(A): Therapy interventions: Speech and language	91	31	1	0	123	74%
(A): Therapy interventions: Dietetics	212	19	1	0	232	91%
(A): Therapy interventions: Orthotics	36	0	0	0	36	100%
(A): Weight management and obesity services	77	158	67	0	302	25%
(A): Musculoskeletal service	1,787	208	2	0	1,997	89%
(A): Nursing and Therapy support for LTCs: Stroke	201	53	17	0	271	74%
(A): Nursing and Therapy support for LTCs: Falls	161	16	0	0	177	91%
(A): Nursing and Therapy support for LTCs: Lymphoedema	48	2	0	0	50	96%
(A): Nursing and Therapy support for LTCs: Diabetes	51	4	0	0	55	93%
(A): Community nursing services (including district nurses and homeless health)	350	0	0	0	350	100%
(A): Urgent Community Response/Rapid Response team	4	0	0	0	4	100%
(A): Intermediate care and reablement	44	0	0	0	44	100%
(CYP): Community paediatric service	178	136	0	0	314	57%
(CYP): Wheelchair, orthotics, prosthetics and equipment	20	1	9	0	30	67%
(A): Therapy interventions: Physiotherapy	22	22	14	0	58	38%
TSDFT Total	4,418	820	111	0	5,349	

Workforce – Executive Summary – Month 2

Month 2 demonstrates continued stabilisation of the workforce position at 6,358.08 WTE, remaining below the planned level of 6,540.42 WTE and indicating a sustained underlying vacancy position. While this reflects improved alignment to plan, it is important to note that this position remains significantly below the original workforce plan, as a number of approved business cases and workforce developments have not yet been realised in practice. These were factored into the planned establishment but are still progressing through internal processes.

As these roles are recruited to, it is expected that substantive WTE will increase, reducing both the variance to plan and the reliance on Bank and Agency staffing.

The in-month financial position shows a favourable variance of £665k underspend against plan, with year-to-date expenditure broadly in line with budget (underspend of £121k). This reflects controlled substantive pay costs; however, this is partially offset by continued overspends in Bank (+£242k) and Agency (+£5k), highlighting ongoing reliance on higher-cost temporary staffing to maintain service delivery.

Workforce performance indicators show a mixed position. Sickness absence has improved marginally to 5.27% but remains above the <5.1% target, with costs stable at c.£13.3m and continuing to represent a material pressure. Turnover has increased slightly to 17.24%, continuing to reflect residual impact of structural change, though underlying turnover remains closer to expected levels.

Appraisal compliance has deteriorated further (AfC 72.64%), while Medical appraisal has improved marginally (73.35%) but remains significantly below the 90% target. Mandatory training shows slight recovery to 86.64%, remaining above target overall; however, key areas such as Information Governance (81.46%) and Manual Handling (64.59%) remain below required levels despite some improvement.

Dependency on temporary staffing persists, with Bank usage at 5.23% (above 4.49% target) and Agency at 1.08% (slightly above target).

Overall, Month 2 reflects a more stable financial and workforce baseline, with improved cost control and early signs of recovery in some performance areas. However, the underlying position remains characterised by workforce gaps and continued reliance on temporary staffing, as planned workforce growth is still being realised through ongoing recruitment and implementation of approved roles.

Workforce Performance Summary - Month 2

	Current Month (May 26)	Current Month (Apr 26)	Target	Change from previous Month	Performance against target	Local Benchmark comparisons
Sickness	5.27%	5.30%	<5.10%			5.4%
Sickness Cost	£13.3	£13.3m	£12.5m			NA
Turnover (12-month rolling)	17.24%	17.11%	<12%			11.90%
AfC Appraisal	72.64%	75.68%	>90%			70.30%
Medical Staff Appraisal	73.35%	72.08%	>90%			NA
Combined Mandatory Training	86.64%	86.08%	>85%			84.60%
Infection Control	84.89%	84.80%	>85%			NA
Information Governance	81.46%	81.14%	>85%			NA
Manual Handling	64.59%	57.62%	>85%			NA
Safeguarding Children	85.84%	85.86%	>85%			NA
Safeguarding Adults	95.07%	95.00%	>85%			NA
Agency % of Budgeted Pay Bill	1.08%	1.54%	<1.06%			NA
Bank % of Budgeted Pay Bill	5.23%	5.49%	<4.49%			NA
Total Workforce Plan WTE	6358.08	6398.75	<6540.42			NA
Substantive Workforce Plan WTE	5995.77	6019.39	<6246.80			NA

Please note: WTE Targets are against Month 2 Plan

Workforce Position to Date

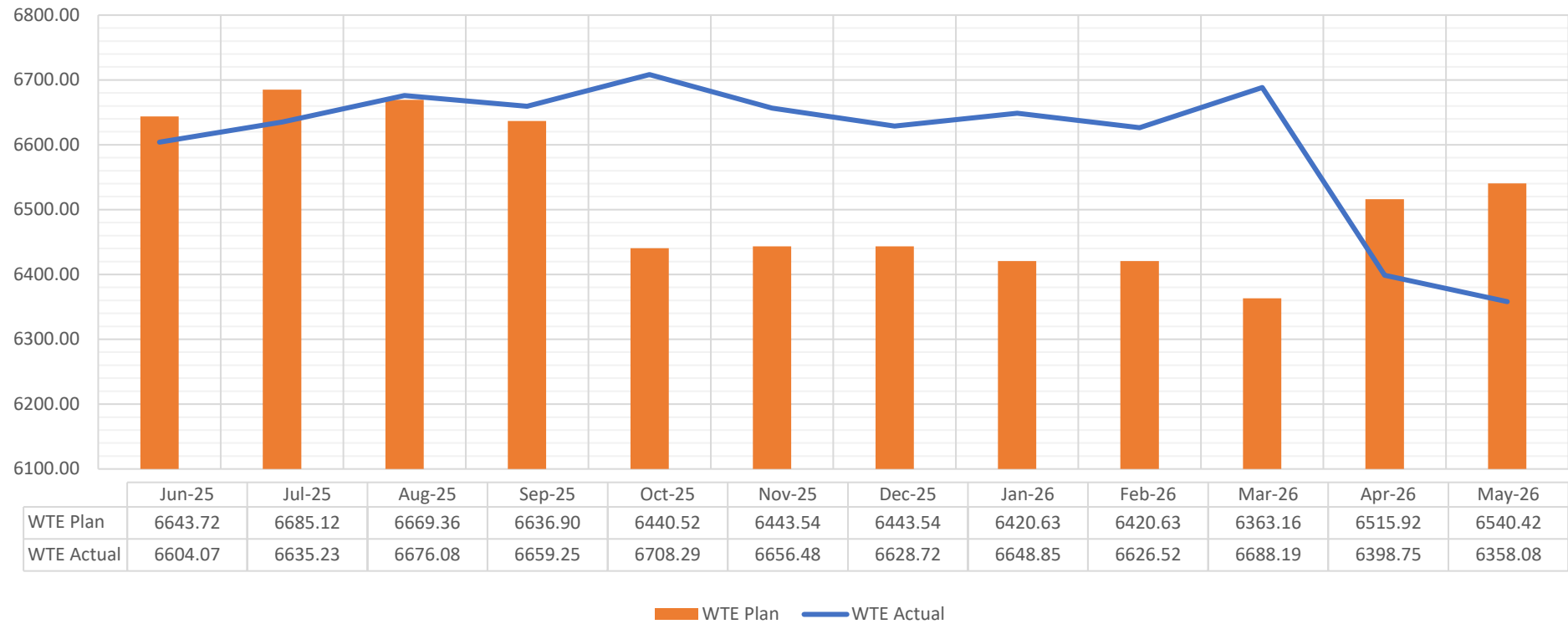
WTE						£					
Month 2	M2 2026/27 Bud WTE	M2 2026/27 Cont. WTE	M2 2026/27 Work. WTE	M2 2026/27 Contract ed + Bank + Agency	WTE Variance to Budget	M2 2026/27 Budget £	M2 2026/27 Spend £	£ Differenc e to Budget	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Agency	35.74	0.00	53.47	53.47	17.73	£345,744	£350,562	£4,818	£692,166	£835,023	£142,857
Bank	257.88	0.00	308.84	308.84	50.96	£1,458,269	£1,700,996	£242,727	£2,920,604	£3,429,206	£508,602
Substantive	6246.80	5995.77	5975.10	5995.77	-251.03	£30,691,297	£29,778,401	-£912,895	£60,335,018	£59,562,636	-£772,381
Grand Total	6540.42	5995.77	6337.41	6358.08	-182.34	£32,495,310	£31,829,960	-£665,349	£63,947,788	£63,826,866	-£120,921

In Month 2, the Trust's total workforce stands at 6,358.08 WTE, which is 182.34 WTE below the planned level of 6,540.42 WTE, reinforcing a sustained vacancy position. Substantive workforce remains significantly below plan with gaps partially offset through continued Bank and Agency utilisation.

The financial position shows an in-month underspend of £665k and a year-to-date underspend of £121k, indicating improved control. However, this position is driven by substantive underspends (-£913k), which are partially offset by continued overspends in Bank (+£243k) and Agency (+£5k).

Overall, while the Trust is operating below establishment and within financial control, the position continues to reflect underlying workforce gaps and reliance on temporary staffing. As planned workforce growth is realised through ongoing recruitment, substantive WTE is expected to increase, supporting improved alignment to plan and reducing dependency on higher-cost staffing over time.

Total Workforce Plan



From April 2026 onwards, a clear step change is observed, with actual WTE reducing sharply to 6,398.75, moving below the planned level of 6,515.92 for the first time in the period and significantly narrowing the historic variance. This shift continues into Month 2, with actual WTE reducing further to 6,358.08 against a plan of 6,540.42, maintaining a position below plan and indicating a sustained re-alignment of workforce levels.

Despite this improvement in the headline position, it is important to note that the current variance reflects planned workforce growth that has not yet been fully realised. As approved workforce developments progress and recruitment is completed, substantive WTE is expected to increase, which should support further alignment to plan while reducing reliance on temporary staffing.

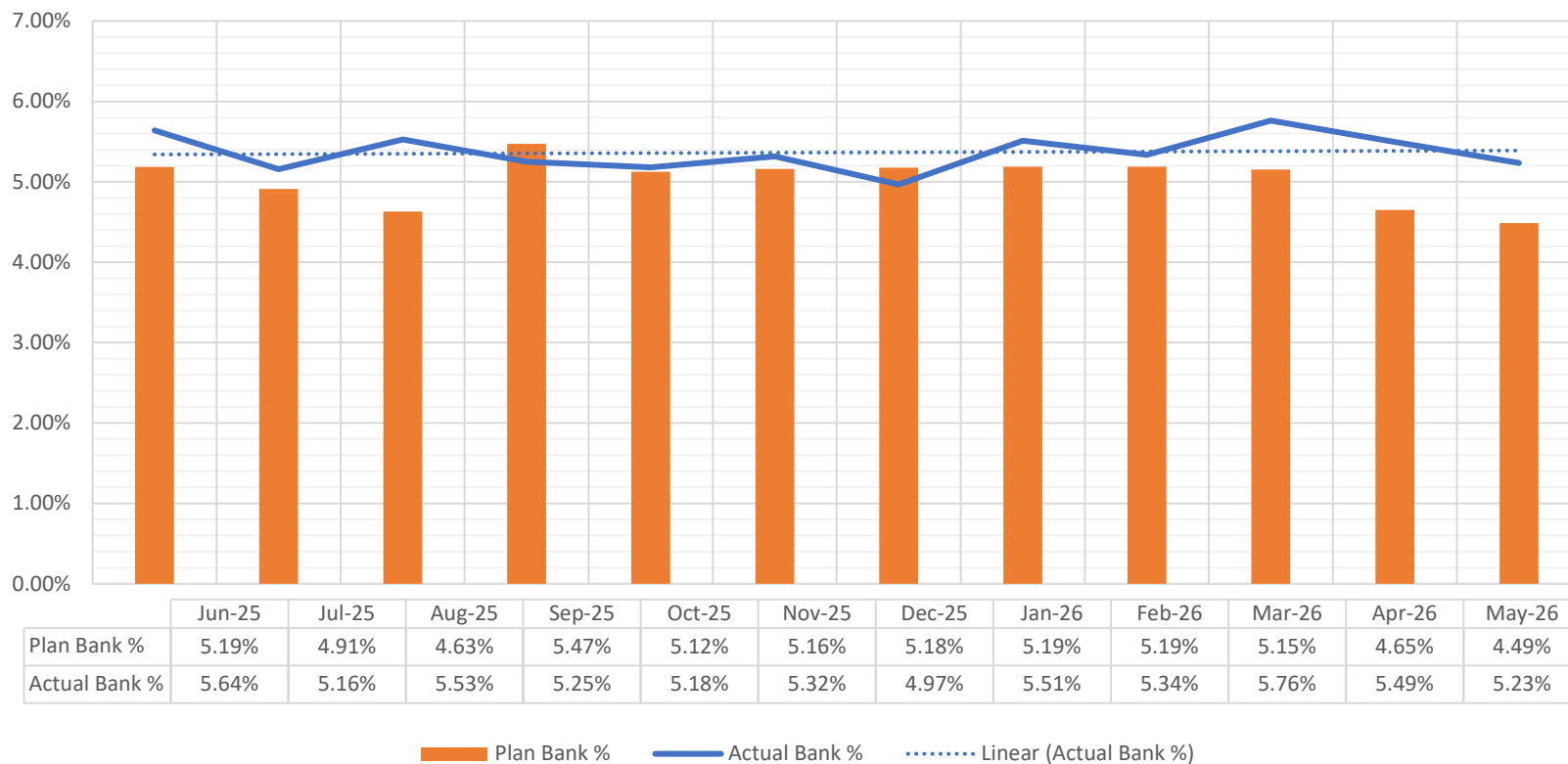
Bank WTE & Spend Analysis by staff group

Month 2	M2 Budget WTE	M2 Worked WTE	Variance of worked to budget	M2 Budget £	M2 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Any other Staff (Board Members)	1.62	0.01	-1.61	£27,329	£0	£-27,329	£29,936	£-490	£-30,426
Medical and Dental	45.70	29.15	-16.55	£490,141	£452,425	£-37,715	£994,125	£1,007,806	£13,681
NHS Infrastructure support	41.42	35.29	-6.13	£124,629	£138,884	£14,255	£273,980	£269,852	£-4,127
Nursing, Midwifery and Health Visiting Staff	73.73	83.54	9.81	£411,990	£483,360	£71,370	£828,046	£924,549	£96,503
Scientific, Therapeutic and Technical staff	2.53	7.06	4.53	£37,021	£42,020	£4,999	£60,199	£82,662	£22,463
Support to Clinical Staff	92.88	153.79	60.91	£367,159	£584,305	£217,146	£734,318	£1,144,825	£410,507
Grand Total	257.88	308.84	50.96	£1,458,269	£1,700,996	£242,727	£2,920,604	£3,429,206	£508,602

In Month 2, Bank usage remains significantly above plan at 308.84 WTE (+50.96 WTE variance), with an in-month overspend of £242.7k and £508.6k year-to-date.

While this represents a continuation of reliance seen in Month 1, there are early indications of stabilisation in usage levels. However, Bank remains the primary driver of temporary staffing cost pressure, particularly within support to clinical staff and nursing groups.

Bank Spend vs Budget



Across the year, Actual Bank % has remained consistently above plan, with some variation. Following higher usage through the summer, there was a brief period of stabilisation in the autumn and an improvement in December, the only month below plan, before increasing again from January and peaking in March at 5.76%.

In April 2026, usage reduced to 5.49%, indicating some easing, although the gap to plan widened as targets reduced.

This trend continues into Month 2, with Actual Bank usage reducing further to 5.23%. However, the planned level has again reduced to 4.49%, maintaining a gap to plan. Overall, this indicates continued reliance on Bank staffing, albeit with early signs of stabilisation.

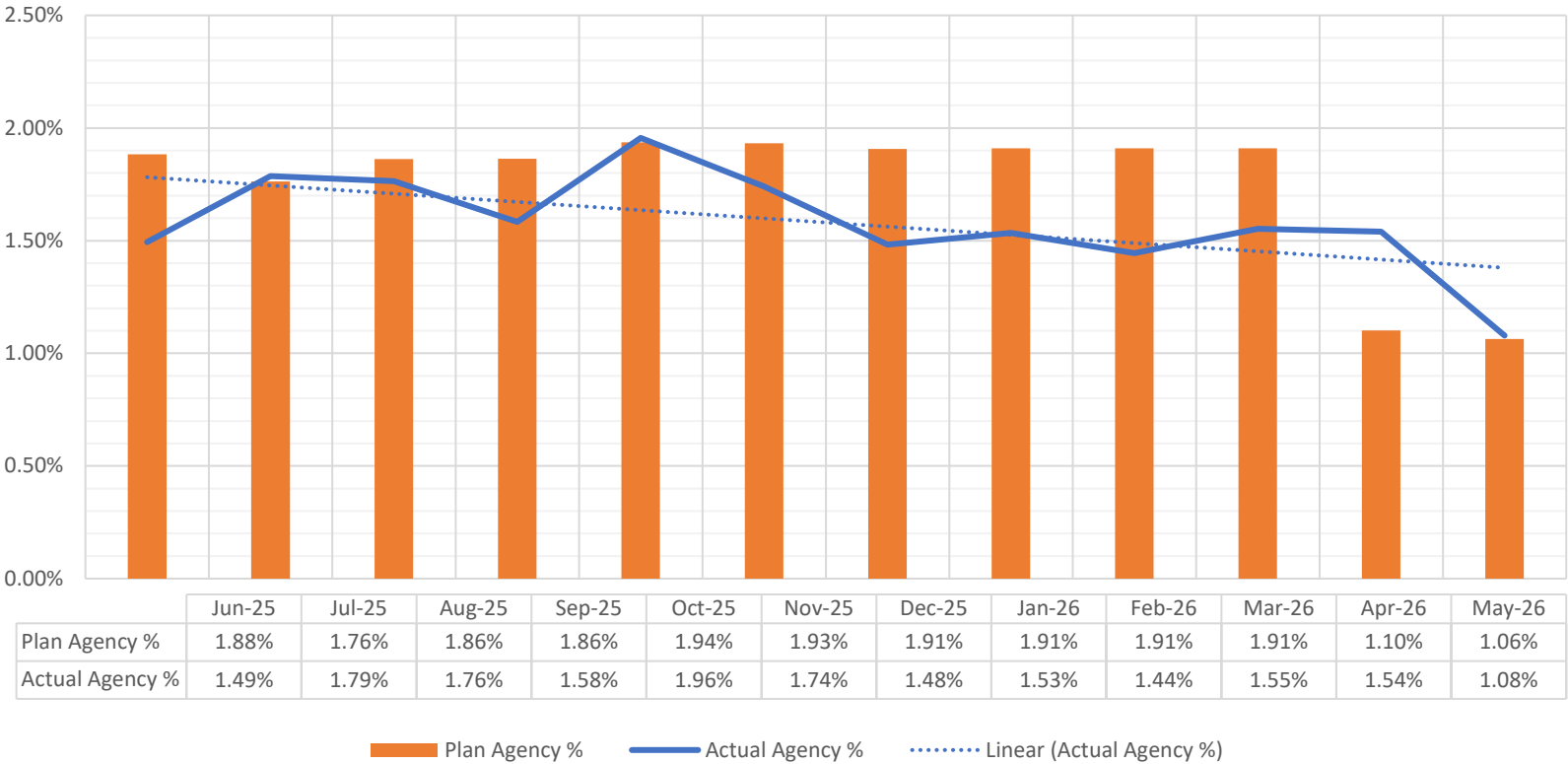
Agency WTE and Spend Analysis by staff group

Month 2	M2 Budget WTE	M2 Worked WTE	Variance of worked to budget	M2 Budget £	M2 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Medical and Dental	8.60	6.89	-1.71	£166,994	£125,570	£41,423.	£334,666	£270,257	£64,408
NHS Infrastructure support	0.00	1.00	1.00	£541	£5,924	£5,383	£1,082	£11,702	£10,620
Nursing, Midwifery and Health Visiting Staff	11.36	38.86	27.50	£42,138	£185,341	£143,203	£84,276	£487,853	£403,577
Scientific, Therapeutic and Technical staff	14.36	5.17	-9.19	£130,797	£27,852	£102,944	£261,594	£59,335	£202,258
Support to Clinical Staff	1.42	1.55	0.13	£5,274	£5,874	£600	£10,548	£5,874	£4,673
Grand Total	35.74	53.47	17.73	£345,744	£350,562	£4,818	£692,166	£835,023	£142,857

Agency usage in Month 2 stands at 53.47 WTE (+17.73 WTE above plan), with a relatively small in-month overspend of £4.8k and a £142.9k year-to-date variance.

This indicates improved control compared to Bank, although reliance remains above planned levels, particularly within nursing.

Agency Spend vs Budget



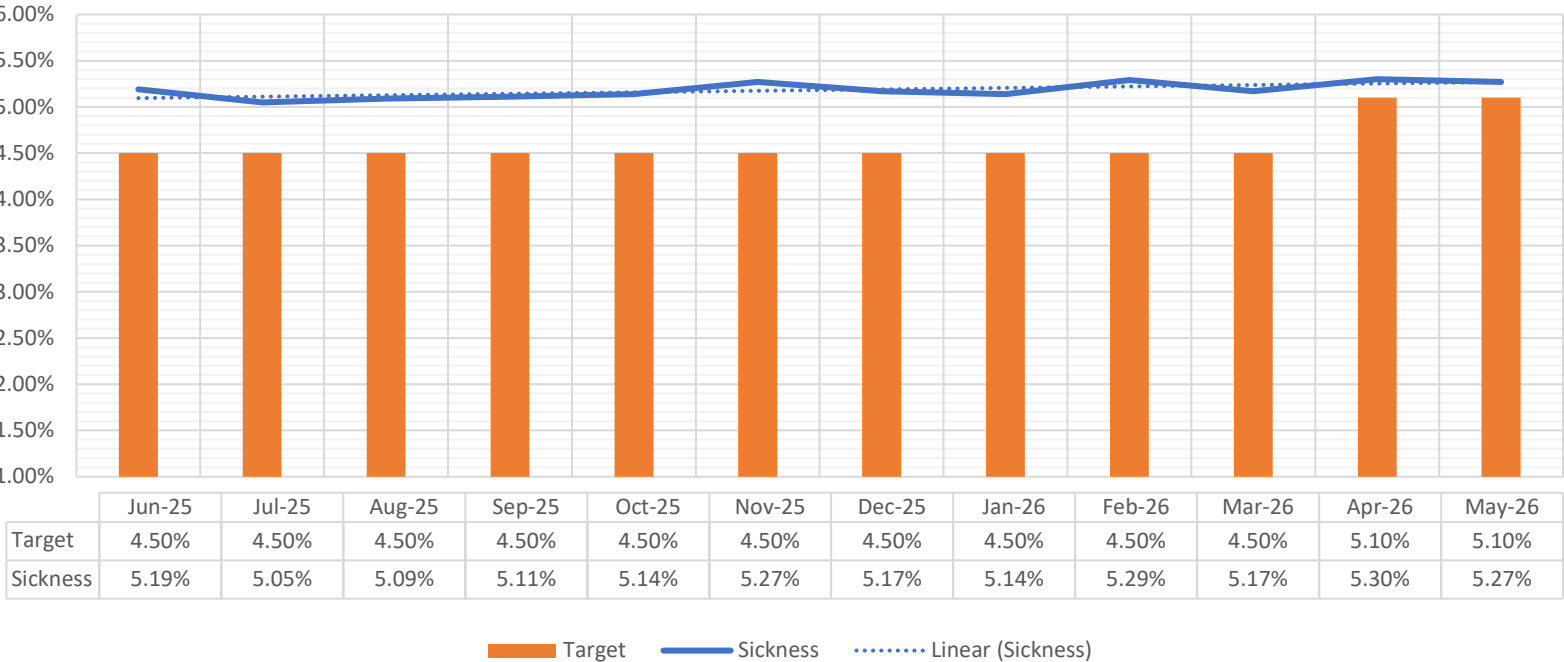
Actual Agency % has remained below plan for most of the year, indicating generally effective control of Agency usage. From January onwards, usage stabilised within a narrow range (~1.44%–1.55%), with a gradual downward trend overall.

In April 2026, Actual Agency usage was 1.54%, broadly stable; however, the planned level reduced sharply to 1.10%, increasing the variance.

In Month 2, Actual Agency usage has reduced further to 1.08%, indicating improved control. This is closely aligned to the reduced plan of 1.06%, significantly narrowing the gap. Overall, this reflects strengthened control of Agency usage and improved alignment to plan, although continued focus will be required to sustain this position.

Sickness

May 26	Apr 26	Target	Change from previous Month	Performance against target
5.27%	5.30%	<5.10%		

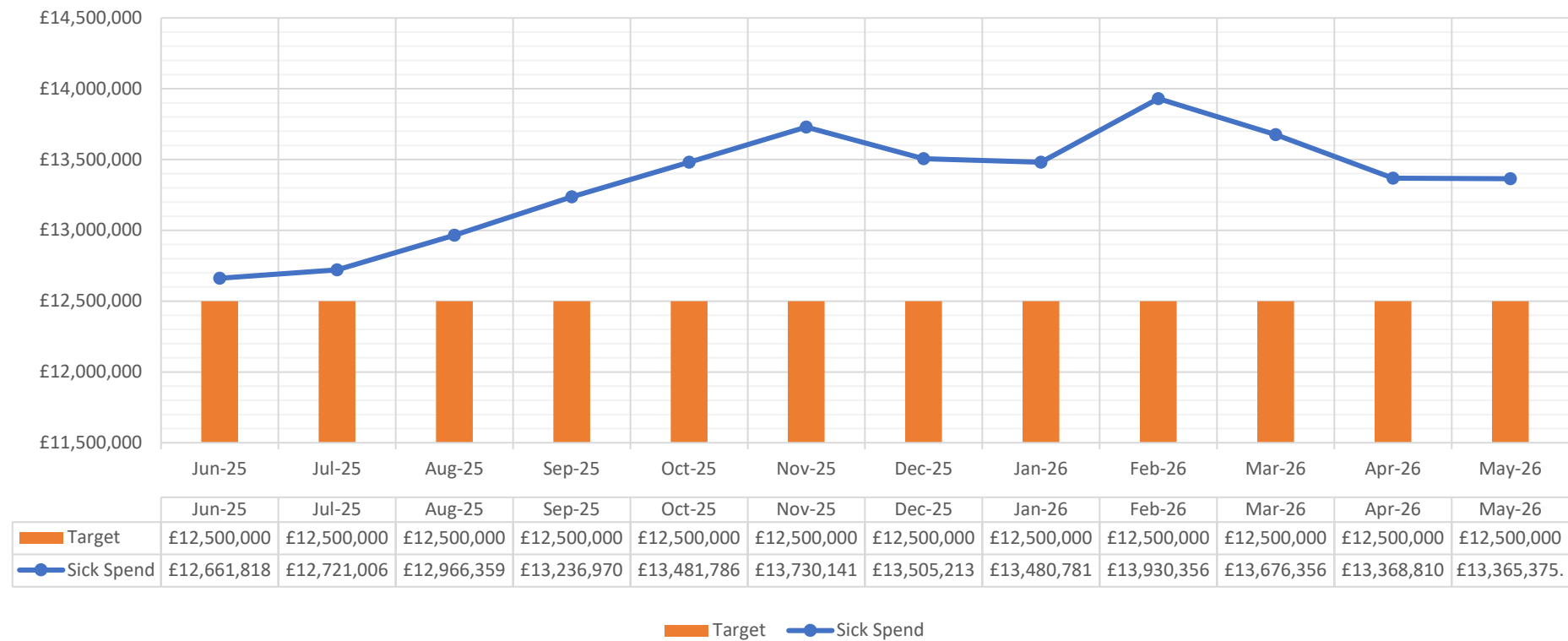


In May 2026, sickness absence has reduced slightly to 5.27%, indicating a marginal improvement from April (5.30%). However, absence remains above the 5.10% target and continues to reflect sustained pressure on workforce availability.

This suggests early signs of stabilisation rather than sustained improvement, and continued focus is required on attendance management and wellbeing interventions.

While there were small month-to-month fluctuations, including a slight improvement in March (5.17%), overall performance continued to track above plan, indicating sustained pressure on workforce availability.

Sickness Cost



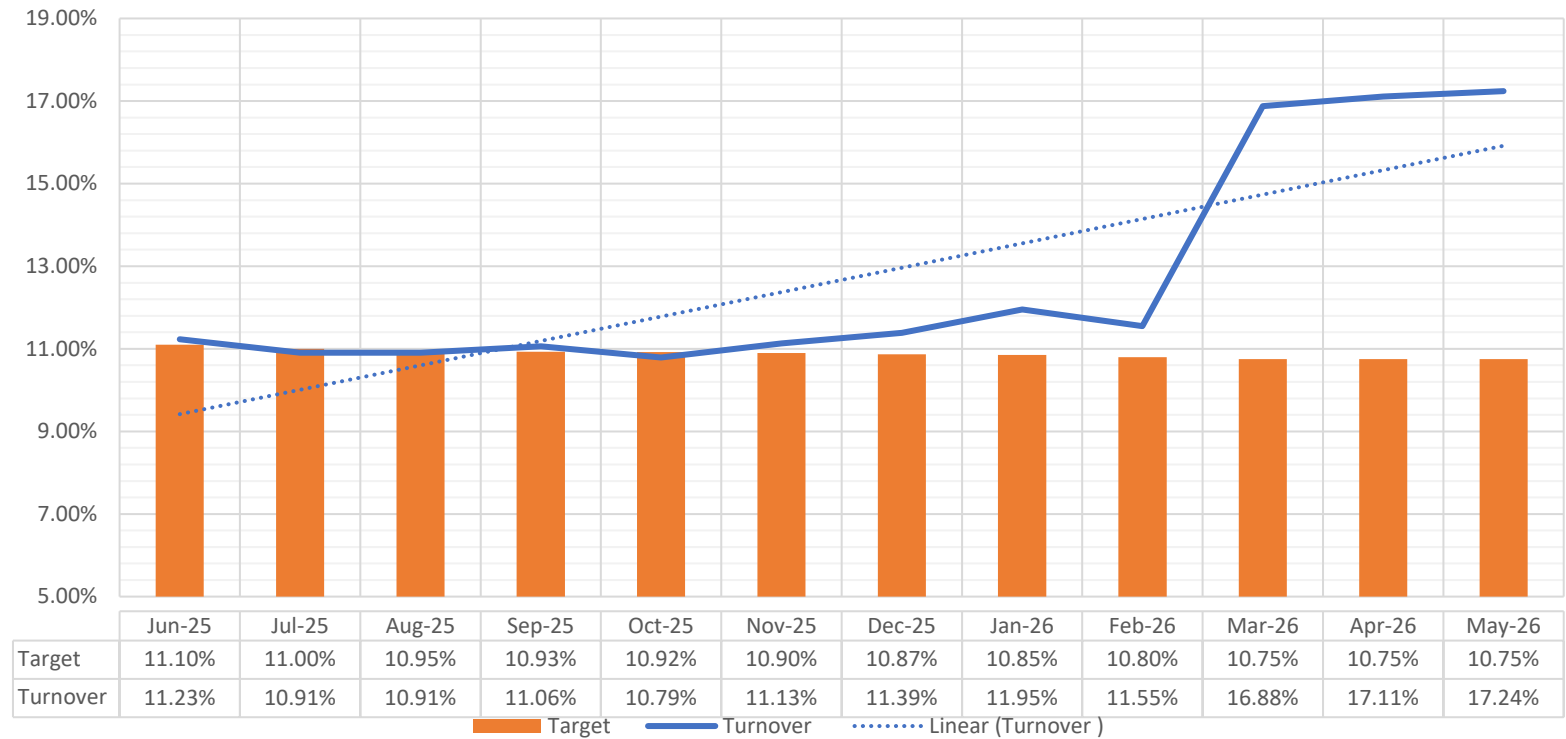
The estimated cost of sickness for the rolling 12 months was £13.68m to the end of March 2026, a reduction from £13.93m in February, indicating a short-term easing following the earlier peak.

This downward trend continued into April (£13.37m) and has stabilised further in May at approximately £13.37m, indicating that reductions have levelled off rather than continuing to fall.

Despite this recent improvement, costs remain significantly above the £12.5m target and prior-year levels, highlighting an ongoing underlying pressure. Overall, while there are signs of stabilisation from peak levels, sickness cost continues to represent a material financial challenge.

Turnover

May 26	Apr 26	Target	Change from previous Month	Performance against target
17.24%	17.11%	<12%		



Turnover has increased to 17.24% in Month 2, rising from 17.11% in April and remaining significantly above the 10.75% target. This follows the sharp increase seen in March (16.88%), with the higher rate sustained into the early months of the year.

It is important to note that turnover is reported as a rolling 12-month metric and therefore reflects historic workforce movement as well as current activity. As a result, the impact of significant organisational changes will continue to be reflected in the metric for several months before falling out of the reporting period. Overall, while turnover appears elevated, the underlying position is more stable. However, it will take time for the full impact of workforce stabilisation to be reflected in the metric, and continued focus is required to support a return to target levels.

Appraisal

	May 26	Apr 26	Target	Change from previous Month	Performance against target
AfC Appraisal	72.64%	75.68%	>90%		
Medical Appraisal	73.35%	72.08%	>90%		

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
 AfC Appraisal	79.77%	80.69%	81.21%	80.51%	81.17%	79.10%	79.53%	79.04%	78.52%	77.65%	75.68%	72.64%
 Medical Appraisal	75.00%	71.43%	68.85%	70.89%	69.51%	73.86%	71.48%	71.90%	68.98%	72.00%	72.08%	73.35%
 Families & Community	80.65%	81.81%	81.58%	83.04%	81.80%	87.97%	84.96%	79.91%	77.87%	78.15%	78.16%	75.21%
 Medicine & Urgent Care	80.51%	79.62%	80.02%	79.63%	78.24%	75.46%	77.10%	75.59%	76.55%	77.21%	73.35%	69.18%
 Planned Care and Surgery Data Table		83.67%	83.28%	82.11%	83.46%	83.24%	82.50%	84.83%	85.16%	83.22%	79.62%	76.82%
 Shared Corporate Services	79.74%	75.09%	76.58%	77.27%	78.69%	75.60%	73.40%	74.62%	71.64%	69.10%	69.66%	67.98%
 ASCT	0%	63.44%	66.22%	65.77%	64.73%	62.50%	64.89%	62.56%	66.67%	66.52%	65.49%	65.02%

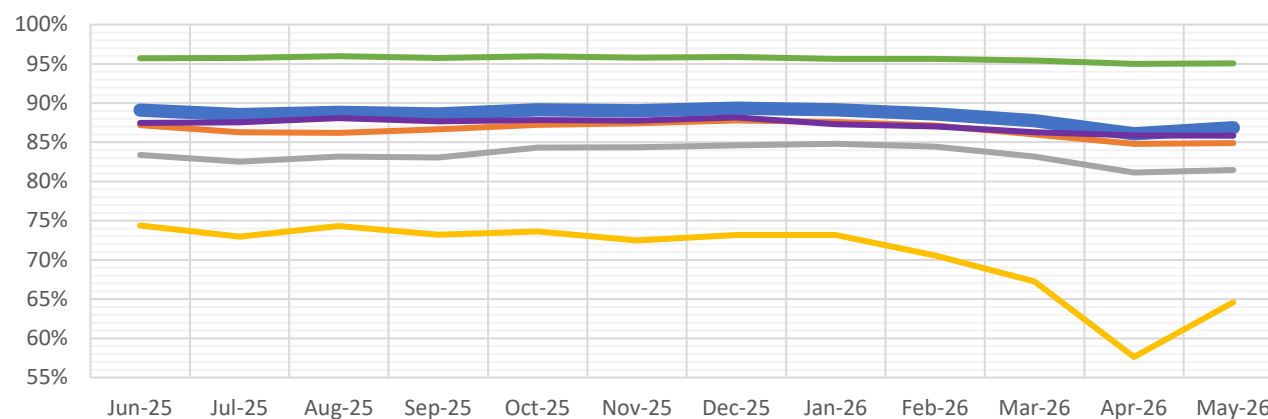
By May 2026, appraisal compliance shows a mixed position. AfC appraisal has declined further to 72.64% (from 75.68% in April), continuing the downward trend and widening the gap to the >90% target. In contrast, Medical appraisal has improved slightly to 73.35%, though remains significantly below target.

At care-group level, performance remains below 80% across most areas. Medicine & Urgent Care has declined further to 69.18%, while Shared Corporate Services has reduced to 67.98%. Families & Communities has also decreased to 75.21%, while Planned Care & Surgery has improved slightly to 76.82% but remains below the 80% threshold. ASCT continues to report the lowest performance at 65.02%.

Overall, the Month 2 position indicates continued deterioration in AfC appraisal compliance alongside marginal improvement in Medical appraisal. Performance remains significantly below expected levels across all areas, highlighting the need for renewed focus on appraisal completion, management oversight, and targeted recovery actions to improve compliance.

Mandatory Training

	May 26	Apr 26	Target	Performance against target	Change from previous Month
Mandatory Training	86.84%	86.08%	>85%		↑



	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Overall Training %	89%	89%	89%	89%	89%	89%	89%	89%	89%	88%	86%	87%
Infection Control	87%	86%	86%	87%	87%	87%	88%	88%	87%	86%	85%	85%
Information Governance	83%	83%	83%	83%	84%	84%	85%	85%	84%	83%	81%	81%
Manual Handling	74%	73%	74%	73%	74%	72%	73%	73%	71%	67%	58%	65%
Safeguarding Children	87%	88%	88%	88%	88%	88%	88%	87%	87%	86%	86%	86%
Safeguarding Adults	96%	96%	96%	96%	96%	96%	96%	96%	96%	95%	95%	95%

Overall mandatory training compliance has improved slightly to 86.84% in May, up from 86.08% in April, and remains above the 85% target. This indicates early signs of recovery following the decline seen at the start of the financial year.

At topic level, performance remains mixed. Manual Handling has improved to 65% from 58% in April but continues to be the most challenged area and remains significantly below target. Information Governance remains below target at 81%, showing little improvement.

Other areas continue to perform strongly, including Safeguarding Adults (95%) and Safeguarding Children (86%), both maintaining compliance above target, with Infection Control also stable at 85%.

Overall, while there are early signs of recovery following the EPIC-related downturn, performance remains variable. Continued focus is required on targeted recovery, particularly in Manual Handling and Information Governance, to support sustained improvement.

Finance

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the financial position year to date (YTD) as at May 2026 and forecast outturn (FOT) for the year ending 31st March 2027.

Year to date revenue position on plan, with key variances noted:

- Under-delivery of CIP (£0.8m adverse)
- Industrial Action Strike costs and income loss (£0.5m adverse)
- Non-Recurrent release of balance sheet flex (£0.5m favourable)
- Income Provision for activity lost due to EPR (£0.9m adverse)
- Underspends against other operational budgets, mainly undrawn reserves for inflation and growth (£1.7m favourable)

Forecast revenue position on plan, with key risks noted:

- Forecasting breakeven outturn but with base case delivery risks of £9.3m relating to low maturity CIP and impact of EPR on contract activity
- Base case forecast suggests risk of £3m against planned ULP

Year to Date CIP position £0.8m adverse to plan:

- CIP delivery YTD of £3.4m against a £4.2m target
- The percentage of schemes assessed as fully developed has increased to 79% (£43.1m)
- Forecast CIP is on plan at £54.4m, but with lower recurrent delivery than planned (£2.4m adverse).

Workforce Update

- The Trust is reporting worked WTEs 203 below plan.
- Bank and agency spend is trending downwards but is above plan and national cap limits

Plan	YTD / Forecast	Measure	Month 02 2026/27 £m
Revenue Plan	YTD	Variance to Plan (Adverse) / Favourable	(0.0)
Revenue Plan	Forecast	Variance to Plan (Adverse) / Favourable	0.0
Revenue Plan	Forecast	Unidentified and High Risk Mitigations	(9.3)
Revenue Plan	Forecast	Recurrent Risk to Underlying Position	(3.0)
CIP Plan	YTD	Variance to Target (Adverse) / Favourable	(0.8)
CIP Plan	Forecast	Variance to Recurrent Target (Adverse) / Favourable	(2.4)
Capital Plan	YTD	Variance to Plan (Overspend) / Underspend	1.4
Cash Plan	YTD	Unplanned Cash Support	3.8
Cash Plan	Forecast	Unplanned Cash Support	7.7

Capital programme update:

- Year to date capital plan £1.4m underspend
- Forecast to deliver full programme, including additional allocation of £1.8m National PDC for Tower Fire Safety

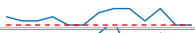
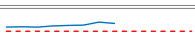
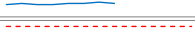
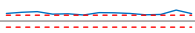
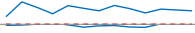
Cash Update:

- The Trust closing cash balance for Month was £3.8m above plan
- The Trust is not forecasting a need for cash support

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.

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS																
Torbay and South Devon NHS Foundation Trust																
Data RAG rated against monthly Operational Plan trajectory Bold number = national data	Target March 2027	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)			1530	1159	725	943	1823	810	624	559	1283	621	755	952	1390	
Ambulance handovers - time lost over 15 mins - Plan														641	676	623
Average handover time (mins) - Actual	30 mins		52	45	32	38	60	33	29	27	45	30	31	38	47	
Average handover time (mins) - Plan	30 mins		44	37	35	34	38	42	42	45	42	41	37	30	30	30
Total average time in ED (hours/minutes) - Actual	Reduction		05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	06:10	06:06	06:07		
Total average time in ED (hours/minutes) - Plan																
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Actual	0		688	494	457	426	655	585	549	520	918	740	734	676	839	
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan														394	655	469
Percentage of patients waiting over 12 hours in ED - Actual			9.8%	7.4%	6.5%	6.1%	9.7%	8.5%	8.3%	7.5%	13.6%	12.1%	10.6%	9.8%	11.7%	
Percentage of patients waiting over 12 hours in ED - Plan					6.3%	5.6%	8.2%	9.9%	8.4%	7.2%	7.0%	7.0%	6.1%			
UEC 4-hour target (RAG against local trajectory to national target) - Actual	82%		70.1%	72.2%	73.5%	74.1%	68.3%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.2%	64.7%	
UEC 4-hour target (RAG against local trajectory to national target) - Plan	82%		73.0%	73.0%	76.0%	76.0%	76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%
% patient discharges pre-noon - Actual	33%		22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	
% patient discharges pre-noon - Plan	33%		33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Percentage of inpatients with No Criteria to Reside (acute) - Actual	<5%		7.7%	7.5%	8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	
Percentage of inpatients with No Criteria to Reside (acute) - Plan	<5%		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Elective recovery																
RTT 78 week wait incomplete pathway - Actual	0		8	8	9	16	13	16	9	9	13	8	7	9	9	
RTT 78 week wait incomplete pathway - Plan	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT 65 week wait incomplete pathway - Actual	0		126	95	97	105	110	109	84	94	83	76	47	76	135	
RTT 65 week wait incomplete pathway - Plan	0		124	103	83	63	43	23	3	0	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual	0		805	740	615	618	615	647	607	663	604	607	600	799	993	
RTT 52 week wait incomplete pathway - Plan	0		887	833	780	728	673	586	505	449	383	327	268	571	546	522
RTT % Incomplete pathways <18 wks - Actual	73.83%		65.6%	68.2%	69.7%	69.5%	70.4%	69.3%	68.7%	67.5%	67.0%	66.8%	66.4%	62.8%	60.4%	
RTT % Incomplete pathways <18 wks - Plan	73.83%		62.8%	63.1%	63.5%	63.8%	64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	62.8%	62.4%	62.4%
RTT Wait for first appointment <18 weeks - Actual	74.0%		71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%	66.5%	
RTT Wait for first appointment <18 weeks - Plan	74.0%		65.7%	66.2%	66.7%	67.2%	67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%	66.3%
Cancer: 28-day FDS - Actual	80.88%		70.5%	75.6%	70.1%	62.3%	67.3%	75.7%	76.2%	78.3%	60.6%	79.7%	75.7%	50.4%	49.3%	
Cancer: 28-day FDS - Revised forecast	80.88%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	50.0%	57.0%	52.0%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual	80.75%		69.6%	63.7%	57.8%	64.5%	63.2%	70.4%	71.1%	79.8%	75.2%	67.1%	60.1%	57.4%	50.4%	
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.75%		74.0%	77.0%	75.7%	75.2%	75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	60.0%	55-60%	70.0%
Cancer: No of patients waiting >62 days to start treatment - Actual			225	223	220	257	176	132	91	119	159	214	201	276	288	
Cancer: No of patients waiting >62 days to start treatment - Plan																
Cancer: % of patients > 62 days to start treatment - Actual			8.9%	7.9%	7.8%	9.2%	7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%	8.6%	
Cancer: % of patients > 62 days to start treatment - Plan																
Diagnostics - proportion waiting over 6 weeks - Actual	15%		32.1%	33.9%	36.7%	37.1%	36.8%	29.4%	28.4%	30.4%	35.8%	30.6%	37.4%	41.6%	34.2%	
Diagnostics - proportion waiting over 6 weeks - Plan	15%							5.0%	4.0%	3.0%	3.0%	3.0%	3.0%	30.6%	29.2%	27.7%
RAG indicator																
Meeting monthly trajectory																
Not meeting monthly trajectory																

Tab 3.1 Integrated Performance and Quality Report (item 5.3.1)

Torbay and South Devon NHS Foundation Trust			INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS														Performance Report - May 2026				
RAG rated against year-end position			Setting	Target 2025_26	13 month trend			May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Year to date
QUALITY LOCAL FRAMEWORK																					
Reported Incidents - Moderate	Trustwide	Trend			46	46	34	46	46	33	41	43	20	41	34	55					
Reported Incidents - Severe	Trustwide	<6		6	1	1	5	4	3	3	3	5	0	4	0	3	3				
Reported Incidents - Death	Trustwide	<1		2	1	1	2	0	0	3	4	4	1	4	0	0	0				
Medication errors resulting in moderate or more severe harm	Trustwide	<1		1	0	0	0	0	1	2	3	0	1	2	0	1	1				
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)	Trustwide	Trend			24	29	19	25	29	21	24	30	17	24	23	30					
Never Events	Trustwide	<1		0	0	0	0	0	0	0	0	1	0	0	0	0	0				
Number of Patient Safety Incident Investigations (PSII)	Trustwide	Trend		2	0	0	1	3	1	0	0	1	0	2	1	0					
Formal complaints - Number received	Trustwide	<20		31	33	45	31	25	27	18	23	21	17	27	17	9	26				
Formal complaints - not acknowledged in 3 days	Trustwide	Trend		25	28	30	21	20	13	15	17	19	11	24	15	8					
Formal complaints - closed in 6 months	Trustwide	Trend		5	10	10	10	18	13	13	16	15	7	10	10	10					
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		103.7	104	103.6	104.6	105.1	105.4	108	106.9										
Standardised Hospital Mortality Rate (SHMI)	Trustwide	100		0.95	0.96	0.95	0.95	0.96	0.96	0.97	0.96										
Safer staffing fill rate - ICO - Day time	Trustwide	90% - 110%		91.5%	92.4%	93.0%	90.9%	91.2%	90.2%	92.1%	92.0%	91.5%	90.4%	90.6%	94.3%	91.3%					
Safer staffing rate - ICO - Night time	Trustwide	90% - 110%		91.8%	94.0%	94.6%	94.4%	95.1%	95.3%	96.6%	95.6%	94.1%	95.4%	95.6%	98.0%	94.1%					
Care Hours Per Patient Per Day: Day	Trustwide	Trend		4.2	4.1	4.2	4.2	4.1	4.1	4.2	4.2	4.1	4.1	4.1	4.4						
Care Hours Per Patient Per Day: Night	Trustwide	Trend		3.4	3.4	3.4	3.4	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.5						
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	8	10	2	9	3	8	6	8	6	3	8					
Number of Healthcare Associated Infection: MSSA	Trustwide	Trend			4	1	5	2	3	5	5	2	3	1	3	1					
Nutrition risk assessment within 24 hours	Trustwide	>95%		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		6.1	5.7	5.7	5.6	4.3	6.0	4.9	5.4	7.2	5.6	5.9	6.8	6.4					
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		70.7%	61.8%	68.1%	47.4%	55.0%	70.3%	75.8%	51.0%	45.0%	60.9%	84.8%	65.0%						
Stroke - % patients admitted to stroke unit within 4 hours	Trustwide	>50%		37.0%	47.3%	28.0%	46.4%	50.0%	49.1%	34.1%	52.9%	34.0%	38.0%	49.1%	17.8%	24.4%					
Mixed Sex Accommodation breaches	Trustwide	Trend		94	265	200	124	220	190	160	222	186	134	180	169	160	329				
Follow ups 6 weeks past to be seen date	Trustwide	6400		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%	98.6%	100.0%	100.0%	98.6%	100.0%							
Maternity 1:1 % Admission to SCBU (full term)	Trustwide	Trend				7.4%	8.3%	7.4%	4.0%	7.8%	5.1%	10.9%	4.4%	8.8%							
Maternity Stillbirths and perinatal deaths	Trustwide	Trend				1	2	0	0	0	0	1	0	0							
Maternity Smoking at time of delivery	Trustwide	Trend				10	9	3	3	5	8	3	3	3							
Maternity 3rd and 4th degree tears - total (%)	Trustwide	Trend				3.1%	3.1%	4.5%	7.7%	6.8%	2.5%	3.1%	5.6%	3.0%							
Maternity PPH>1500mls (%)	Trustwide	Trend				3.5%	1.4%	4.1%	4.4%	3.6%	0.7%	4.3%	1.4%	1.6%							
Maternity Birth rate	Trustwide	Trend						145	136	140	148	141	148	123							

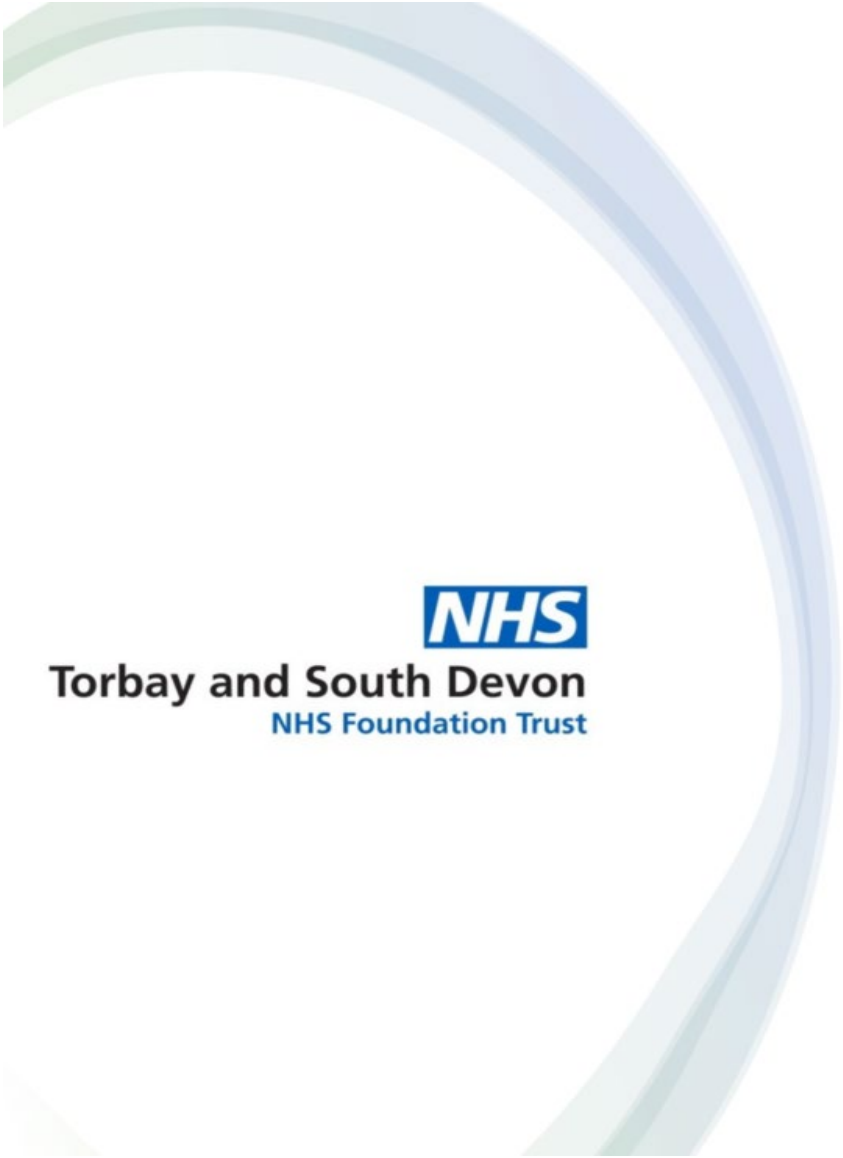
Tab 3.1 Integrated Performance and Quality Report (item 5.3.1)

Torbay and South Devon NHS Foundation Trust		INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS														Performance Report - May 2026	
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Year to date
WORKFORCE MANAGEMENT FRAMEWORK																	
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.0%	5.0%	5.1%	5.1%	5.1%	5.2%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%		
Appraisal Completeness	Trustwide	>90%		79.8%	79.5%	80.2%	80.5%	80.5%	80.5%	78.8%	78.9%	78.7%	78.1%	77.3%	75.5%	72.7%	
Mandatory Training Compliance	Trustwide	>85%		84.7%	85.3%	85.0%	85.4%	85.5%	86.2%	86.2%	87.9%	85.9%	85.0%	84.1%	85.3%	83.3%	
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		11.0%	11.0%	10.9%	10.9%	10.8%	10.8%	11.1%	12.8%	12.9%	10.6%	15.0%	15.4%	10.2%	
COMMUNITY & SOCIAL CARE FRAMEWORK																	
Carers Assessments Completed year to date	Trustwide	40% (Year end)		18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.0%	18.1%	18.4%	18.1%			17.8%
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							515	503	506	472	492	436			
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		240	222	235	199	215	264	229	207	243	191	204			2688
Community waiting list	Trustwide					7622	7890	7812	7863	7688	7004	7236	8040	7058			
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		202	204	211	166	190	241	208	211	242	195	204			2478
Community Hospital Length of Stay (days) - (general)	Community Hospital	NONE SET		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%		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		88.8%	87.8%	89.9%	85.8%	90.4%	91.3%	94.5%	91.8%	92.6%	93.8%	91.0%	77.0%		90.5%
Urgent Community Reponse (2 hour) - Number of referrals	Trustwide	157		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		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		778.1	783.4	750.6	721.9	687.9	737.6	742.8	729.7	753.3	734.9	745.4	729.7		729.7
Proportion of clients receiving direct payments	Trustwide	25%		18.2%	18.5%	18.8%	18.5%	17.8%	18.2%	18.2%	18.0%	18.1%	18.4%	18.1%	17.8%		17.8%
% reablement episodes not followed by long term SC support	Trustwide	83%		86.9%	88.3%	89.1%	88.8%	88.9%	88.6%	88.9%	89.1%	89.1%	88.9%	94.2%	95.7%		95.7%
PERFORMANCE FRAMEWORK																	
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		33.5%	31.7%	31.7%	24.9%	30.9%	38.0%	38.9%	37.0%	37.9%	41.0%	33.6%	29.9%	23.8%	
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		93.3%	90.7%	91.4%	88.9%	91.4%	91.1%	93.1%	92.9%	92.7%	95.8%	93.4%	83.0%	83.1%	
Cancer - 62-day wait for treatment - national reporting (2024/25 target 70%) (2025/26 target 75%)	Trustwide	75%		70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	75.2%	67.1%	66.2%	57.4%	50.4%	
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		22	52	24	28	29	21	21	20	27	44	44			
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	67.0%	66.8%	66.4%	62.8%	60.4%	
On the day cancellations for elective operations	Trustwide	<0.8%		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		5	11	21	11	11	17	17	14	11	11	11			
Theatre Utilisation	Trustwide	85%		83.2%	81.1%	76.7%	82.3%	82.7%	83.2%	81.8%	80.3%	82.8%	81.5%	81.3%	66.0%	73.4%	
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		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%		95.9%	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%		71.0%	72.6%	75.3%	71.4%	68.3%	66.0%	68.8%	69.5%	68.9%	68.1%	66.8%	55.3%	60.6%	

Tab 3.1 Integrated Performance and Quality Report (item 5.3.1)

Torbay and South Devon NHS Foundation Trust		INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS												Performance Report - May 2026			
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Year to date
Percentage of inpatients with No Criteria to Reside (Torbay GP registered patients)	Acute	<5%		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%		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			5.9	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		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		32.5	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			1122	951	716	804	1250	933	957	813	1277	965	1170	1228	1384	2612
Ambulance handover delays > 60 minutes	Acute	0		601	531	302	390	764	203	121	103	450	135	167	303	478	781
UEC - patients seen within 4 hours (2025/26 plan target 78%)	Trustwide	78%		70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.1%	64.7%	64.6%
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute			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			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			04:10	03:54	03:48	03:50	04:07	04:10	04:03	03:59	04:14	04:24	04:37	05:34	05:41	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute			08:59	08:04	07:08	07:05	08:58	08:15	08:05	08:16	11:37	10:16	09:36	09:48	11:18	
Corridor Care - Emergency Department	Acute	0										1130	1040	813	1017	1014	
Diagnostic tests longer than the 6 week standard	Trustwide	5%		37.8%	34.0%	37.0%	37.0%	37.0%	29.0%	28.0%	30.0%	36.0%	31.0%	37.0%	41.6%	34.2%	
Dementia - Find - monthly report	Trustwide	>90%		96.5%	96.8%	93.6%	97.7%	95.1%	94.9%	96.9%			95.8%	81.5%			96.3%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		81.9%	75.7%	80.0%	77.5%	77.8%	77.5%	71.4%	73.8%	75.6%	71.5%	72.0%			82.7%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		61.0%	64.6%	62.5%	60.8%	58.0%	60.6%	67.2%	63.5%	59.8%	52.5%	61.3%			63.9%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		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										99%	101%	104%	106%	99%	#N/A		109%
Elective inpatient admissions										69%	78%	87%	87%	81%	#N/A		84%
Admitted Patient Care Total										96%	99%	103%	103%	97%	#N/A		106%
Outpatient - first appointment										110%	105%	103%	105%	109%	#N/A		105%
Outpatient - first appointment with procedure										132%	143%	146%	133%	135%	#N/A		145%
Outpatient - follow-up with procedure										148%	125%	124%	124%	112%	#N/A		133%
Outpatient Appointment Total										126%	117%	116%	115%	113%	#N/A		119%
ERF Income Grand Total (% above 2019/20)		114%								109%	109%	111%	109%	104%	#N/A		114%
Non-ERF activity 2025/26 vs 2024/25																	
Non-elective admissions											100%	100%	102%	104%	#N/A		105%
UEC attendances (Type 1 and 3)											94%	110%	113%	105%	#N/A		105%

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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%		



Safer Staffing Dashboard - April-2026

Report Version: 2
Published: 15/05/2026 09:04

Safer Staffing Dashboard - Inpatient Wards - April-2026

Our priorities for 2025-2026: Triangulation of our workforce metrics and Patient Sensitive Indicators

Report Version: 2 (Published: 15/05/2026 09:04)

Ward	Beds		Staffing Fill Rates				Actual Staffing Split					Care Hours Per Patient Day (CHPPD)										HR Metrics			Temporary Staffing		Ward Accred. ¹	PATIENT SENSITIVE INDICATORS															
	Establ. Beds	Bed Occ.	Days		Nights		RN v Care Staff Splits		Days		Nights		Day v Night Split		RN / Midwives		Care Staff		Overall Day		RN / Midwives		Care Staff		Overall Night			Sickness Rate	Turnover Rate	Vacancy Rate	Prop. Bank Hours	Prop. Agency Hours		Safety				Feedback					
			RN / Midwives	Care Staff	RN / Midwives	Care Staff	% 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						Planned	Actual	Planned	Actual	No Harm	Harm	Medicine Errors	% Obs Taken on Time	Patient Complaints	% Positive Resp.	Number of Resp.	
																																											(Ward-24)
Families and Communities	Brixham Hosp Ward	20	92.2%	157.4%	86.9%	106.7%	101.1%	54.7%	45.3%	41.3%	58.7%	54.9%	45.1%	1.2	1.9 (+0.7)	1.9	1.6 (-0.2)	3.1	3.6 (+0.5)	1.1	1.2 (+0.1)	1.7	1.7 (+0.0)	2.8	2.9 (+0.1)	9.9%	6.2%	12.8%	12.2%	0.5%		0	2	0	0	1	0	1	88.0%	0	100.0%	19	
	Dawlish Hosp Ward	16	91.2%	110.1%	95.0%	115.8%	100.1%	43.6%	56.4%	53.6%	46.4%	56.1%	43.9%	1.6	1.7 (+0.2)	2.3	2.2 (-0.1)	3.9	4.0 (+0.0)	1.4	1.7 (+0.2)	1.4	1.4 (+0.0)	2.9	3.1 (+0.2)	7.3%	10.4%	5.9%	3.0%	2.1%		0	0	0	0	2	1	1	90.2%	0	-	0	
	John Macpherson	18	49.1%	79.3%	94.0%	99.9%	76.7%	55.9%	44.1%	72.3%	27.7%	60.7%	39.3%	3.9	3.1 (-0.8)	2.6	2.4 (-0.2)	6.5	5.5 (-1.0)	2.6	2.6 (-0.0)	1.3	1.9 (-0.3)	3.9	3.6 (-0.3)	7.5%	8.1%	-1.2%	2.6%	0.0%		0	0	0	0	0	0	1	-	0	100.0%	6	
	Louisa Cary	19	55.0%	90.8%	115.0%	88.3%	109.5%	70.3%	29.7%	70.8%	29.2%	50.9%	49.1%	5.7	5.2 (-0.5)	1.9	2.2 (+0.3)	7.6	7.4 (-0.2)	5.7	5.0 (-0.7)	1.9	2.1 (+0.2)	7.6	7.1 (-0.5)	7.3%	15.4%	16.4%	8.5%	4.0%		0	0	0	0	0	0	4	-	0	92.3%	26	
	Newton Abbot Hosp (General Ward)	30	95.6%	96.9%	93.6%	101.7%	101.5%	50.9%	49.1%	50.0%	50.0%	60.5%	39.5%	1.8	1.8 (-0.1)	1.8	1.7 (-0.1)	3.7	3.5 (-0.2)	1.1	1.1 (+0.0)	1.1	1.1 (+0.0)	2.2	2.3 (+0.0)	5.2%	8.9%	5.5%	7.9%	7.6%		0	1	0	0	3	5	0	88.2%	0	100.0%	20	
	Newton Abbot Hosp (Stroke Ward)	30	94.6%	95.3%	101.0%	102.3%	101.1%	43.0%	57.0%	50.3%	49.7%	61.3%	38.7%	1.6	1.6 (-0.1)	2.0	2.1 (+0.0)	3.7	3.7 (-0.1)	1.1	1.1 (+0.0)	1.1	1.1 (+0.0)	2.2	2.3 (+0.0)	1.7%	8.5%	3.1%	3.4%	1.1%		0	0	1	0	2	1	0	90.5%	0	100.0%	14	
	SCBU	10	54.0%	82.6%	64.3%	84.7%	57.7%	79.4%	20.6%	81.5%	18.5%	50.0%	50.0%	6.4	5.1 (-1.1)	2.1	1.4 (-0.8)	8.5	6.6 (-1.9)	6.4	5.4 (-1.0)	2.1	1.2 (-0.9)	8.5	6.6 (-1.9)	1.1%	19.7%	15.4%	6.7%	0.8%		0	0	0	0	0	0	1	-	0	-	0	
Medicine and Urgent Care	Totnes Hosp Ward	16	93.9%	109.0%	110.4%	105.3%	130.4%	39.7%	60.3%	44.7%	55.3%	56.0%	44.0%	1.4	1.5 (+0.1)	2.0	2.3 (+0.2)	3.4	3.7 (+0.3)	1.3	1.3 (+0.1)	1.3	1.6 (+0.4)	2.5	2.9 (+0.4)	10.5%	24.6%	6.2%	23.1%	2.3%		0	1	0	0	2	2	0	87.8%	0	100.0%	6	
	Cheetham Hill	28	99.0%	90.3%	106.9%	105.7%	124.6%	41.3%	58.7%	38.9%	61.1%	57.3%	42.7%	2.2	2.0 (-0.2)	2.7	2.8 (+0.2)	4.9	4.8 (-0.0)	1.3	1.4 (+0.1)	1.8	2.2 (+0.4)	3.1	3.6 (+0.5)	4.9%	11.3%	8.8%	12.9%	11.7%		0	0	0	0	2	5	0	92.0%	0	-	0	
	Coronary Care Unit	14	88.8%	99.1%	-	101.1%	-	100.0%	0.0%	98.9%	1.1%	56.4%	43.6%	3.7	3.7 (+0.0)	0.0	-	3.7	3.7 (+0.0)	2.8	2.8 (+0.0)	0.0	0.0 (+0.0)	2.8	2.9 (+0.1)	1.8%	6.9%	3.2%	11.3%	2.2%		0	0	1	0	1	0	1	93.4%	0	100.0%	29	
	Dunlop	24	97.9%	89.4%	99.0%	101.1%	107.6%	50.8%	49.2%	48.4%	51.6%	52.9%	47.1%	1.9	1.7 (-0.2)	1.7	1.7 (-0.0)	3.6	3.4 (-0.2)	1.5	1.5 (+0.0)	1.5	1.6 (+0.1)	2.9	3.0 (+0.1)	3.2%	4.5%	6.9%	5.6%	2.2%		0	0	0	0	1	2	95.5%	0	100.0%	13		
	EAU4	24	82.9%	94.4%	104.2%	100.0%	104.1%	53.1%	46.9%	54.6%	45.4%	49.2%	50.8%	2.6	2.5 (-0.1)	2.1	2.2 (+0.1)	4.8	4.7 (-0.1)	2.6	2.6 (+0.0)	2.1	2.2 (+0.1)	4.8	4.8 (+0.1)	6.5%	12.7%	1.5%	12.5%	15.9%		0	0	0	0	3	5	1	90.6%	0	100.0%	15	
	George Earle	28	95.1%	92.5%	90.1%	100.1%	102.9%	46.1%	53.9%	42.2%	57.8%	58.5%	41.5%	2.1	2.0 (-0.2)	2.6	2.3 (-0.3)	4.7	4.3 (-0.4)	1.3	1.3 (+0.0)	1.7	1.8 (+0.0)	3.0	3.0 (+0.1)	7.6%	3.1%	-11.2%	10.6%	4.5%		0	0	0	0	4	1	0	93.7%	0	-	0	
	McCallum - Short-Stay	17	90.9%	97.5%	97.2%	102.2%	98.2%	57.2%	42.8%	51.0%	49.0%	53.1%	46.9%	2.7	2.7 (-0.1)	2.0	2.0 (-0.1)	4.8	4.6 (-0.1)	2.0	2.1 (+0.0)	2.0	2.0 (-0.0)	4.1	4.1 (+0.0)	8.6%	0.0%	-4.3%	16.5%	4.6%		0	0	0	0	1	1	2	89.5%	1	100.0%	5	
	Midgley	26	97.7%	104.0%	74.2%	116.8%	97.4%	58.4%	41.6%	54.6%	45.4%	51.0%	49.0%	2.3	2.3 (+0.1)	2.3	1.7 (-0.6)	4.5	4.0 (-0.5)	1.8	2.1 (+0.3)	1.8	1.8 (-0.0)	3.6	3.9 (+0.3)	10.1%	13.9%	6.2%	14.1%	9.9%		0	0	0	0	2	5	0	93.2%	0	100.0%	9	
	New Forrest	29	98.7%	92.4%	98.4%	105.8%	108.0%	54.0%	46.0%	49.5%	50.5%	50.0%	50.0%	2.0	1.9 (-0.2)	1.6	1.6 (-0.0)	3.6	3.5 (-0.2)	1.6	1.7 (+0.1)	1.6	1.7 (+0.1)	3.2	3.5 (+0.2)	8.3%	9.9%	-5.9%	17.6%	13.0%		0	0	1	0	5	5	0	94.1%	0	96.7%	30	
	Simpson	28	99.4%	93.4%	82.1%	109.0%	112.3%	48.7%	51.3%	42.1%	57.9%	55.3%	44.7%	2.2	2.0 (-0.1)	2.6	2.1 (-0.5)	4.7	4.1 (-0.6)	1.3	1.4 (+0.1)	1.7	1.9 (+0.2)	3.0	3.4 (+0.3)	7.2%	9.2%	-8.9%	16.8%	12.3%		0	0	0	0	3	5	1	92.1%	0	-	0	
Planned Care	Ainslie	26	92.3%	95.4%	92.4%	102.5%	107.9%	50.8%	49.2%	55.9%	44.1%	56.1%	43.9%	2.4	2.1 (-0.1)	2.4	2.2 (-0.2)	4.7	4.5 (-0.3)	1.9	1.9 (+0.0)	1.4	1.5 (+0.1)	3.3	3.5 (+0.2)	5.6%	10.6%	3.7%	9.2%	4.3%		0	1	0	0	1	1	2	91.1%	1	-	0	
	Allerton	29	99.4%	102.2%	105.4%	100.1%	119.8%	69.3%	30.7%	52.7%	47.3%	57.6%	42.4%	2.8	2.8 (+0.1)	1.2	1.3 (+0.1)	4.0	4.1 (+0.1)	1.6	1.6 (+0.0)	1.2	1.4 (+0.2)	2.8	3.0 (+0.2)	2.3%	16.3%	-14.6%	9.5%	8.8%		0	0	0	0	3	1	2	89.0%	0	100.0%	31	
	Cromie	25	98.4%	98.4%	96.8%	101.1%	98.9%	56.0%	44.0%	50.6%	49.4%	59.4%	40.6%	2.3	2.3 (-0.0)	1.9	1.8 (-0.1)	4.2	4.1 (-0.1)	1.4	1.4 (+0.0)	1.4	1.4 (-0.0)	2.8	2.8 (+0.0)	3.7%	1.4%	-12.1%	6.4%	2.8%		0	2	0	0	6	0	0	91.1%	0	-	0	
	Ella Rowcroft	16	70.8%	91.7%	90.2%	85.7%	105.4%	43.3%	56.7%	55.0%	45.0%	57.6%	42.4%	2.5	2.3 (-0.2)	3.3	3.0 (-0.3)	5.8	5.3 (-0.5)	2.5	2.1 (-0.4)	1.7	1.8 (+0.1)	4.2	3.9 (-0.3)	2.8%	7.0%	-13.1%	6.5%	0.8%		0	0	0	0	2	2	1	91.7%	0	100.0%	1	
	Intensive / Critical Care Unit	10	50.3%	76.7%	43.3%	72.1%	-	94.1%	5.9%	100.0%	0.0%	53.0%	47.0%	20.6	15.8 (-4.8)	2.3	1.0 (-1.3)	22.8	16.8 (-6.1)	20.6	14.8 (-5.7)	0.0	-	20.6	14.8 (-5.7)	4.9%	11.2%	21.1%	1.0%	0.5%		0	0	2	0	0	0	0	9.1%	0	-	0	
	Turner	18	97.0%	81.4%	85.0%	107.8%	107.6%	54.5%	45.5%	50.0%	50.0%	53.6%	46.4%	3.3	2.7 (-0.6)	2.6	2.2 (-0.4)	5.9	4.9 (-1.0)	2.0	2.1 (+0.2)	2.0	2.1 (+0.1)	3.9	4.2 (+0.3)	6.5%	11.4%	16.3%	11.8%	5.0%		0	0	0	0	2	1	0	93.3%	0	100.0%	25	
	Warrington	17	96.7%	101.2%	98.8%	100.0%	136.7%	50.6%	49.4%	42.3%	57.7%	55.9%	44.1%	2.1	2.1 (+0.0)	2.1	2.0 (-0.0)	4.1	4.1 (+0.0)	1.4	1.4 (+0.0)	1.4	1.9 (+0.5)	2.8	3.3 (+0.5)	3.5%	6.4%	-10.7%	12.5%	0.5%		0	0	0	0	1	0	1	91.6%	0	100.0%	16	
ALL WARDS		518	89.4%	94.3%	94.0%	98.0%	106.8%	55.4%	44.6%	54.5%	45.5%	55.2%	44.8%	2.6	2.4 (-0.1)	2.1	1.9 (-0.1)	4.6	4.4 (-0.3)	2.0	1.9 (-0.0)	1.5	1.6 (+0.1)	3.5	3.5 (+0.1)	5.8%	9.9%	2.4%	9.0%	4.8%		0	7	5	0	46	42	21	91.5%	2	98.9%	265	

Below each RAGed figure are indicators giving the RAG status (where available) for past 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 - April-2026 - Assurance

Measure	Assurance	Narrative	Mitigation	Actions

Tab 3.1 Integrated Performance and Quality Report (item 5.3.1)

Measure	Summary ¹	Initiative	Mitigation	Actions	
STAFFING METRICS					
Bed Occupancy		Our bed occupancy indicates that were are running at an bed occupancy rate of 94.8% this is an increase of 5.4% from March 26 . 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 April 2 this reflects both the Easter Holiday operational pressures and workforce pressures with high annual leave usage.	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	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			
	Nights	RN / Midwives			
		Care Staff			
Care Hours Per Patient Day (CHPPD)	Days	RN / Midwives	The Trust overall actual CHPPD is this is slightly over the planned target of 7.42. The actual CHPPD for RN/Midwives in March 26 is 6.02 this is over the planned of 4.13. The overall actual CHPPD for HCSW is 4.93.This is over the planned target of 3.27. The increase in CHPPD is reflective of the staff required to backfill and support the EPIC system launch, this required all areas to provide super users as supernumerary staff for 2 weeks in the run up to and in the stabilisation phase of the EPIC launch.	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 than 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			
		Overall			
	Nights	RN / Midwives			
		Care Staff			
		Overall			
HR Metrics	Sickness Rate		Organisational absence this currently resides at 5.8% this remains stagnant as a metric. Turnover rate has increased to 9.8% this is decrease of 0.1% from Machr 26.Focused recruitment campaigns and reduction in the onboarding timeline have supported this decrease within the Nursing workforce. On boarding days have increased by anaverage of 10 days per month taking the time lag closer to 60 days as opposed to 50 days.	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				
	Vacancy Rate				
Temporary Staffing	Prop. Bank Hours		The current proportion of temporary workforce hours supporting pipelines currently resides at: bank proportion 12.8% this is an increase of 3.8% from March 26.Agency proportion has also increased from 4.8% to 5.4% from March 26, this is a reflection of operational pressure and workforce pressures such as increased sickness which has required backfilling from the temporary workforce. Focused work is being undertaken to support the migration of agency staff onto NHSP. The process for approving of agency shifts now is being governed by the Directors of Nursing the review process is ensuring all mitigations have been reviewed prior to agency shifts being released to agencies.	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				
Ward Accreditation		Many of the inpatient areas are now consistently achieving silver in their accreditation. This ensure that wards are working toward CQC 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					
Red Flags	ETOC Red Flags	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. Data for March 26 indicates that areas are now suing red flags more approristely to flag risks. Trends and usages are picked up monthly at the organisational workforce council.	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				
Mod. Harm Incs and Above		Moderate harm incidents has seen an increase from 5 to 16 in the month of April 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.	
Safety	Pressure Ulcers G2+ Acq. in Our Care	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	April 26 has seen a decrease in the incidents of falls with falls no harm decreasing from 46 to 40. Incidents with harm have increased from 41 to 40.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			

Tab 3.1 Integrated Performance and Quality Report (item 5.3.1)

Feedback	Medicine Errors		Medicine errors has seen an increase in April 26 from 21 to 27. 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, this we know has increased for the month of April. 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		Trust compliance for this metric has remained stagnant in March 2026 at 98.9%. The average for this metric has remained consistent for the last 8 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 report to be sent to ADNPP and trends to be escalated via care groups.
	Patient Complaints		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.
	FFT	% Pos. Resp.	Patient feedback in captured responses is 265. 98.9% of these were positive. Please note the figures to this have not altered over the last quarter this indicates that our process for catching real time feedback from our patients, relative and visitors is not effective and or robust.	QR codes have been developed for all clinical areas to ensure that accessibility of providing feedback has improved. Where the patient group are unable to use QR codes volunteers have been used to support patients in completing feedback questionnaires. There is a monthly trust wide report so our senior leader can track the number of responses and work within their care group to improve upon this.	Report monthly on patient responses themes and trends. To ensure areas who are not yet collecting data are supported by their ADNPP to begin the data collection process.
		No. of Resp.			

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) - April-2026

Torbay and South Devon 
NHS Foundation Trust

STAFFING METRICS		Emerg. Dept
Number of Attendances		6,839
Staffing Fill Rates	Days RN / Midwives	99.9%
	Care Staff	105.6%
	Nights RN / Midwives	99.2%
	Care Staff	58.2%
Actual Staffing Split	Days % RN / Midwives Hours	60.7%
	% Care Staff Hours	39.3%
	Nights % RN / Midwives Hours	73.6%
	% Care Staff Hours	26.4%
	Day / Night Split % Day	55.0%
	% Night	45.0%
HR Metrics	Sickness Rate (Mar-26)	9.4%
	Turnover Rate	9.3%
	Vacancy Rate	-4.0%
Temporary Staffing	Prop. Bank Hours	12.3%
	Prop. Bank Hours	12.3%
Accreditation		

PATIENT SENSITIVE INDICATORS		Emerg. Dept
Number of Unplanned Reattendances		249
Service Delivery Times	% Waiting > 4 Hrs	54.5%
	% Waiting > 12 Hrs	9.9%
	Avg. Triage Time (mins)	27
	Ambulance Handovers < 30 mins	49.8%
Safety	All Red Flags	0
	Mod. Harm Incs and Above	5
	Medicine Errors	4
	PUs G2+ Acquired in Our Care	0
	Falls No Harm	2
	Harm	2
	Sepsis % Overall Sepsis 6 Compliance	77%
	% Antibiotics within 1 Hour	100%
	Patient Complaints	0
	Feedback % Positive Resp. (Jul-25)	100.0%
FFT Number of Resp. (Jul-25)		28

Safer Staffing Dashboard - Emergency Care (ED Only) - April-2026 - Assurance

Torbay and South Devon 
NHS Foundation Trust

Measure	Assurance Summary ¹	Narrative	Mitigation	Actions

STAFFING METRICS						
Staffing Fill Rates	Days	RN / Midwives		Care staff fill rate for both days and nights remain below the 90% tolerance in the department at an average of 84%. This reflects the current vacancy rate for HCSW which remains elevated. Strategic work is underway to support ED recruitment and pipeline planning with focused ED adverts and the relaunch of the HCSW new to care pathway. The fill rate for RNs during both days and nights remain just above 90% at the lowest end of our tolerance. Currently the RN workforce in ED is heavily reliant on temporary staffing. There has been continual focus on filling substantive vacancies within the department. The vacancy rate for RNs has significantly improved; to support the onboarding timeline the temporary workforce will be used with the view to decrease use as new starters join the organisation.	internal redeployment, enhanced bank usage, prioritisation of high-acuity areas, and escalation protocols to maintain patient safety. Workforce plans continue to focus on recruitment, retention, and development of alternative roles to improve resilience."	Prioritise Patient Safety Maximise Internal Workforce Strengthen Escalation & Oversight Improve Patient Flow Use Flexible Workforce Models Control and Optimise Agency Use Focus on Recruitment & Retention Support Staff Wellbeing
		Care Staff				
	Nights	RN / Midwives				
		Care Staff				
HR Metrics	Sickness Rate			April 2026 has seen an increase in the sickness rate from 9.4% from 8.7%. Staff turnover has decreased by 1.2%. Vacancy rate although green at - 4.0% must be treated with caution due to the elevated turnover rate; meaning that the vacancy position for the department fluctuates frequently.	Improve Workforce Wellbeing Strengthen Staff Retention Enhance Recruitment Effectiveness Optimise Workforce Planning and Supply Increase Organisational Oversight and Accountability	Improve Workforce Wellbeing Strengthen Staff Retention Enhance Recruitment Effectiveness Optimise Workforce Planning and Supply Increase Organisational Oversight and Accountability
	Turnover Rate					
	Vacancy Rate					
Temporary Staffing	Prop. Bank Hours			Use of temporary staffing within the department is red. In April 26 saw the proportion of bank staff at 17.2% this is a decrease of 4.9%. Agency use is at 12.3% this is a decrease of 3.9%. There is a plan underway to support agency migration to bank and focused efforts to plan ahead to fill vacancies.	Maximise Bank Utilisation (Prop. Bank Hours) Prioritise fill through internal bank before agency usage Increase uptake via incentives and improved shift visibility	Improve Workforce Flexibility Encourage cross-deployment of suitably skilled staff Expand flexible working options to increase bank participation
	Prop. Bank Hours					
PATIENT SENSITIVE INDICATORS						
Number of Unplanned Reattendances				Unplanned reattendances have remained the same for April 26 at 249. This reflects the increase in population over the half term Easter break and is a common theme across the ED service during summer months.	Strengthen Demand Management Implement streaming and triage models to redirect non-urgent attendances Promote use of alternative services (GP, UTCs, NHS 111)Improve Patient Flow Through ED Reduce delays in assessment, treatment, and discharge Work with site teams to improve timely admissions and bed availability Enhance System-Wide Coordination Collaborate with community, primary care, and ambulance services Proactively manage surges and escalation periods	Strengthen Escalation and Oversight Activate escalation frameworks during high attendances Monitor real-time activity and respond quickly to pressures Promote Preventative and Community-Based Care Support initiatives that reduce avoidable ED attendances Improve access to urgent and same-day care pathways
Service Delivery Times	% Waiting > 4 Hrs			4 hour waits increased in April by 5.2%. 12 hour waits have decreased by 1.4% despite increased use of the service during Easter. Time to triage has increased by 9 minutes . Ambulance handover time has also decreased 6.3%.	THP 45 protocol now embedded to support this the Trust has a well practiced surge SOP. This support timely handover of patients , ensuring patients are off loaded from ambulances and care for in one of the Trusts escalated areas. Focused work is also underway looking at discharges and use of the discharge lounge to supportpatient flow.	To ensur robust use of the Surge SOP. To collect Trust data on discharge to understand blockers for discharges. To collect, rept and review data trends for use of escalated areas.
	% Waiting > 12 Hrs					
	Avg. Triage Time (mins)					
	Ambulance Handovers < 30 mins					
	All Red Flags			To reduce red flags, moderate harm incidents, medication errors, pressure ulcers (grade 2+ acquired in care), falls (no harm and harm), and to improve Sepsis 6 and timely antibiotics, the ED should focus on standardised pathways, rapid risk recognition, and reliable safety processes embedded at triage and throughout patient flow. This includes strengthening early		arly Risk Identification: Consistent triage screening (sepsis, falls, skin integrity) Standardisation: Use checklists, protocols, and care bundles (Sepsis 6, medication safety)
	Mod. Harm Incs and Above					
	Medicine Errors					
	PUs G2+ Acquired in Our Care					
Throughout March 26 the Department has seen its safety metrics						

Tab 3.1 Integrated Performance and Quality Report (item 5.3.1)

Safety	Falls	Falls - No Harm		The Department has seen no safety incidents fluctuate. Great work has been completed and reflected in the reduction of G2 pressure ulcers resulting in 0 for April 26. There has been 5 moderate events, with 4 falls 2 of which resulted in harm. Medicine in ED decreased to 4 despite the high use of temporary staffing and workforce pressures. The Sepsis 6 compliance has increased to 88% with compliance for antibiotics administration at 100% within the hour.	assessment protocols (e.g. sepsis and falls risk screening at triage), improving clinical decision support and communication, ensuring adequate staffing and skill mix during peak demand, and reinforcing a culture of safety through daily huddles, incident review, and learning loops. Consistent use of checklists, digital prompts (EPR alerts), and escalation triggers can minimise variation in care delivery while supporting timely interventions such as antibiotic administration within one hour. Environmental optimisation (e.g. safe patient areas, pressure-relieving equipment) combined with staff education and real-time audit/feedback will further reduce avoidable harm and support compliance with national quality standards.	Medication Safety: Rapid senior review and prompt treatment (especially antibiotics) Medication Safety: Electronic prescribing and high-risk medication checks Environment & Equipment: Safe areas for frail patients; pressure-relieving equipment available Staffing & Flow: Right skill mix and escalation during crowding Monitoring & Learning: Real-time data dashboards, safety huddles, and incident reviews
		Falls - Harm				
	Sepsis	% Overall Sepsis 6 Compliance				
		% Antibiotics within 1 Hour				
Feedback	Patient Complaints			The Department has seen 2 complaints for April 26. 100% of patient feedback was also positive reflecting the kind, caring and compassionate workforce that we have working in the department. Please note the figures to this have not altered over the last quarter this indicates that our process for catching real time feedback from our patients, relative and visitors is not effective and or robust.	Improve patient feedback outcomes by focusing on clear communication, timely care, and patient-centred experience throughout the ED journey. Ensuring patients feel informed, respected, and updated—especially during long waits—will positively influence FFT responses and reduce complaints. Embedding structured feedback collection, rapid response to concerns, and visible learning from feedback will help build trust and drive continuous improvement.	Improve Communication: Ensure consistent, clear updates to patients on waiting times and care progress Respond Early to Concerns: Address issues in real time to prevent escalation into formal complaints Enhance Patient Experience: Focus on dignity, privacy, and comfort across the ED journey Increase Feedback Capture: Make it easy and routine for patients to give FFT feedback (e.g. digital options, prompts at discharge) Promote Positive Interactions: Reinforce staff behaviours that support compassionate, patient-centred care Act on Feedback: Regularly review themes from complaints and FFT and implement visible improvements Close the Loop: Share “you said, we did” outcomes with staff and patients to build trust and engagement
		% Positive Resp.				
	FFT					
		Number of Resp.				

¹ Definitions for the Assurance Summary categories are given in the 'Notes and Definitions' section of this document.

Safer Staffing Dashboard - April-2026 - Notes and Definitions

STAFFING METRICS

Measure		Applicability	RAG Criteria			Notes and Definitions
			Red	Amber	Green	
Beds	Established Beds	Inpatient Only	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	Inpatient and Emergency	<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					
Actual Staffing Split	Days	Inpatient and Emergency	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					
	Day / Night Split		N/A	N/A	N/A	Figures represent the actual (rather than planned) split between Day and Night for Registered Nurses and Care Staff combined.
	Night					
Care Hours Per Patient Day (CHPPD)	RN / Midwives	Inpatient Only	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 exceeds the Planned CHPPD. The RAG status is only applied to the Actual CHPPD column and is based on the relative difference between the Acutal CHPPD and the Planned CHPPD. A Green RAG status is assigned where there was no Planned staffing but Actual staffing was present.
	Days					
	Overall Day					
	RN / Midwives					
	Nights					
	Overall Night					
HR Metrics	Sickness Rate	Inpatient and Emergency	>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 exceeds 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. Please note that the 'All Wards' figures for the Sickness Rate and Turnover Rate measures are averages (mean) figures.
	Turnover Rate		>=14%	N/A	<14%	
	Vacancy Rate		>20%	>=10% and <=20%	<10%	
Temporary Staffing	Prop. Bank Hours	Inpatient and Emergency	<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%	>5%	
Accreditation		Inpatient and Emergency	N/A	N/A	N/A	Ward accreditation indicates national recognition of the general standard of care provided by a ward. There are five levels of accreditation: ○ 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 <i>not</i> the accreditation statuses for the months prior to the current reporting month.

Safer Staffing Dashboard - April-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	EToC Red Flags	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.
				All Red Flags	>=5	>=3 and <5	<3
		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).
	Falls	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).
	Sepsis	% 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 - April-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.
	FFT				
	Number of Responses	N/A	N/A	N/A	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.

Safer Staffing Dashboard - April-2026 - Notes and Definitions (cont.)**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 - April-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 Nights	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.
RN/Midwives Care Staff			
RN/Midwives Care Staff			
Actual Staffing Split Days Nights			
% RN / Midw. % Care Staff Hours			
% RN / Midw. % Care Staff Hours			
RN / Midwives Care Staff			
Overall Day RN / Midwives			
Care Hours Per Patient Day (CHPPD) Nights 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 - April-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 % Waiting > 12 Hrs Avg. Triage Time (mins)	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. 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.

Tab 3.1 Integrated Performance and Quality Report (item 5.3.1)

	Amb. Handovers < 30 mins				Figures for the Ambulance Handovers measure are taken from querying warehoused Symphony data.
Safety	Red Flags Raised	EToC Red Flags All Red Flags	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.
	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.
	Grade 2+ Pressure Ulcers Acquired in Our Care				The 'Moderate Harm Incidents and Above' measure additionally filters for incidents with a Severity of Moderate, Severe or Death harms.
	Falls	No Harm Harm			The 'Grade 2+ Pressure Ulsers' 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.
	Sepsis	% Overall Sepsis 6 Compliance % Antibiotics within 1 Hour	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.
	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.
Feedback	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.
	FFT	% Positive Responses Number of 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.

Finance and Operations

Committee

Elective Activity Report

Date of meeting	Date report produced
24 th June 2026	23 rd May 2026

Author(s)		Report approved by	
Name and title:	Sam Wadham-Sharpe Interim Chief Operating Officer	Name and title:	Sam Wadham-Sharpe Interim Chief Operating Office
		Date:	15 th June 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 details the current position of referral to Treatment (RTT) elective activity and performance, including current recovery plans and trajectories to return to planned performance levels. The below is a summary of the key points of the paper.

Activity v Plan

- Currently behind plan in all four activity areas
- This was expected for 6 weeks post Epic go live however recovery has taken longer in some specialities

Waiting List Growth and Performance v Epic Plan

- Waiting list growth remains within the levels expected through Epic go live modelling
- RTT performance is slightly behind Epic go live modelling, but number of clock stops required to recover performance in year remains as per the model
- ~700 cardiology patients requiring transfer on to Epic which would increase waiting list to slightly over expected level and provide ~1% performance improvement to RTT
- Current % of waiting list more than 52 weeks is 2.7% (1.8% pre-Epic go live) and has reduced in May with forecast to continue reducing

Recovery Plan

- Deep dives undertaken in specialities across medicine and surgery
- Majority of activity and performance issues (65-week waiters) are held in ENT, Ophthalmology and Orthopaedics
- 65 week wait clearance forecast in ENT and Ophthalmology by September
- Orthopaedic current September 65 week wait position is 58
- Additional actions for capacity under review and non-admit wait focus in place with aim to reduce this number
- Orthopaedic external deep dive to be presented to executives on 19th June

Additional Key Information/Actions

- 6000 pathways identified requiring validation as potential duplicate records. Expected to reduce to ~5200 by end of 19th June
- Improved theatres and outpatients booking processes being enacted
- Ongoing theatre refurbishment impacting on activity levels
- Review between finance and operations to understand any risk to finance plan through underperformance and to create joint proposal for future cost of recovery

Section	Assurance (Actuals) (Limited/Satisfactory/ Significant)	Assurance (Plan)
Elective Activity Q1	Limited	Satisfactory
Elective Performance Q1	Limited	Limited
Elective Recovery Plan	Limited	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 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 recovery support programme (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 paper details the current position of RTT elective activity and performance, including current recovery plans and trajectories to return to planned performance levels.
2. As part of the Epic go live modelling the Trust expected to see the RTT waiting list grow to 35,500 and a 4% worsening of RTT performance from March by the end of June. This was the position agreed with regional and national teams as part of our extensive go live planning. We 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.
3. The Trust operating plan submission and Go Live activity impacts have been developed using speciality level data and analysis. We have followed the following methodology to develop our forecast, with no reductions planned in elective day case or elective ordinary activity, beyond those expected during a bank holiday weekend.
 - The impact analysis uses the baseline of annual activity calculated to working day and applied to the go live period as operating plan activity.
 - The percentage reductions agreed by teams have been applied at specialty level to give a revised activity plan, again being based on working days.
 - The resulting gap is calculated and represents the activity loss and activity that will need to be recovered over the course of the year to achieve operating plan.
 - Application of historic RTT clock stop in both new and f/up ORTT OP activity types has been applied to forecast the likely loss of clock stop activity.
4. To recover the levels of clock stops between August 26 and March 27 to meet the performance within the plan, the Trust will need to deliver an average 690 additional clock stops each month, which is ~7% over and above our 25/26 clock stop run rates.

2. Current Position

1. The Trust is still in an active period of activity stabilisation following the implementation of a new electronic patient record on 3rd April 2026. This has particularly impacted the ongoing run-rate in outpatient activity across a number of specialties. Issues range from user confidence, additional administration, workflow set-up to correct coding and recording of information. There continues to be two weekly 'activity stabilisation' meetings per week, with EPIC colleagues to address these issues.

2. The overall position of year-to-date activity remains below plan in key areas, with Day Cases at 92%, Elective Inpatients at 78% (impacted by closure of two theatres due to maintenance), Outpatient New Attendances at 85%, and Follow-ups reported at 100%, noting this is also influenced by data quality and pathway configuration issues. There are areas of variance with regards to recovery which will be outlined below, alongside recovery activities taking place now, and with future plans this year.
3. A break down of the current activity levels in each of the key domains of elective ordinary, day case, 1st outpatient and follow up outpatient can be seen below. It should be noted that in some areas, the move to Epic has resulted in a change in classification of activity that was accounted for in planning. For example, template prostate biopsies were previously counted as day case activity but are now recorded as outpatient with procedure.

YTD position against plan

Summary of activity delivery v
Operational plan from EPIC Go live

	week commencing									
Daycase	6/4	13/4	20/4	27/4	4/5	11/5	18/5	25/5	1/6	YTD total
Actual	572	713	801	779	649	757	793	654	799	6516
Operational plan	676	845	845	845	676	845	845	676	845	7098
difference	-105	-132	-44	-66	-27	-88	-52	-22	-46	-582
% diff	84%	84%	95%	92%	96%	90%	94%	97%	95%	92%

	week commencing									
Inpatient	6/4	13/4	20/4	27/4	4/5	11/5	18/5	25/5	1/6	YTD total
Actual	20	52	49	63	40	62	60	51	54	451
Operational plan	55	69	69	69	55	69	69	55	69	579.6
difference	-35	-17	-20	-6	-15	-7	-9	-4	-15	-129
% diff	36%	75%	71%	91%	72%	90%	87%	92%	78%	78%

	week commencing									
1st OP	6/4	13/4	20/4	27/4	4/5	11/5	18/5	25/5	1/6	YTD total
Actual		1153	1504	1974	2070	1634	2161	2074	1540	16326
Operational plan		1832	2290	2290	2290	1832	2290	2290	1832	19236
difference		-679	-786	-316	-220	-198	-129	-216	-292	-2910
% diff		63%	66%	86%	90%	89%	94%	91%	84%	85%

	week commencing									
Follow up OP	6/4	13/4	20/4	27/4	4/5	11/5	18/5	25/5	1/6	YTD total
Actual		3782	4898	5799	6012	5438	6604	6723	5106	50795
Operational plan		4850	6062	6062	6062	4850	6062	6062	4850	50920.8
difference		-1068	-1164	-263	-50	588	542	661	256	-126
% diff		78%	81%	96%	99%	112%	109%	111%	105%	100%

4. At the time of writing this paper the current RTT waiting list is within forecasted growth at 35,245. The current RTT performance is slightly under the forecasted levels at ~60%. It should be noted that roughly 700 cardiology records have not been correctly moved over from previous systems to Epic and as such if these records were accurately recorded then the waiting list growth would exceed the levels originally forecast but the RTT performance would improve by ~1% due to all of these patients being under 18 weeks. There is no risk to these patients as all records have been clearly identified and a process is in place to update these records into Epic swiftly.
5. A further review is planned between operations and finance to understand the risk of the underperformance on the financial position. At the time of writing the impact on the current underperformance on the income position is still being worked through. It should be noted that the 26/27 elective plan was developed to recover the lost activity later in the year and the actual plan itself was not adjusted to demonstrate this.

6. The piece of work detailed above will be important as in some specialities, the current under delivery of activity has not resulted in a significant worsening of performance. As such, there will need to be a joint proposal created between operations and finance as to whether to recover that activity in year, especially if it would require high cost solutions to achieve this.

3. Speciality Level Detail

1. Work has been ongoing through June to review each speciality and understand their current position against recovery, the size of any activity backlog built through Epic go live, the performance issues this has or could create, and the actions required to recover performance positions.
2. The two tables below describe the medical (inc women and children) and surgical specialities positions for RTT performance pre Epic go live, their current RTT position and the backlog activity position broken down by non admitted and admitted activity.

Medicine (inc women and children)

Speciality	RTT 31 March	RTT Now	Non-Adm	Admitted
Cardiology	76.6%	61.71%	0	0
Clinical Neuro-Phys	44.4%	43.33%	0	2
Dermatology	75.23%	75.05	713	12
Endocrinology	65.32	60.22%	0	1
Neurology	68.48%	63.01%	126	0
Respiratory	79.12%	78.85%	59	4
Gynaecology	67.03%	60.84%	0	38
Paediatrics	88.79%	81.50%	0	14

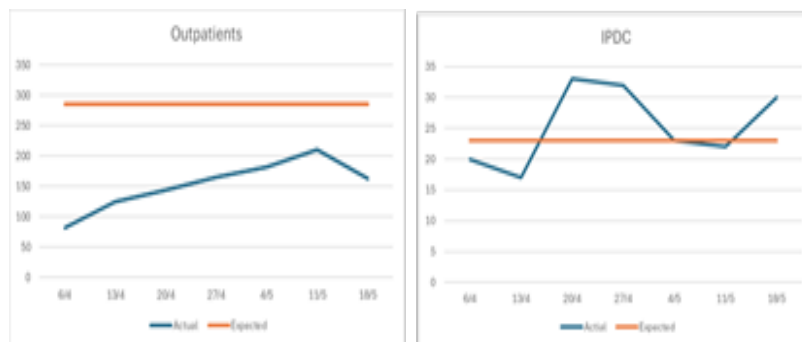
Surgery

Specialty	Description of current position compared to 31 March 26.	RTT 31 March	RTT Now	Recovery no's	
				Non-Ad	Admitted
Breast Surgery	Already improved and better position than 31st March 26.	95.6	96.2	0	0
Colorectal Surgery	Non-admitted stable, need to recover 32 patients over 18 weeks.				
	Needs to recover 48 non admitted	72.9	65.3	32	48
ENT	Non-admitted stabilising, need to recover 327 patients over 18 weeks.				
	Admitted stable, over 18 weeks less than March but conversion of OPA will require recovery	57.8	52.2	327	0
Gastro	Non-admitted stable, need to recover 87 patients over 18 weeks.				
	EPIC review needed for admitted pthways	89.6	86.2	87	0
Ophthalmology	Non-admitted still needs recovery to post EPIC numbers, 551 patients to recover manly Glaucoma news.				
	Admitted hampered by theatre closures, 68 patients to clear	64.4	56.3	551	68
Oral surgery	Non-admitted stabilising, need to recover 248 patients over 18 weeks.				
	Admitted stable, need to recover 9 patients.	57	51.4	248	9
Orthodontics	Non-admitted stable, need to recover 22 patients.				
		65.7	56.1	22	0
Pain	Non-admitted stable, need to recover 39 patients				
	Admitted deteriorating, need recovery plan to clear 29 patients.	57.1	43	39	29
Plastics	Stable	69.7	84.3	0	0
Restorative	Stable, lower <18 week numbers causing drop in RTT	84.2	73.3	0	0
T&O	Non-admitted stable, need to recover 90 patients over 18 weeks.				
	Admitted stable, need to recover 1 patient over 18 weeks	50	48.4	90	1
UGI	Non-admitted stabilising, need to recover 35 patients over 18 weeks.				
	Admitted deteriorating, need to recover 59 patients over 18 weeks.	59.4	55.2	35	59
Urology	Non-admitted deteriorating, need to recover 214 patients over 18 weeks.				
	Admitted stabilising, need to recover 17 patients over 18 weeks.	66.6	55.9	214	17
Vascular	Improving position.	77.6	80.3	0	0
TOTAL				1645	231

- The dermatology backlog of activity is created as a result of the planned cancer activity reductions and has been addressed as part of the separate cancer recovery paper with expected improvements in July. A range of recovery actions are in place for specialities of concern and these can be found in the supplementary pack. Further focus is being taken in ENT, Orthopaedics and Ophthalmology due the numbers of patients at risk of breaching the 65 week wait standard and further information on the recovery and the 65 week wait forecast is provided in the following sections.

4. ENT

- There is a New Outpatient backlog 450 attendances (c.50 clinics) and waiting list growth since go live is 280 patients. Day case activity is on plan as noted in Figure 3. There is still some clinician variance in stabilisation with some back to 100% and some at 80% currently.

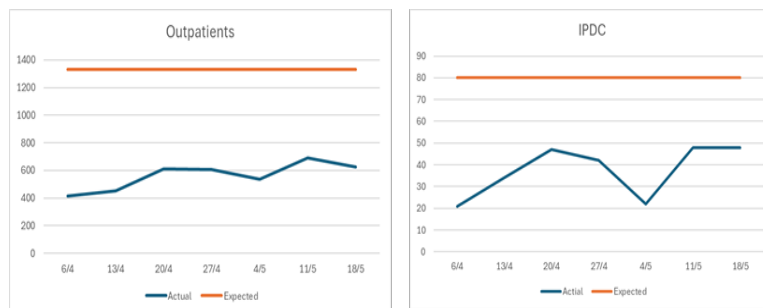


2. The current position includes 20 patients waiting over 65 weeks, comprising one admitted and 19 non-admitted pathways. The specialty is working to a trajectory that eliminates all 65-week waits, and a view to clear all 52+ week waits by the end of September. Delivery is being supported through a combination of insourced outpatient clinics and targeted internal capacity, with four insourced clinics per month during June and July expected to deliver approximately 160 additional patient appointments per month. Further insourcing is being pursued for August and September to sustain this trajectory. Alongside this, dedicated June theatre and clinic lists are being prioritised for long waiters, and capacity is increasing following the phased return of a consultant from sickness.
3. The admitted backlog has been validated and reduced from 21 to 19 patients requiring treatment, with a significant proportion (12 patients) currently under the care of a single consultant. Active redistribution of these patients is underway to optimise use of available capacity and reduce concentration risk. There has also been an SAS doctor post recruited to as part of the Elective Delivery Plan this year, and this individual will be delivering 4-5 clinics per week by Aug/Sept. There is an additional cancer nurse as part of the Elective Plan this year which will be recruited to due Q2. Based on current plans, all admitted long waiters are expected to be treated by the end of August. For completeness, this will also address the cancer Faster Diagnostic Standard (FDS) recovery position in ENT.
4. Based on the actions and activity in place the forecasted ENT 65 week wait clearance plan is below

	April 2026	May 2026	June 2026	July 2026	August 2026	Sept 2026
65w admitted		2	0	0	0	0
65W non-admitted	1	5	10	12	15	0
Total	1	7	10	12	15	0

5. Ophthalmology

1. The current position shows 38 patients waiting over 65 weeks, comprising 5 admitted and 33 non-admitted pathways, with backlog pressure predominantly concentrated within non-admitted demand. Performance remains significantly below plan in day case activity at around 40%, with cataract pathways the primary driver. There is also a substantial follow-up backlog, estimated at approximately 5,800 patients, alongside a new patient backlog of around 370 attendances. These positions are not yet fully reflected within EPIC reporting and continue to require validation and workflow resolution.



2. Operational delivery is currently constrained by a combination of reduced consultant capacity, with the majority operating at approximately 60% of expected levels for follow-up clinics, and ongoing pathway and system inefficiencies following EPIC go-live. These include late theatre starts, inefficiencies within hybrid cataract and pre-operative assessment clinics, and challenges accessing diagnostics and biometry, all of which are restricting throughput. The virtual pathway is not yet delivering intended benefits due to a lack of clarity around workflow and ordering processes, while the Glaucoma service continues to be impacted by reliance on non-digitised historic paper records, creating both inefficiency and clinical risk. These are all areas of focus to resolve in the next two weeks.
3. Recovery efforts are therefore focused on immediate stabilisation of pathways and rapid expansion of usable capacity over the next one to two months. Additional consultant-led clinics for lids and minor operations are being introduced to support a “see and treat” approach, directly targeting the non-admitted backlog. In parallel, insourcing capacity is being mobilised, with clinician recruitment and EPIC training underway, alongside further expansion through the Surgical Consortium to increase both outpatient and surgical throughput. Capacity will also improve from late June with the phased return of a corneal consultant, enabling restoration of graft activity and supporting increased day case output.
4. One of the insourcing groups ‘Affordable Healthcare’ which has been used previously, has a substantive consultant that is EPIC trained that can deliver 24 per day for three full days per week over six weeks. This roughly equates to 400 first outpatient appointments which would provide enough capacity for every patient waiting on the work queue. For the treatment conversions it is planned that TSD local consultants will reorganise job plans to deliver the theatre work and this agreement is being pursued
5. Based on the actions and activity in place the forecasted Ophthalmology 65 week wait clearance plan is below

	April 2026	May 2026	June 2026	July 2026	August	Sept
65w admitted	8	6	9	5	3	0
65W non-admitted	11	14	16	12	3	0
Total			25	17	6	0

6. Orthopaedics

1. There is a 50 patient day case backlog (c.10 lists). The stabilisation data shows T&O to be broadly on contract plan, however there is further coding work to understand if this is the true position given some consultants are still at 80% clinic capacity. The industrial action had the potential to impact T&O in June however all cancelled theatre lists have been recovered with the original patients able to be treated.
2. Within Trauma and Orthopaedics (T&O), the current position reflects the largest area of admitted pathway risk within the Trust, with 74 patients waiting over 65 weeks, comprising 48 admitted and 26 non-admitted pathways.
3. A programme of additional elective capacity is being planned, including seven weekend operating lists across June and July, each delivering approximately four patients per list. This is complemented by a planned 'super clinic' on 25 July, expected to provide around 120 outpatient appointments over the course of the weekend, supporting both new and long-wait follow-up activity. This model will be tested and used again in subsequent months. Capacity will further increase from July with the arrival of a new consultant, alongside strengthened use of the Surgical Care Practitioner workforce, who are supporting delivery of virtual fracture clinics and enabling consultants to focus on face-to-face elective care.
4. In parallel, an external consultant is leading a pathway review to optimise clinic and theatre templates, ensuring that existing capacity is being utilised as effectively as possible. This is supported by strengthened validation processes to ensure that patients are actively managed and removed promptly where appropriate. The outputs of this work will be presented to the executive on 19th June.
5. The admitted position remains complex. Within hips and knees, there are currently 18 patients with confirmed treatment dates and a further 44 undated patients in June, including a small number who are pencilled for treatment. Other subspecialties retain smaller residual undated cohorts. While there is confidence that the June non-admitted 65-week cohort will be accommodated within planned activity, pressure remains with tip-ins going into July. Looking ahead, the July pipeline includes 17 patients already dated, with a further 57 requiring scheduling.
6. On a conservative trajectory, the specialty is forecasting a reduction to approximately 18 non-admitted breaches by September, with around 40 admitted breaches remaining at that point. This reflects the scale of the admitted backlog and the time required to safely recover patients through surgical pathways, despite the additional capacity being brought online. Further actions during this month have focused on tightening operational grip on planning, scheduling and utilisation. A four-weekly timetabling huddle is being implemented to improve forward planning discipline, reduce rework, and ensure clinics and theatres are opened in a timely and coordinated way. This is supporting a more stable and predictable booking position across both outpatient and elective pathways.

7. Operational processes have also been strengthened at a tactical level. This includes proactive “man-marking” of tandem cases, with admissions clerks working closely with rota coordinators to identify and allocate capacity in real time. This approach has delivered a significant improvement, reducing waiting tandem cases from 32 in February to 4 in June, with ongoing real-time allocation now in place to prevent reaccumulating.
8. Based on the actions and activity in place the forecasted Orthopaedic 65 week wait clearance plan is below

	April 2026	May 2026	June 2026	July 2026	August 2026	Sept
65w admitted	41	47	48	45	45	40
65W non-admitted	11	12	16	13	18	18

7. Additional Information/Actions

Non-Admitted Pathways

1. To support the Trust to recover its 65 week wait position as swiftly as possible, additional focus is being placed on non-admitted waiters with the performance team providing extra scrutiny on those waiting without a next event booked. This information is being reviewed weekly by the Chief Operating Officer and oversight meetings booked where further escalation required. The Trust is aiming to clear all non-admitted 65-week waiters by September. The table below demonstrates the significant opportunity from ensuring all non-admitted patients have a next appointment booked in correct timeframes.

July Non-Admitted Not Booked / Booked			
	Not Booked	Booked	Grand Total
Cardiology	1	2	3
Colorectal Surgery	1	6	7
Endocrinology	15	6	21
Ent	25	12	37
Gastroenterology	2		2
Geriatric Medicine		1	1
Gynaecology	2		2
Ophthalmology	30	2	32
Orthodontics		1	1
Pain Management	6	1	7
Trauma & Orthopaedics	10	8	18
Upper Gastrointestinal Surgery		2	2
Urology	6	12	18
Grand Total	98	53	151

Validation

2. A detailed review of RTT data has identified a high volume of possible duplicate pathway entries, with approximately 6,000 records requiring validation. These duplicates are present both within single pathways and across multiple pathways for individual patients. Based on an initial estimate of around 10 minutes per pathway, this represents a significant operational effort of circa 133 days of full-time work. By the 19th June this should have reduced to ~5200 and a review of

benefit will be undertaken at this point. Equivalent functionality to Netcall within EPIC is not yet live, although this is scheduled to go live in the week commencing 15 June. This is expected to enhance validation processes once available.

Theatre (6-4-2)

3. Prior to the implementation of EPIC, adherence to the 6-4-2 booking standard within theatres has been challenged. Despite this, there has been a noticeable improvement in performance over the past two weeks, supported by increasing pre-operative assessment capacity and a renewed focus on forward booking discipline.
4. The introduction of a formal escalation process, alongside enforcement of a two-week list lock, has strengthened oversight and reduced late, non-urgent additions to theatre lists. This has led to greater stability across pathways and fewer late changes and cancellations. Further progress remains contingent on securing sustained investment in pre-assessment capacity. In addition, earlier system constraints around setting up new clinics restricted the ability to respond flexibly to demand. This has now improved following escalation through the EPIC team, with turnaround times reducing from an initial six weeks to approximately seven days, enabling more responsive capacity planning.

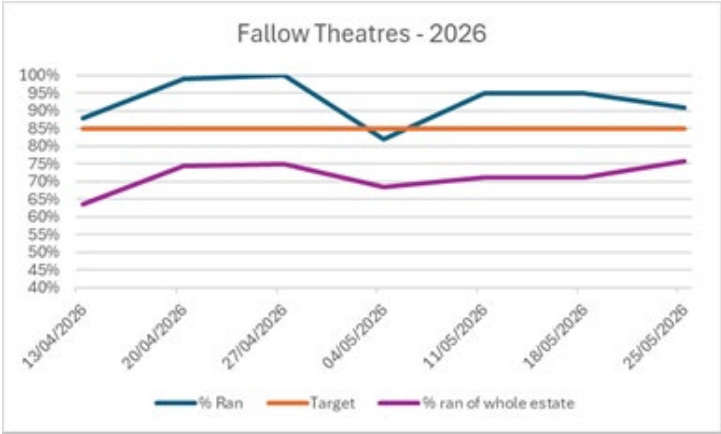
Outpatients

5. Outpatient booking performance reflects similar operational pressures, with current booking lead times averaging two to three weeks. A key constraint is limited rota visibility, with many services unable to confirm clinic schedules beyond three to five weeks in advance, and some operating at shorter planning horizons.
6. This lack of forward visibility, combined with vacancies within booking teams and frequent short-notice changes to clinics, continues to limit booking capacity and consistency. The interaction between rota management, theatre planning, and annual leave further compounds these challenges.
7. Ongoing engagement with service leads and Associate Medical Directors is focused on improving rota discipline, reducing last-minute changes, and strengthening escalation routes where constraints persist. While progress is being made, the position remains constrained, and further improvement will depend on greater consistency in workforce planning and booking processes across specialties.

Theatre closure due to maintenance

8. Day surgery 3 (DSU3) and Eye Unit 1 (ESU1) remain out of action due to planned refurbishment. Initially hoped to have DSU5 on line to help compensate activity loss from beginning of July 2025 but this has been delayed slightly. Timetable in the interim in place, which has been aligned to speciality need and waiting list position to ensure lost activity is shared appropriate.
9. Graph 1 shows the number of theatres being utilised. The blue line takes into consideration the closed theatres, as this has been reflected in our theatre stocktake nationally. The lower line shows utilisation assuming all theatres were operational. We have had a number of weeks of 100% utilisation of current

allocation. We have had two bank holidays also. Of those weeks where we are not met 100% this has been impacted by planned theatre maintenance and clinical effectiveness.



8. Assurance recommendations and summary

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

Section	Assurance (Actuals) (Limited/Satisfactory/ Significant)	Assurance (Plan)
Elective Activity Q1	Limited	Satisfactory
Elective Performance Q1	Limited	Limited
Elective Recovery Plan	Limited	Limited



Torbay and South Devon
NHS Foundation Trust

Financial Performance Report

Month 2

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Torbay and South Devon
NHS Foundation Trust

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Torbay and South Devon
NHS Foundation Trust

Executive Summary

Key Financial Measures and Headlines



Torbay and South Devon
NHS Foundation Trust

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the financial position year to date (YTD) as at May 2026 and forecast outturn (FOT) for the year ending 31st March 2027.

Year to date revenue position on plan, with key variances noted:

- Under-delivery of CIP (£0.8m adverse)
- Industrial Action Strike costs and income loss (£0.5m adverse)
- Non-Recurrent release of balance sheet flex (£0.5m favourable)
- Income Provision for activity lost due to EPR (£0.9m adverse)
- Underspends against other operational budgets, mainly undrawn reserves for inflation and growth (£1.7m favourable)

Forecast revenue position on plan, with key risks noted:

- Forecasting breakeven outturn but with base case delivery risks of £9.3m relating to low maturity CIP and impact of EPR on contract activity
- Base case forecast suggests risk of £3m against planned ULP

Year to Date CIP position £0.8m adverse to plan:

- CIP delivery YTD of £3.4m against a £4.2m target
- The percentage of schemes assessed as fully developed has increased to 79% (£43.1m)
- Forecast CIP is on plan at £54.4m, but with lower recurrent delivery than planned (£2.4m adverse).

Workforce Update

- The Trust is reporting worked WTEs 203 below plan.
- Bank and agency spend is trending downwards but is above plan and national cap limits

Plan	YTD / Forecast	Measure	Month 02 2026/27 £m
Revenue Plan	YTD	Variance to Plan (Adverse) / Favourable	(0.0)
Revenue Plan	Forecast	Variance to Plan (Adverse) / Favourable	0.0
Revenue Plan	Forecast	Unidentified and High Risk Mitigations	(9.3)
Revenue Plan	Forecast	Recurrent Risk to Underlying Position	(3.0)
CIP Plan	YTD	Variance to Target (Adverse) / Favourable	(0.8)
CIP Plan	Forecast	Variance to Recurrent Target (Adverse) / Favourable	(2.4)
Capital Plan	YTD	Variance to Plan (Overspend) / Underspend	1.4
Cash Plan	YTD	Unplanned Cash Support	3.8
Cash Plan	Forecast	Unplanned Cash Support	7.7

Capital programme update:

- Year to date capital plan £1.4m underspend
- Forecast to deliver full programme, including additional allocation of £1.8m National PDC for Tower Fire Safety

Cash Update:

- The Trust closing cash balance for Month was £3.8m above plan
- The Trust is not forecasting a need for cash support

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.

Executive Summary



Torbay and South Devon
NHS Foundation Trust

The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the position at Month 1 for the year ending 31st March 2027.

The Trust set a breakeven plan for 2026-27 including £57.8m Deficit Support (DSF) and a CIP target of £54.4m. Trust's financial position at the end of May shows a month end position of **£4.7m** deficit, as planned. The position excluding DSF is **£14.3m** deficit at the end of April, as planned. The Trust was on plan overall, but with the following significant variances noted within this balanced position: under-delivery against CIP target (£0.8m adverse to plan), costs of cover and lost income from Industrial Action (£0.5m adverse to plan) offset with non-recurrent balance sheet flex released to meet these costs (£0.5m favourable to budget), a provision against contract income was made to recognise activity lost through EPR implementation (£0.9m adverse to plan). These adverse variances were offset by other favourable budget variances (£1.7m favourable to plan) mainly undrawn reserves funding for inflation and growth.

The Trust is forecasting delivery of the planned outturn but recognises forecast risks to delivery of between **£9.3m** in the base case and up to **£23.6m** in the downside risk assessment, with risk to the recurrent underlying position of £3.0m (base case) and £7.0m (downside risk assessment). The Trust will continue to work with operational leads, NHSE and the ICB to accelerate CIP delivery, refine forecast estimates and narrow the forecast range.

Year to date at Month 2 the Trust has recognised CIP delivery of **£3.4m** against a **£4.2m** target (**£0.8m** adverse to plan). Since the plan was submitted intensive work has been undertaken on developing the CIP plans. This has seen a material improvement in plan development and delivery risk assessment, fully developed plans have increased by £21.8m and low risk schemes have increased by £21.1m. The Trust is forecasting full delivery of the £54.4m target.

The Trust is reporting a cash balance of **£24.1m** as at 31st May 2026, **£3.8m** higher than planned, due to slower than planned settlement of capital accruals from 2025/26 capital programme offset with other working capital timing differences. 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.

At Month 2 the Trust has spent **£1.8m** of capital compared to plan of **£3.3m**, an underspend of **£1.4m**. The Trust is forecasting to spend up to capital limits, including an additional £1.8m National PDC Capital towards the Tower Fire Safety scheme.

Information on Month 2 financial performance for Devon ICS is not yet available, although all partner organisations have informally reported on plan financial delivery. All Devon ICS partner organisations have submitted balanced plans.

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.



Torbay and South Devon
NHS Foundation Trust

Finance Plan Delivery - Revenue

Financial Position



Torbay and South Devon
NHS Foundation Trust

Care Groups	In Month			YTD			Forecast Outturn			YTD Variance					
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Total	Income	Pay	Non-Pay	Passthrough	CIP
	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Surplus / (Deficit) £m	Fav / (Adv) £m	Fav / (Adv) £m	Fav / (Adv) £m	Fav / (Adv) £m	Fav / (Adv) £m	Fav / (Adv) £m
Families & Communities	(8.1)	(7.9)	0.2	(15.4)	(15.6)	(0.2)	(80.5)	(85.9)	(5.5)	(0.2)	0.2	(0.0)	(0.3)	0.0	(0.1)
Medicine and Urgent Care	(8.6)	(8.3)	0.3	(16.6)	(16.5)	0.0	(92.7)	(96.6)	(3.9)	0.0	0.1	(0.0)	0.1	0.0	(0.1)
Planned Care and Surgery	(13.7)	(13.9)	(0.2)	(26.8)	(27.9)	(1.1)	(152.1)	(161.3)	(9.3)	(1.1)	0.3	(0.9)	0.1	0.0	(0.6)
Adult Social Care – Torbay	(2.9)	(2.7)	0.2	(5.0)	(5.3)	(0.3)	(23.7)	(28.3)	(4.7)	(0.3)	(0.0)	(0.0)	(0.0)	0.0	(0.2)
Total Frontline Services	(33.3)	(32.8)	0.4	(63.7)	(65.3)	(1.6)	(348.9)	(372.2)	(23.3)	(1.6)	0.5	(0.9)	(0.2)	0.0	(1.0)
Corporate	(5.5)	(5.0)	0.5	(10.6)	(9.9)	0.7	(62.2)	(61.0)	1.2	0.7	0.0	0.6	(0.2)	0.0	0.3
Workplace (Estates)	(2.5)	(2.6)	(0.1)	(5.0)	(5.1)	(0.1)	(29.0)	(30.8)	(1.9)	(0.1)	(0.0)	0.1	0.0	0.0	(0.2)
Total Professional Support Services	(8.0)	(7.6)	0.4	(15.6)	(15.0)	0.6	(91.2)	(91.9)	(0.7)	0.6	0.0	0.7	(0.2)	0.0	0.1
Healthcare Contract Income	36.2	34.0	(2.2)	71.5	70.1	(1.4)	430.7	426.8	(3.9)	(1.4)	(1.1)	0.0	(0.0)	0.0	(0.2)
Reserves	(0.0)	0.9	0.9	(1.8)	0.1	2.0	(16.4)	9.2	25.6	2.0	(0.8)	0.9	1.6	0.0	0.2
Prior Periods	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	(0.0)
Other Trust Budgets	(2.1)	(1.7)	0.4	(4.7)	(4.3)	0.4	(31.9)	(29.7)	2.2	0.4	(0.0)	(0.0)	0.3	0.0	0.2
Other Budgets	34.1	33.2	(0.9)	65.0	66.0	1.0	382.4	406.3	24.0	1.0	(1.9)	0.9	1.9	0.0	0.1
Total Excluding Deficit Support Fund (DSF)	(7.2)	(7.2)	0.0	(14.3)	(14.3)	0.0	(57.8)	(57.8)	(0.0)	(0.0)	(1.4)	0.7	1.5	0.0	(0.8)
Deficit Support Fund (DSF)	4.8	4.8	0.0	9.6	9.6	0.0	57.8	57.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Including Deficit Support Fund (DSF)	(2.4)	(2.4)	0.0	(4.7)	(4.7)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(1.4)	0.7	1.5	0.0	(0.8)

The Trust set a breakeven plan for 2026-27 including £57.8m Deficit Support (DSF) and a CIP target of £54.4m.

Trust's financial position at the end of May shows a month end position of **£4.7m** deficit, as planned. The position excluding DSF is **£14.3m** deficit at the end of April, as planned.

The Trust was on plan overall, but with the following significant variances noted within this balanced position:

- under-delivery against CIP target (£0.8m adverse to plan),
- costs of cover and lost income from Industrial Action (£0.5m adverse to plan) offset with non-recurrent balance sheet flex released to meet these costs (£0.5m favourable to budget),
- a provision against contract income was made to recognise activity lost through EPR implementation (£0.9m adverse to plan).
- These adverse variances were offset by other favourable budget variances (£1.7m favourable to plan) mainly undrawn reserves funding for inflation and growth.

The Trust is forecasting delivery of the planned outturn but recognises forecast risks to delivery of between **£9.3m** in the base case and up to **£23.6m** in the downside risk assessment, with risk to the recurrent underlying position of £3.0m (base case) and £7.0m (downside risk assessment). The Trust will continue to work with operational leads, NHSE and the ICB to accelerate CIP delivery, refine forecast estimates and narrow the forecast range.

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

Forecast Risks and Mitigations



Torbay and South Devon
NHS Foundation Trust

Category	Detail	Recurrent/ Non-Recurrent	Month 2 YTD
			(Risks) / Mitigations
			£M
Plan			(4.7)
CIP	FYE Delivery risk on amber and red CIP schemes	R	(0.8)
CIP	In Year slippage on recurrent schemes	NR	(1.5)
CIP	Delivery on Non-Recurrent Schemes	NR	1.5
Elective Recovery	Capped ERF Delivery	NR	0.0
Elective Recovery	Loss of Activity due to EPR Implementation	NR	(0.9)
Other Plan Variances	Industrial Action - Costs	NR	(0.5)
Other Plan Variances	Industrial Action - Funding	NR	0.0
Other Plan Variances	High Cost Drugs - ICB Risk Share Proposal	NR	0.0
Other Plan Variances	High Cost Drugs - Negotiate full 12month gain share	NR	0.0
Other Plan Variances	Other Operational Budget and Reserves Underspends	R	1.7
Inflationary Pressures	Nurse Band 5 Job Profile Review Costs	R	0.0
Inflationary Pressures	Nurse Band 5 Job Profile Review Funding	R	0.0
Net Risks			(0.5)
Mitigations	Balancesheet Flexibility	NR	0.5
Mitigations	Unidentified Mitigations	NR	0.0
Mitigations			0.5
Plan Net Risk to Forecast			0.0
Outturn			(4.7)

	Net Non-Recurrent (Risk)/ Mitigation	NR	(0.9)
	Net Recurrent (Risk)/ Mitigation	R	0.9

Plan Underlying Deficit			
Forecast Recurrent Risk		R	0.9
Forecast Underlying Deficit			

Forecast Outturn				
Downside Risk	Difference Worst to Base Case	Base Case	Difference Best to Base Case	Upside Risk
(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations	(Risks) / Mitigations
£M	£M	£M	£M	£M
0.0	0.0	0.0	0.0	0.0
(6.0)	(3.0)	(3.0)	3.0	0.0
(9.1)	(4.6)	(4.6)	4.6	0.0
1.6	0.8	0.8	(0.8)	0.0
(1.3)	(1.3)	0.0	0.0	0.0
(4.5)	(2.0)	(2.5)	2.5	0.0
(1.2)	(0.7)	(0.5)	0.0	(0.5)
0.0	(0.5)	0.5	0.0	0.5
(2.0)	0.0	(2.0)	0.0	(2.0)
0.0	(2.0)	2.0	0.0	2.0
0.0	0.0	0.0	0.0	0.0
(5.0)	0.0	(5.0)	0.0	(5.0)
4.0	(1.0)	5.0	0.0	5.0
(23.6)	(14.3)	(9.3)	9.3	0.0
0.0	(1.0)	1.0	(1.0)	0.0
23.6	15.3	8.3	(8.3)	0.0
23.6	14.3	9.3	(9.3)	0.0
0.0	0.0	0.0	0.0	0.0
0.0	0.0	0.0	0.0	0.0

7.0	4.0	3.0	(3.0)	0.0
(7.0)	(4.0)	(3.0)	3.0	0.0

(65.0)	0.0	(65.0)	0.0	(65.0)
(7.0)	(4.0)	(3.0)	3.0	0.0
(72.0)	(4.0)	(68.0)	3.0	(65.0)

The Trust is forecasting achievement of the breakeven revenue plan but recognises forecast risks to delivery of £9.3m in the base case, with up to £23.6m in downside risk, with risk to the recurrent underlying position (£3.0m base case, £7.0m downside risk) reflecting non-recurrent issues with CIP slippage and EPR implementation not expected to impact the position recurrently.

The Trust will continue to work with operational leads, NHSE and the ICB to accelerate CIP delivery, refine forecast estimates and narrow the forecast range.

Further details of risks on following slide.

Action: Continue bi-monthly FDG meetings to maintain focus on accelerating plans through maturity and into delivery and resolve other emergent risks.

Action: Escalate High Cost Drugs Gain Share through Devon CFOs for urgent resolution.

Forecast Risks and Mitigations



Torbay and South Devon
NHS Foundation Trust

CIP Risk (base assumption £6.8m adv): The Trust recognises risk to plan delivery of between £0m and £13.6, with the most significant uncertainty being CIP delivery. At Month 2 25% of CIP schemes were still at low maturity levels, the downside risk is that none of these schemes deliver, driving a £13.6m variance to plan. The base case assumes that around 50% of these plans are brought to full maturity and delivery, with remaining risk of £6.8m and the upside assessment that all plans fully deliver.

Elective Recovery Risk – ERF Cap (base assumption £0.0m adv): The Trust operating plan includes £3.1m overperformance against contract ERF, including a risk provision against the EPR activity loss. The ICB has set a risk share on the contract that support variable overperformance on ERF up to the value in contract across the System (so any provider underperformance may be utilised to support other provider overperformance) and at 50% on any net overperformance up to a System cap of £5m. On a pro-rata basis if all providers overperformed to the level set out in the operating plan the Trust's share of income would be £1.8m, £1.3m below plan. The Trust base forecast assumes that the Trust can adjust RTT delivery plans to manage within this envelope, with downside risk that the full £1.3m income loss is realised.

Elective Recovery Risk – EPR Activity Loss (base assumption £2.5m adv): Data quality issues are preventing full assessment of contract activity and earnings, a provision was made against contract income in month 2 of £0.9m, however subsequent data suggests that activity may be c20% down on 2025-26 baselines, with associated loss of income at c£2.5m. This assessment is indicative only and rapid work is being undertaken to validate 'lost' and incomplete activity which may materially change this estimate. A down side risk of £4.5m assumes that income losses at this rate are ongoing for further periods.

Industrial Action Loss (base assumption £0.0m adv): Industrial action impacts of £0.5m were recognised in Month 1, downside risk forecast assumes sustained action with an impact similar to 2025-26, with costs of £1.2m and no national funding. The base case assumes that national funding is provided to meet cost impacts of industrial action (as it has for the previous few years).

High Cost Drugs £0.0m adv): The ICB has proposed a risk share on high cost drug switches that allows the Trust 50% of the gain for the first three months. Acute providers have CIP plans built on an initial agreement for full benefit for the first 12 months. The downside is a risk of £2m that the ICB will not honour the original agreement and the base case is that they will reinstate those terms to mitigate this risk.

Other Operational Budget Over/Underspends (base assumption £0.0m adv): The Trust's reserves and operational budgets are underspent in Month 2, the forecast assumes that once CIP delivery is transacted and reserves are drawn to identified cost pressures that delivery of underlying position will be neutral to plan.

Nurse Band 5 Job Profiles (base assumption £0.0m adv): The Trust's estimate to the cost of reviewing Band 5 nurse job profiles is £5.0m. National funding has been announced to meet these costs, but the allocation methodology has not been shared. The base case assumes that the job review costs can be contained within funding limits, with downside risk recognising that major pay change funding often falls short of full cost, especially if the allocation is based on income uplifts and Trust costs exceed income allocations.

Balance sheet Flex (base assumption £1.0m fav): The Trust has £2.0m NR contingency in balance sheet flexibility, of which £1.0m has been deployed to support the costs of voluntary redundancy. In the base case and downside risk forecast assumes deployment of the remaining balance to mitigate CIP delivery risk.

DSF (base assumption £0.0m adv): The Trust is forecasting on plan delivery, therefore no loss of DSF has been forecast, however it should be noted that NHSE have briefed that DSF will be withdrawn to the extent that the Trust does not deliver financial performance.

Forecast Bridge to Runrate



Torbay and South Devon
NHS Foundation Trust

Year to Date to Forecast Bridge	£M
YTD Surplus/(Deficit)	(4.7)
Adjust non-recurrent Industrial Action - Costs	0.5
Adjust non-Recurrent Industrial Action - Income	(0.5)
Adjust non-Recurrent Provision for EPR lost activity	0.9
Adjust other non-recurrent transactions	0.1
Recurrent YTD Surplus/(Deficit)	(3.7)
Recurrent Monthly Runrate	(1.8)
Recurrent runrate (M3-12)	(18.3)
Runrate Forecast Surplus / (Deficit)	(22.9)
CIP above runrate	33.9
Inflation	(2.9)
Investment	(9.2)
EPR income recovery	0.9
Other	0.2
Forecast Surplus / (Deficit)	(0.0)
Risk low maturity CIP delivery	(6.8)
Risk of EPR activity loss	(2.5)
Risk Adj Forecast Surplus / (Deficit)	(9.3)

Action: Trust will urgently identify and address key areas of contract income loss.

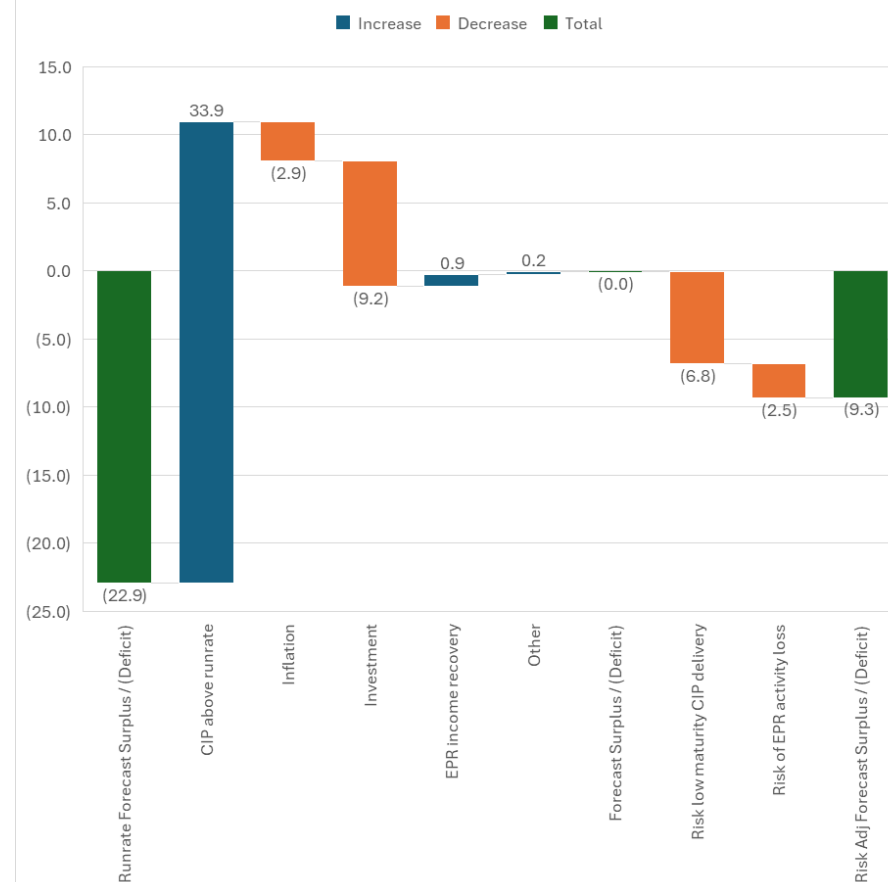
Action: Trust will prioritise planned investments to deliver contract activity and operational performance.

The Trust's detailed forecast for Month 2 reflects an expectation of full CIP plan delivery, commitment in full of all Trust reserve budgets for months 3-12 and recovery of income lost in EPR implementation phase up to full contract value to achieve breakeven.

This forecast requires runrate improvements of £2.29m per month in order to deliver a breakeven outturn, as well as restoration of lost activity.

Aligned to base case risks the Trust recognises risks to CIP delivery and full contract activity achievement of £9.3m, to give a base adjusted risk to forecast of £9.3m.

Bridge Runrate to Forecast Outturn and Risk Adjusted Forecast Outturn



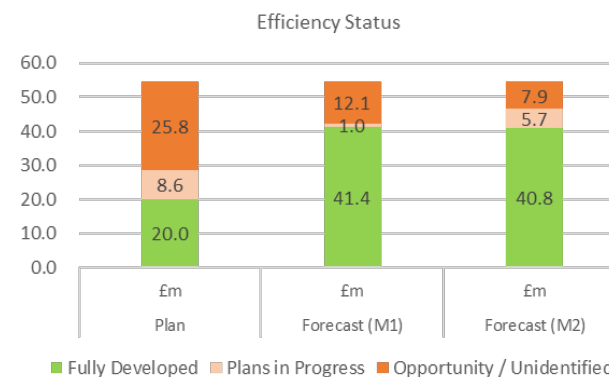
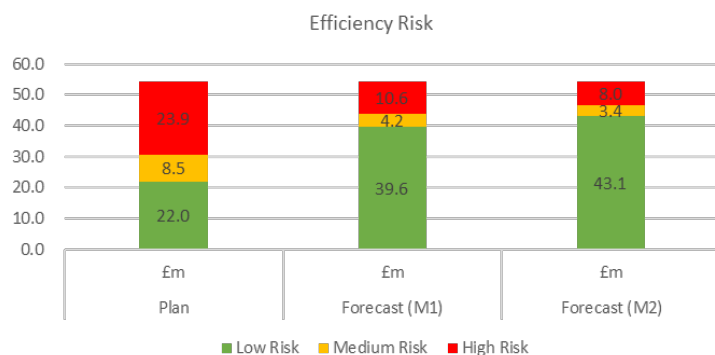
Efficiencies – Maturity and Risk



Torbay and South Devon
NHS Foundation Trust

	M2			Forecast Outturn		
	Plan CIP delivery £m	Actual CIP Delivery £m	Var +/- £m	Plan for the year £m	Forecast £m	Var +/- £m
Recurrent efficiencies	3.8	1.5	(2.3)	43.4	41.0	(2.4)
Non-recurrent efficiencies	0.4	1.9	1.5	11.0	13.4	2.4
Total	4.2	3.4	(0.8)	54.4	54.4	0.0
Recurrent %	91%	44%		80%	75%	
Non-recurrent %	9%	56%		20%	25%	

Year to date the Trust has recognised delivery of £3.4m against a £4.2m target (£0.8m adverse to plan). The Trust is forecasting full delivery of the £54.4m target.



Since the plan was submitted intensive work has been undertaken on developing the CIP plans. This has seen a material improvement in plan development and delivery risk assessment, fully developed plans have increased by £21.8m and low risk schemes have increased by £21.1m. Whilst good progress has been made there is **limited assurance** around delivering the full efficiency requirement due to c21% of plans still being medium / high risk.

Workforce Position



Torbay and South Devon
NHS Foundation Trust

	Year to date			Full Year			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	(0.0)	(0.0)	0.0	(0.2)	(0.2)	0.0	7	5	1
Pay - substantive	(60.3)	(59.5)	0.8	(355.7)	(352.3)	3.4	6,240	5,970	270
Pay - bank	(2.9)	(3.4)	(0.5)	(17.0)	(20.2)	(3.2)	258	309	(51)
Pay - agency	(0.7)	(0.8)	(0.1)	(4.1)	(4.7)	(0.6)	36	53	(18)
Grand Total	(63.9)	(63.8)	0.1	(377.0)	(377.3)	(0.3)	6,540	6,337	203

At the end of May 2026, there are 203 worked WTE less than plan. At Month 2, undelivered CIP is higher than plan (71 WTE), offset with vacancies, including growth reserves (99 WTE vacancy)

The year to date financial position is £0.1m below plan.

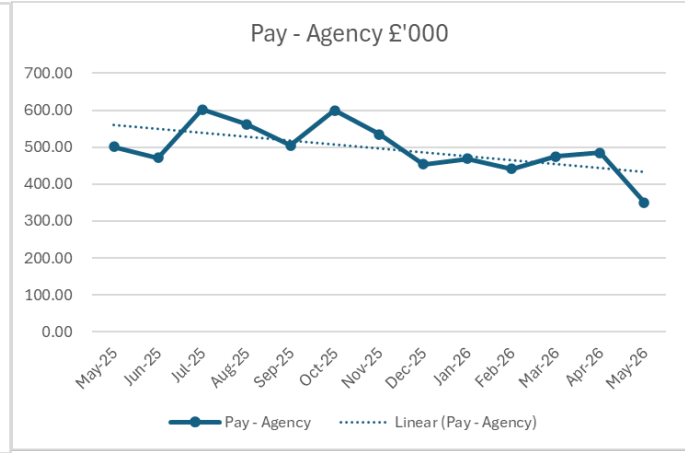
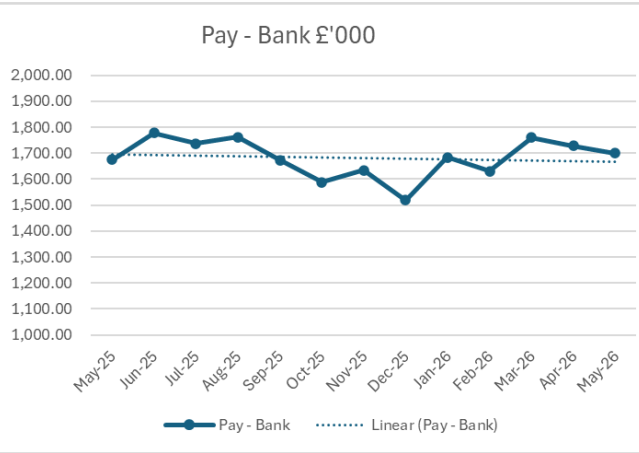
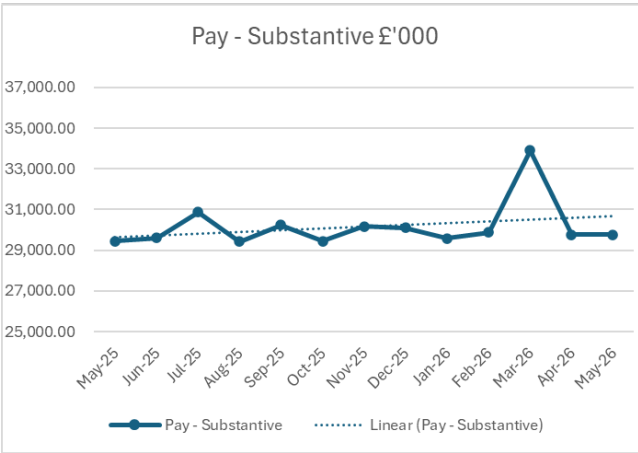
This is due to **£0.4m** Industrial Action costs not in plan, **£0.6m** under delivery of CIP, partially mitigated by net vacancies, including growth reserves (£1.3m)

WTE	Narrative
5,996	ESR Reported contracted WTE 31st May 26
53	Agency
309	Bank
129	Overtime and additional hours
(114)	Maternity and adoption leave
(35)	Sickness
6,337	Total reported worked WTEs 31st May 26

Workforce Trend

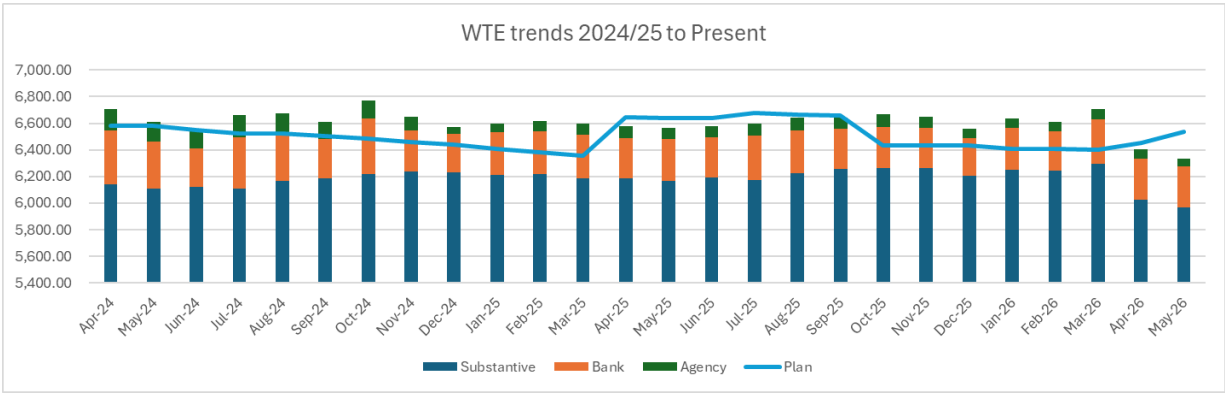


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Agency nursing spend has reduced significantly from Month 1 (and runrate), however the Trust remains above cap for both bank and agency spend.

Worked WTEs are significantly lower than 2025-26 averages due to transfer of CFHD.



Activity



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Elective Recovery Risk – EPR Activity Loss: Data quality issues are preventing full assessment of contract activity and earnings, as described in slide 9.

The table below shows the latest estimate of activity performance at Month 2, whilst data quality issues are being investigated and corrected.

The table below shows the main data issues identified, the impact and timeframe to investigate and resolve them.

2026/27 cumulative to M2 activity

Setting	% vs plan	% vs 25/26
Outpatient	78%	64% *
Day Case	79%	88%
Elective	70%	76%

*Planned outpatient activity reduction as a result of Epic implementation

No	Issue	Potential Impact	Team leading	Estimated timeframe to investigate&resolve
1	Clarity of what activity is Acute vs Community	Affects national reporting as each area requires a separate submission. Potential impact on activity and income reporting.	BI team	End of June
2	OP activity flagged as Outpatient without a clinic code	Need to understand if real activity and what dataset it should be reported against	BI and Epic teams	End of June
3	Activity where the TFC in Epic is different to the plan submission	Impact on comparison to plan and potential impact on activity and income reporting.	Finance and Ops teams	Updated view end of June-might be end of July before full impact is known.
4	Pathways missing activity due to Epic configuration	Activity is not being recorded in the same way as plan/previous year. Potential impact on activity and income reporting	Finance and Ops teams	Updated view end of June-might be end of July before full impact is known.
5	Potentially missing activity	Clinics providing activity in PAS cannot be matched in Epic. Need to check where activity is being recorded. Potential impact on activity and income reporting.	Finance and Ops teams	Updated view end of June-might be end of July before full impact is known.
6	OP procedures are not being recorded correctly	Potential impact on activity and income reporting as activity might just be recorded as a standard OP attendance.	Finance and Ops teams	Updated view end of June-might be end of July before full impact is known.

- It is estimated that 80% of outpatient clinic profiles have now returned to expected levels, following a planned reduction during Epic implementation. Operational teams are tracking performance and working to improve the performance % of clinics not back at expected levels.
- No planned impact on Day Case or Elective activity from Epic implementation was assumed. However, having 2 theatres out of action for Estates work is having a short-term impact and whilst some activity is being delivered in fallow slots in other theatres, the plan assumes this activity will be recovered by year end.
- Overall Waiting List size has increased in line with planned expectation. RTT is down to c60% against a target of 74% for March. The improvement challenge has increased from 7 to 14%. Further PTL and clock stop validation is being undertaken and up to 6,000 pathways are being reviewed.
- An activity and income schedule will be produced for Month 3 with known data issues flagged to show actual values.

Productivity



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NHS Foundation Trust

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. This will be updated for M3 with the latest information.

Productivity Metrics (national data) – M10 25/26 vs M10 24/25

M11	M11 2526 vs M11 2425
Inflation adj. expenditure growth	0.30%
Cost weighted activity growth	3.60%
Implied productivity growth	3.30%

- 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 11, implied productivity is improved from same period in 24/25 by 3.3%
- 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 underway as part of the refresh of the Trusts Improvement plan (Our Plan for Better Care). This is increasing focus on productivity and improving 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. Deep dive work is underway in T&O and initial conversations have started with emergency medicine.

Productivity



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Cost Type and Category	Cost Growth 2025/26 v 2019/20 Inflation Adjusted %	Acute Activity growth 2025/26 v 2019/20 %	Cost Growth Exceeding Activity growth %
Adult Social Care – Torbay	6.4%		6.4%
Children and Family Health Devon	0.8%		0.8%
Continuing Health Care	1.7%		1.7%
Pharmacy Manufacturing Unit	-2.9%		-2.9%
High Cost Drugs	2.3%		2.3%
GPST Gross Up	1.3%		1.3%
Exclusions for Implied Productivity	9.7%	0.0%	9.7%
Families & Communities	-0.6%	0.8%	-1.4%
Medicine and Urgent Care	3.0%	2.4%	0.6%
Planned Care and Surgery	2.2%	6.9%	-4.4%
Shared Corporate Services	1.5%		1.5%
CNST & Insurance	0.4%		0.4%
Pensions and Financing	1.6%		1.6%
Inclusions for Implied Productivity	8.1%	10.1%	-1.8%
Total Cost Growth	17.8%	10.1%	7.0%

The Trust has begun additional analysis to identify, at a specialty level, movements in productivity since in 2019-20.

Using a comparable methodology to NHS England the Trust has assessed a c7% loss of productivity taking account of increases in cost of 17.8% and increases in tariff activity of 10.1%*.

Of the total reported deterioration of 7%:

- 9.7% of the deterioration relates to costs which do not have a corresponding offset in expected acute activity (mainly Adult Social Care cost growth above inflation of 6.4%)
- The remaining cost and activity movements on acute and community contracts equates to a 1.8% improvement in productivity.

Action: The Trust will continue to validate and refine the analysis to identify productivity gains and losses at a specialty level.

*Note: this is the growth in spells and attendance volumes only, a further 13% growth in average tariff has been identified relating to increases in acuity and complexity in the period, which has not been included in this analysis, but is relevant as a reflection of increased demand for beds, intensity of need for care, diagnostics etc.



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Finance Plan Delivery - Capital and Cash

Cash Position



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CashFlow analysis

	Plan £m	Actual £m	Variance £m	Forecast Outturn £m
Opening cash balance	39.4	35.5	(3.9)	35.5
Operating surplus/(deficit) - excluding finance costs	(3.2)	(3.6)	(0.3)	7.2
Capital Non-Cash movements (depr&amort)	4.3	4.2	(0.0)	25.3
Working Capital Movement	(0.1)	(3.3)	(3.2)	(10.7)
Net cash generated from / (used in) operations	0.9	(2.7)	(3.6)	21.8
Net Capital Expenditure (Purchase/Disposals)	(23.5)	(7.5)	16.0	(38.5)
Interest Received	0.3	0.3	0.0	1.6
Net cash generated from/(used in) investing activities	(23.2)	(7.2)	16.0	(37.0)
PDC paid/received	4.7	0.0	(4.7)	(3.5)
Loans paid/received	(0.4)	(0.4)	0.0	(2.0)
Capital on finance leases and PFI	(0.7)	(0.7)	0.0	(5.0)
Interest element on loans, finance lease and PFI	(0.4)	(0.3)	0.0	(2.1)
Net cash generated from/(used in) financing activities	3.2	(1.5)	(4.7)	(12.6)
Closing cash balance	20.3	24.1	3.8	7.7

Cash Risk: Non-cash backed balance sheet releases and failures to meet CIP targets remain as potential risks. A 2026-27 payment schedule has yet to be received for Torbay council monthly income receipts of **£5m**. The M01 receipt was late and M02 has yet to be received. Discussions are taking place to resolve this uncertainty.

Action: Liaise with Torbay Council to resolve non-payment of M1-2 contract income.

The closing cash balance for M2 is £3.8m higher than plan, explained by:

- The opening cash balance variance of **£3.9m** at the start of the year reflecting the timing of payments to creditors.
- Net cash generated from operations shows a negative variance of **£3.6m** to plan, primarily due to non-receipt of the scheduled monthly contract income receipt from Torbay Council of **£5m**.
- Investing activities show a **£16.0m** variance, mainly reflecting the slower than planned settlement of capital accruals and creditors from 2025-26 capital programme.

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(3.6)
Finance income	0.3
Finance expense	(1.3)
PDC dividend expense	(1.0)
Other gains/(losses) including disposal of assets	(0.0)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(5.6)
Capital donations/grants/peppercorn lease I&E impact	0.1
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.8
TOTAL Provider Surplus/(Deficit) - System performance measure	(4.7)

Cash Forecast



Torbay and South Devon
NHS Foundation Trust

	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
Start Date 01.06.2026	£m	£m	£m	£m	£m	£m
Cash Balance B/F	23.9	25.2	13.2	21.6	15.5	8.9
Total Receipts	64.6	56.2	70.7	57.6	60.3	70.5
Total Payments	(63.2)	(68.2)	(62.3)	(63.7)	(66.9)	(63.1)
Net Movement	1.4	(12.0)	8.4	(6.1)	(6.6)	7.5
Cash Balance C/F	25.2	13.2	21.6	15.5	8.9	16.3

The Month 2 cashflow forecast has been prepared on the following basis:

- The forecast for M03 - M08 2026/27 is based on the agreed 2026/27 plan with a break-even position.
- 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 Month 2 Trust financial plan.
- This forecast assumes 100% of CIP is achieved.
- The forecast assumes that Deficit Support Funding (DSF) is not withdrawn at any time during this period.

Capital Programme and Funding Sources



Torbay and South Devon
NHS Foundation Trust

Gross capital expenditure	YTD M2			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Property, land and buildings	0.2	0.5	0.3	9.1	11.0	1.9
Plant and equipment	0.5	0.0	(0.4)	3.3	3.3	0.0
IT	2.5	1.4	(1.1)	9.0	9.0	0.0
Other	0.1	0.0	(0.1)	2.6	2.6	0.0
Disposals / other deductions	0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)
Gross capital expenditure	3.3	1.8	(1.4)	24.0	25.8	1.8
Less PFI capital (IFRIC12)			0.0	(0.7)	(0.7)	0.0
Gross capital expenditure (excl PFI/IFRIC12 impact)	3.3	1.8	(1.4)	23.3	25.1	1.8
Less grants, donations and peppercorn leases			0.0	(0.1)	(0.1)	0.0
Total CDEL (Including National PDC)	3.3	1.8	(1.4)	23.2	25.0	1.8
Total CDEL (Excluding National PDC)	3.3	1.8	(1.4)	23.2	25.0	1.8

Capital CDEL Limits	YTD M2			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Trust CDEL Limit	3.3	1.8	(1.4)	22.3	22.3	0.0
Trust Funded CDEL	3.3	1.8	(1.4)	22.3	22.3	0.0
National PDC: Community Diagnostics Centres	0.0	0.0	0.0	0.8	0.8	0.0
National PDC: Endoscopy	0.0	0.0	0.0	0.2	0.2	0.0
National PDC: Tower Fire Safety	0.0	0.0	0.0	0.0	1.8	1.8
National PDC Funded CDEL	0.0	0.0	0.0	0.9	2.7	1.8
Total CDEL	3.3	1.8	(1.4)	23.2	25.0	1.8

Capital Cash Sources	YTD M2			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
National PDC Funding	0.0	0.0	0.0	0.9	2.7	1.8
Capital Support PDC	0.0	0.0	0.0	1.1	1.1	0.0
Depreciation	4.3	4.2	(0.0)	25.3	25.3	0.0
Lease funding	0.1	0.0	(0.1)	3.6	2.0	(1.6)
Lease capital repayments	(0.5)	(0.5)	0.0	(3.1)	(3.1)	0.0
PFI Capital repayments	(0.2)	(0.2)	0.0	(1.9)	(1.9)	(0.0)
Repayment of Borrowing	(0.4)	(0.4)	0.0	(2.0)	(2.0)	0.0
Donations	0.0	(0.0)	(0.0)	0.1	0.1	0.0
Other	0.0	(1.3)	(1.3)	(0.1)	0.7	0.8
Total Funding Sources	3.3	1.8	(1.4)	24.0	25.0	0.9

Capital Spend Month 2

- At Month 2 the Trust has spent £1.8m of capital compared to plan of £3.3m, an underspend of £1.4m.
- The most significant variance was on EPR, with spend of £1.3m compared to plan of £2.4m, an underspend of £1.1m.

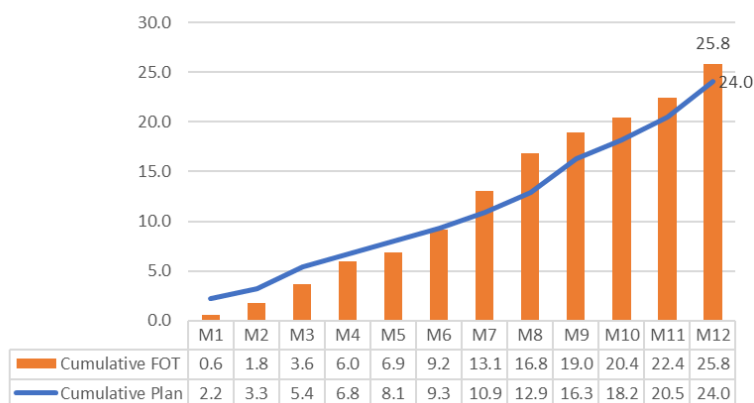
Capital Programme Forecast



Torbay and South Devon
NHS Foundation Trust

Monthly Profile	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Actual	0.6	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.8
Property, land and buildings	0.1	0.4											
Plant and equipment	0.0	0.0											
IT	0.6	0.9											
Other	(0.1)	0.0											
FOT	0.6	1.3	1.8	2.3	0.9	2.3	3.9	3.7	2.1	1.4	2.0	3.5	25.8
Property, land and buildings	(0.0)	0.3	0.6	1.2	0.8	1.7	3.1	3.6	0.4	1.0	1.7	3.1	17.4
Plant and equipment	0.0	0.0	0.1	0.2	0.0	0.2	0.7	0.1	1.6	0.1	0.0	0.0	3.0
IT	0.6	0.9	1.0	1.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	4.2
Other	0.0	0.0	0.1	0.0	0.0	0.3	0.0	0.0	0.0	0.3	0.3	0.3	1.1

2026/27 Cumulative Forecast Outturn vs. Plan (£m)



Capital Forecast

- The Trust's capital programme includes a cash requirement of £1.1m, for which an application will need to be made to NHSE Capital Team, with feedback regarding the success of the application expected around October.
- The Trust is forecasting to spend up to capital limits, subject of approval of the £1.1m capital cash support.
- The Trust has received confirmation of an additional £1.8m National PDC funding towards Tower Fire Safety.

Statement of Financial Position



Torbay and South Devon
NHS Foundation Trust

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	320.8	299.1	(21.7)
Other Non-Current Assets (Receivables)	4.0	4.2	0.2
Cash & Cash Equivalents	20.3	24.1	3.8
Working Capital (excl cash)	(47.6)	(51.3)	(3.7)
Non-Current Liabilities (Loans/Leases/Other)	(51.3)	(52.3)	(1.0)
Total Assets Employed (Assets + Liabilities)	246.3	223.8	(22.4)
Public Dividend Capital	360.7	359.5	(1.1)
Revaluation	60.7	54.8	(5.9)
Surplus / (Deficit) Sub Total	(5.4)	(5.6)	(0.2)
I&E reserves	(169.8)	(184.9)	(15.2)
Reserves Total	246.3	223.8	(22.4)

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(3.6)
Finance income	0.3
Finance expense	(1.3)
PDC dividend expense	(1.0)
Other gains/(losses) including disposal of assets	(0.0)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(5.6)
Capital donations/grants/peppercorn lease I&E impact	0.1
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.8
TOTAL Provider Surplus/(Deficit) - System performance measure	(4.7)

- Fixed assets are **£21.7m** below the plan. This is driven by the 2025/26 asset revaluation of **£18.3m**. The remaining variance reflects capital underspend YTD of £1.4m and movements in capital accruals.
- Cash has a positive variance of **£3.8m** above plan, offset with higher than planned working capital balances of **£3.7m**.
- The revaluation reserve movement of **£5.9m** relates to the DV asset revaluation of **£4.6m**, recognised through reserves, and the transfer of the cumulative revaluation surplus following the disposal of Dartmouth Hospital of £1.3m.
- PDC reflects an additional receipt of £3.5m system capital PDC funding for EPR allocated late in M12, which was not included in the planning return, offset by lower than planned revenue PDC support of £4.7m, giving a net variance **£1.1m**. I&E reserves variance of **£15.2m** reflects the DV PPE revaluation in 2025/26.



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Actions

Actions



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- Trust will continue bi-monthly FDG meetings to maintain focus on accelerating plans through maturity and into delivery and resolve other emergent risks.
- Trust will escalate High Cost Drugs gain share through Devon CFOs for urgent resolution.
- Trust will urgently identify and address key areas of contract income loss.
- Trust will prioritise planned investments to deliver contract activity and operational performance.
- The Trust will continue to validate and refine the analysis to identify productivity gains and losses at a specialty level.
- Trust will liaise with Torbay Council to resolve non-payment of M1-2 contract income.



Torbay South Devon NHS Foundation Trust

Post Live Summary

APPENDIX 1

OVERALL SUMMARY **Watch**

RECIPIENTS

To: Sam Wadham-Sharpe, Kevin Pirie, Jo Blackler, Mike Green, Richard Collins, Josh Langdon, Adrian Harris, Jason Scott
From: Ashwin Ramaswami (Technical Coordinator), Tara Kneller (Implementation Director)
Cc: Elias Stewart (Implementation Executive), David Taylor (Technical Coordinator)

OVERVIEW

Congratulations on a successful Epic Go-Live across the trust! The post-live visit - including the staff survey and Post-Live Stabilisation Assessment (PLSA) - provided an opportunity to step back from day-to-day stabilisation activity and take a more holistic view of how the organisation is functioning following go-live. The visit is timed early in the post-live stabilisation period, allowing us to capture end-user experiences while staff are still becoming familiar with the system and when training, adoption, and workflow interventions can have the greatest impact.

Based on our observations, review of relevant metrics, and comparison with other Epic implementations, we assess the organisation **overall at a watch status**. This rating is driven primarily by pockets of dissatisfaction among key user groups (*notably cancer care, some SDEC areas, and SSPAU*), several high-impact metrics that have not yet returned to baselines (including select outpatient activity measures and cancer performance), personalisation/proficiency data, and lack of a confirmed long term governance plan.

ISSUES NEEDING EXECUTIVE INTERVENTION

Cancer Performance and Outpatient Activity Stabilisation

Cancer 62-day PTL volume remains significantly above baseline and has not begun to decrease at a rate that will enable TSD to meet national recovery commitments. 28-day Faster Diagnosis Standard compliance decreased significantly in April and May as expected and is not on track to recover by June as originally committed to NHS-England. Inability to return to baselines may impact Plymouth's go-live approval by NHS-E. The primary cause is reduced activity during and following the go-live.

Noable at risk specialties with activity below baseline affecting cancer performance:

- **Dermatology** - First attendances at 70% of the 26-27 target (156/224 for w/c 18 May) with a cumulative deficit of ~736 new patient appointments since go-live; follow-ups significantly behind at 45% (147/325) with ~1,243 outstanding. The service indicates that the gap is primarily operational (staffing) and locum shifts are being filled to tackle the backlog, though an EPR team review also identified order default and note template improvement opportunities to support clinician efficiency as capacity is restored.
- **Gynaecology** - First attendances at 64% of the 26-27 target (98/154 for w/c 18 May) with a cumulative deficit of ~425 new patient appointments since go-live; follow-ups have recovered but ~71 remain outstanding. Schedules still running below pre-live capacity due to staffing concerns; a department restructure and surgical waiting list review underway.
- **Urology** - First attendances remain below the 26-27 target at 62% (53/85 for w/c 18 May) with a cumulative deficit of approximately 294 reduced new patient appointments since go-live; follow-ups have recently recovered but carry a backlog of roughly 216 reduced attendances from the initial post-go-live weeks.

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



Torbay South Devon NHS Foundation Trust

Post Live Summary

ISSUES NEEDING EXECUTIVE OVERSIGHT

Long Term EPR Governance

One Devon has not yet finalised and communicated the long term governance arrangements. It is important that this is agreed by the end of June to enable communication to staff across TSD, UHP and RDUH on the process and to set expectations for how projects will be prioritised. We recommend that the long term governance model is agreed by 30 June and communicated to staff across Devon ahead of the UHP go-live.

User Satisfaction – Cancer Care

TSD has retained Bookwise Duo as a parallel scheduling system alongside Epic in infusion areas, causing patient safety and operational challenges - patients are receiving conflicting appointment reminders, arriving without booked Epic appointments, and medication preparation is being delayed because pharmacy cannot rely on Epic reports alone. Given the severity of these issues, you approved an expedited implementation of Epic functionality called the 'Infusion Template Generator' for TSD to remove the dual-booking solution ahead of the UHP 23 July 2026 go-live.

STAFF SURVEY RESULTS

Before our visit, we conducted a survey of your staff who use Epic to assess their satisfaction with the system and identify key areas for further investigation. The results indicate an overall satisfaction rating of 5 out of 10 (392 respondents) which is near the top of Epic UK implementations at this stage post live. Notable areas of success include response times, system support, and preference compared to previous systems. **Ongoing training** and **in-system reporting** are areas in which staff are looking for additional support. User groups who expressed the most dissatisfaction with their workflows based on survey results includes outpatient nurses, clinical nurse specialists, and ophthalmology staff.

Question	Torbay South Devon Avg. Score	Epic UK Go-Live Median Score	Epic UK Percentile
Number of respondents	392	-	-
Overall, I am satisfied with Epic.	5	4	71%
Epic is easy to use, and designed for my needs.	5	4	76%
Epic is making things easier for me in my day-to-day job	4	4	50%
I prefer Epic to our previous system.	5	3	86%
Epic has helped us maintain or improve upon the quality of patient care.	4	3	60%
The response time of the system (screen loading times, processing times, etc.) is satisfactory.	8	7	87%
I feel supported in my use of Epic by the EPR Programme	5	4	93%
The training and readiness activities I received helps me do my job.	2	2	50%
I am able to appropriately take action from reports in Epic.	4	4	50%

Questions are answered on a 0-10 point scale from Strongly Disagree - Strongly Agree, with 5 being 'neither agree nor disagree'

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



Torbay South Devon NHS Foundation Trust

Post Live Summary

SUCCESS CRITERIA		
Criteria	Status	Comments
Long-term operational governance stood up and effective		See Areas Needing Executive Oversight
Operational Performance & Reporting is stable		See Areas Needing Executive Intervention
MyChart Activation		Current Activation Rate: 32% with ~2% monthly growth Target: -60% (in April 2027)
Thrive Training program established		Planned to start on 17 August following the UHP go-live. Registration will open on 8 June. Thrive provides post live education and focusees on personalisation and efficiency tools
Clinicians completed personalisation		Basic: 75% complete, Advanced: 14% completed <i>Note: Midwives are included and only 20% have completed basic personalisation</i>
Executives have reports they need and visualise data in Epic		COO and care group directors are using Epic dashboards. CNO/CMO are starting to explore using Epic, but further scoping is required to
Login experience meets approved design		Login setup is quick for users and follows the One Devon standard
End User Devices		98% of devices passed TDR and the end user devices team quickly delivered additional requirements as they've arisen post go-live
Technical Stability		No major technical incidents at Torbay, resilient network design is working well and the first Epic planned downtime was non-disruptive.
Business Continuity		BCA PCs fully deployed and appropriate downtime reports available on >95% of machines with remaining gaps being resolved by Nursing IOs.

ACTIVITY & PERFORMANCE STABILISATION				
Metric	Status	Current Value	Baseline/Goal	Comments
ED 4 Hour Performance (Type 1)		49%	55%	Initial drop in performance is within expected guardrails given users learning new workflows and processes. Rates have stabilised and been gradually increasing.
RTT PTL Volume & Performance		Volume: 34,718 Performance: 62.42%	Volume: 35,507 Performance: 62.42%	Volume has continued to increase longer than anticipated due to reduced activity but remains below projection for EOM May.
Diagnostic PTL Volume & Performance (excluding Imaging)		Volume: 2,421 Performance: 79.18%	Volume: 1,810 Performance: 79.00%	Volume is stabilising but continues to increase due to reduced activity and remains significantly above baseline.
Cancer PTL Volume & 62 Day Performance		Volume: 3,547 Performance: 91.40%	Volume: 2,449 Performance: 91.47%	Volume is stabilising but continues to increase due to reduced activity and remains significantly above baseline.

STATUS KEY							
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



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Clinical and Operational KPIs				
Metric	Status	Current Value	Baseline/ Goal	Comments
Barcode Medication Administration (BCMA)		82%	80%	Value for combined patient and medication scanning. The current value is the month to date value on the 26 th of May.
Essential Birth Documentation		91%	90%	All births from 3 April to 26 May 2026.
Admission Medication Reconciliation		39%	80%	80% target exceeds all current UK sites – improvement here would assist with drug interactions and clinician efficiency as well as support faster discharge med rec.
Discharge Medication Reconciliation		84%	90%	Growth of ~1% per week
Expected Date of Discharge (EDD) Accuracy		36%	40%	TSD is performing slightly better than NDH and RDE over the last month with EDD accuracy. EDDs should be reviewed, discussed, and updated daily during board rounds.
Outpatient visits outcomed and closed within 7 days		94%	>95%	Operational teams should focus on these specialties with the >50 open encounters more than 7 days old: Nephology, Respiratory Medicine, Cardiology, and Paediatrics. The services most affected are found on the Activity Stabilisation Lead Indicators Dashboard.
Main dispensary TTO processing time (avg)		168 minutes	120 minutes	TSD dispensary recently implemented a new workflow for initial review and expect this number to come down further over June toward baseline
Theatre Utilisation		68%	80%	TSD is already performing better than RD&E and NDH. The baseline of 80% is baseline for Epic sites and can be adjusted to reflect their goals if needed.
Community 2-Hour Admission Avoidance Compliance (Urgent Care Response)		88%	>95%	Lower compliance is partially due to confusion with the nursing UCR referral workflow rather than missed responses. The Home Care team is actively working on a streamlined process. To note, Torbay teams didn't previously report on Nursing UCR activity.

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



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AREA STATUS						
CLINICALS						
EMERGENCY SERVICES	INPATIENT WORKFLOWS (GENERAL)	DOCTORS	CANCER CARE	AHPs	AMU	GYNAECOLOGY
MATERNITY	INFECTION CONTROL	DAY CASE (NON-SURGICAL)	ICU	RESEARCH	OPHTHALMOLOGY	DERMATOLOGY
OMFS/ ORTHODONTICS						
ANCILLARY & PROCEDURAL						
ANAESTHESIA	THEATRES	ENDOSCOPY	RADIOLOGY	PHARMACY	CARDIOLOGY	PATHOLOGY
PHLEBOTOMY & DAs	BLOOD TRANSFUSION LAB	VIRTUAL WARD				
COMMUNITY						
SLT	COMMUNITY NURSING	COMMUNITY THERAPY	COMMUNITY IC/UCR	0-19 TORBAY	NEUROREHAB	COMMUNITY PHARMACY
ACCESS, ACTIVITY, AND OPERATIONS						
HOSPITAL LOGISTICS (HOUSEKEEPING AND PORTERING)	PATIENT FLOW & DISCHARGE	BOOKING	REPORTING	ACTIVITY & FINANCE	CODING	MEDICAL RECORDS
PERFORMANCE / VALIDATION	CANCER PERFORMANCE					
PATIENT EXPERIENCE AND TRAINING						
MYCHART AND WELCOME	TRAINING					
STATUS KEY						
Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved
					N/A	



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CLINICALS		
AREA	SUCSESSES & ACTION ITEMS	
EMERGENCY SERVICES 	<i>Successes</i>	• Workflow Efficiency - Staff report strong satisfaction and tangible day-to-day efficiencies: remote access to records, secure chat between nursing and medical staff, and orders completed from a single location. • Four Hour Breach - The four-hour breach rate is 3-4% below legacy figures and continues to improve. • Venous Blood Gas ordering at triage has been actively reduced, removing clinically unnecessary tests and is generating quantifiable cost saving benefits.
	<i>Action Items</i>	• Sepsis Alerting - ASAP team to engage Clin Doc to review and adjust sepsis alert sensitivity and raise a ticket to suppress automated observation requests for palliative and end-of-life patients. • Bed Management - ASAP team to communicate to bed managers and SRU about workflow for bed rejection and patient destination update process. • ED Performance Metrics - ASAP and operational leads to agree internal ED metrics for post-go-live performance measurement, focusing on clinician-level touchpoints such as time from assigned clinician to referral and time from physician encounter start to disposition.
	<i>Optimisation</i>	• Physician Builder Programme - Confirm the physician builder training strategy. • GP Discharge Letters - develop a departmental SmartPhrase for GP discharge letters using SmartLinks to pull in relevant results automatically and reduce clicks. • MyChart Instant Activation in ED - Investigate MyChart instant activation on arrival via SMS or email and add a sign-up prompt to the ED registration workspace (Sherlock 11309301). • Ambient Technology - Pursue ambient AI solutions across Devon for ED users to reduce documentation and improve clinical efficiency.
INPATIENT WORKFLOWS 	<i>Successes</i>	• Go-live safety metrics are well within targets across all visited wards. Barcode medication scanning compliance rates remain significantly above UK Epic Go-Live averages with patient scanning at 94% and medication scanning at 84%. • System Confidence - Team culture in the CCU is highly supportive, making use of user-driven tip-sharing messaging groups. This has boosted both learning pace and confidence in the system across the unit. • Overall, inpatient doctors are happy with key inpatient workflows. See more inpatient doctor items within the 'doctor' section below.
	<i>Action Items</i>	• Discharge Med Rec - Clin Doc team to work with Orders and IOs to reinforce discharge med checks in areas which are lagging, as this has downstream impacts on pharmacy and is causing discharge delays. • Rover adoption is lower than expected due to users' lack of confidence using the devices, and lack of confidence in application functionality. Patient monitoring device integration issues at go-live were perceived by end users to be Rover related. This has since been resolved, and confidence in Rovers must be reinforced through NIO engagement.

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 DOCTORS		• Secure Chat - Clin Doc team to work with Orders and NIOs to reinforce appropriate usage of Secure Chat between nursing and surgical/medical staff.
	Optimisation	• Med Supply Checks - Allerton Ward do not have ward supplied meds, so the ward supply check is not an applicable, yet required, task for nurses. Clin Doc team to investigate configuration options to exempt Allerton (and similar wards) from these tasks. • VIP Scores - Ward nurses identified opportunities for improvement in accessibility of VIP score catheter assessments. Clin Doc team to explore options to improve assessment visibility.
	Successes	• Doctor Workflows - Doctors were mostly happy with Epic. Many of the issues they ran into were workflow-related; once they had the education to understand how to do their workflows correctly, they were able to resolve many of their issues. The doctor-related metrics are mostly green, indicating proper usage of the system and the completion of essential workflows
 CANCER CARE	Action Items	• Discharge Letters - Doctors are struggling to complete discharge letters in a timely manner, especially in SDEC departments. The Orders, HIM, ClinDoc, and ASAP EPR teams are working together to streamline this workflow and ensure only the patients who need a discharge letter are listed as missing their letters. This will improve trust in the system from end users and make it clear when a ward is missing letters from recently discharged patients. • SDEC Workflows - Many issues reported from end users were related to needing education on the correct workflows. This was especially common in SDEC, community hospitals, or virtual wards where users may be doing workflows that would normally not be in scope for "normal" inpatient doctors. The team has been helping to facilitate conversations to determine best practice for these users.
	Optimisation	• General Medicine Specialty - There are many references in the system to "General Medicine", which is not a specialty used at TSD. This has led to some confusion and should be updated for clarity. • Subspecialty Level Data - Operational leadership would like to be able to look at metrics on a subspecialty-level to narrow down the scope and help determine which specific groups are struggling with doctor workflows. The Orders team can work on these requests for specific metrics.
 CANCER CARE	Successes	• Electronic home prescriptions. Paperless multi-cycle oral chemotherapy prescribing was reported as a significant improvement over previous workflow. Paperless TTAs were also reported from the day unit as a notable benefit. • Timely letters were reported by both consultants and medical secretaries as an efficiency gained with Epic. • MDT functioning has benefitted from an integrated system across specialties and trusts, with clinicians citing consolidated access to results and inputs as a clear step forward.
	Action Items	• Transition day-case infusion scheduling to be fully within Epic. The current process for maintaining appointments in two systems is unsustainable. Efficiencies that either system might provide are undermined by the extra work required to keep the two in sync. Observed inefficiencies include:

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		○ 2x Additional Admin FTE staff required to compare Bookwise and Epic full time. This lowers the admin team's capacity to prepare for new appointment requests. ○ Out of date demographic information in Bookwise leading to incorrect telephone numbers and even deceased patients appearing. ○ Day unit nurses modifying ~20% of appointments each day to resolve discrepancies. Using Bookwise as their source of truth risks missing treatment deferrals or other clinical actions taken in Epic. ○ Pharmacy is unable to reliably use reports and appointments in Epic to complete screening and dispensing. This makes it difficult to identify potential efficiencies within Epic and carries the same risk as nursing that clinical changes to treatment planning might be missed. On the morning we visited, two patients had already arrived at Ricky Grant without an appointment in Epic. With this being a regular occurrence, the dual booking systems are very likely leading to delays in patient care. ● Next Steps (Sherlock 11280578) ○ Amy Coates to make Bookwise read-only for non-admin staff. ○ Charlotte Smith to educate nurses on correct Epic workflows including treatment day deferral, creating ad-hoc visit requests, and completing nursing pod assignments in Snapboard. ○ Sarah Reed/David Wilson to develop a plan to adopt Epic's advanced infusion scheduling tools - the Infusion Template Generator and Visit Assignment Wizard. We expect the features within these to be required for nurses to be fully satisfied with a move to just Epic. ● With proper planning, Epic can potentially provide application build resources at no cost through a Level Up programme.
	Optimisation	● FTT Form Updates – The form should be changed to use date-based entry for IV. Later optimisations to strongly consider are separate statuses per treatment plan type, and using the IT Chemo form to indicate IT Chemo fit to treat (Sherlock 11140990). ● Separate the haem/onc waiting list workqueue into SACT and non-SACT queues - One list for the entire specialty is creating filtering challenges where SACT admins and medical secretaries are inappropriately modifying requests meant for the other group, and the volume of requests making it harder to identify duplicates. To properly optimise, appointment request orders will require more advanced logic to require clinic code entry in some cases. ● Replace Therapy Plans with Supportive Care plans for recurring haem/onc supportive care. Supportive Care plans have the same structure as Treatment Plans, which cancer clinicians are familiar and comfortable with. Their discrete day structure makes planning, preparing, and adjusting future treatments easier and more intuitive, especially when aligning with SACT treatment.

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ALLIED HEALTH PROFESSIONALS (AHPs) 	Successes	Dietetics: Staff remarked positively on notes, letters, and follow-ups functionalities, and reported satisfaction with user-level customisation via SmartTool adoption. Trauma & Ortho: Strong enthusiasm for cross-site record access, legible notes, SmartPhrases, and Secure Chat. Referrals described as easy.
	Action Items	Issue Reporting and Escalation - IOs to work with AHP leadership to establish a regular meeting and/or practice for formalising Epic requests and escalation paths. The absence of (or lack of awareness around) these processes was found to be a pattern across teams. Reporting Tools - Clin Doc team to work with Cogito to equip Dietetics with Epic reporting tools. Dietetics feel that this could elevate their work and provide key performance and safety insights. - Speech & Language therapists are struggling in various areas including navigator assessment content, receipt of inappropriate patient referrals, and process standards. Oscar Fisher-Smith to submit tickets for these requests for Clin Doc team to evaluate and track operational adoption.
	Optimisation	Tip sheets should be created and user education options to be expanded to reinforce workflow expectations. . AHP Reports requiring custom build may fall to the optimisation queue depending on patient care impact and build complexity.
AMU 	Successes	Track Boards - A fix was deployed post go-live to correct track board status logic, ensuring patients remain in awaiting triage status until triage is fully complete. Triage Plan Data - Baseline EXETER triage plan conversion data is now available, providing an initial split between admit-to-AMU and admit-to-SDEC outcomes to inform future patient class configuration decisions.
	Action Items	Patient Class Documentation - ASAP team to work with Grand Central to assess the best approach for prompting users to set the appropriate patient class at the right point in the workflow. General Medicine Specialty - ASAP team to work with end users to remove general medicine from the posting order options and communicate correct specialty attribution to all AMU clinical staff; brief coding and informatics colleagues on FCE reporting implications. OOH Triage Hub - ASAP team to confirm and document the correct process for ED staff handling out-of-hours triage hub admissions, including cancellation of the AMU pre-admission entry.
	Optimisation	Discharge Summary Backlog - Identify quick wins to reduce the discharge summary backlog and establish a sustainable SOP to prevent recurrence. OOH Discharge Management - Explore assigning a named AMU consultant per day on a rota basis to improve admission attribution and discharge summary ownership for out-of-hours arrivals. Legacy Triage List - Work through legacy triage expected list entries and establish a process to keep the list clean going forward.

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					N/A		



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GYNAECOLOGY 	Successes	Ad-hoc reportable workflows – Users have embraced the ad-hoc COSD and Colposcopy reportable workflows built and clinicians are successfully documenting required reportable elements built into SmartForm tools.
	Action Items	Proforma Build – Justin Chapman will build out critical proforma build (such as PMB) by 26 June. ATE support – Justin to help facilitate thrive sessions to increase consultant efficiency of documenting RTTs, placing orders, and adding visit diagnoses by the end of June.
	Optimisation	Colposcopy Waiting List – Justin and the Springboard team will explore splitting out Colposcopy to a separate department and waiting list to clarify management of these screenings. Gynae History SmartLink – Justin will build SmartLink that will pull in Gynae history by the end of June.
MATERNITY 	Successes	Whiteboard Usage - The Epic whiteboard is actively used and loved, with staff expressing how attached they already felt to it! This has significantly reduced time needed for manual board updates and has increased patient status visibility. Improved Real Time Documentation - Maternity users find that Epic is reinforcing real-time documentation practice, which is a positive change. This was noted to have previously been impossible to audit on paper documentation.
	Action Items	Patient Messaging - Stork team and MyChart to establish/clarify both policy and build solutions surrounding patient messaging. Patients are currently messaging about urgent issues despite an explicit warning in MyChart not to do so. Badgernet Tool Access - Nursery nurses reported missing access to certain Badgernet abstraction tools. Stork team to work with Users and Security to ensure access is updated for affected users. Workspace Consistency - Users are seeing different workspace configurations when caring for the same patient depending on the patient's location, resulting in inconsistent views when navigating the chart. The Stork team will revise workspace build to minimise disparities.
	Optimisation	Whiteboard Display - Midwives have requested to display babies directly under their mothers on the Epic whiteboard for ease of viewing. Stork team to investigate configuration options. Epic Monitor - Stork team to reconfigure the Epic monitor to display babies regardless of their location. Babies are often with their mothers in neighbouring wards, but still under SCBU care.
INFECTION CONTROL 	Successes	Overall Happiness - The infection control team is happy with Epic and excited to use the reporting tools. Infection Data - The Orders team has completed build to upload infection data from Epic and send it to their required government reporting systems. This is brand-new functionality that was set up by the analyst team to simplify these reporting workflows. Previously, the infection prevention control team had to manually input this data, so this will be a major time-saving opportunity.
	Action Items	IPC Reporting - The Orders team should continue to work with the infection control team to ensure the reporting workflows work successfully.

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DAY CASE AREAS (Non-Surgical) 	Optimisation	• Bugsy Functionality - The infection control team does not have access to full Bugsy functionality because they also have a third-party system for their infection control workflows, ICNet. In the future, look into the feasibility of moving completely from ICNet to Epic for these workflows. This would simplify the workflow for the team as they'd only need to access one system to complete their work.
	Successes	• Letters workflow optimisation – Users in the MAAT were advised on letter-writing efficiency enhancements such as personalised letter templates and routing drafts to themselves when they need to return to update information in the letter prior to sending.
	Action Items	• SSPAU Workflow Improvement - SSPAU is struggling with workflows in Epic. Since they can have emergency, inpatient, outpatient, or day case patients, there are multiple ways to do many workflows, which can lead to confusion when there isn't a consistent way across the ward to work. Epic met with SSPAU users while onsite to provide education on these workflows to determine the best next steps. ASAP is working on making some changes to their build to allow users to see the necessary information in two activities, rather than needing to check multiple different activities.
ICU 	Optimisation	• Referral triage layer – Stuart Marks and Nattie Maynard to investigate feasibility of building a referral triage workflow for MAAT so that services can be appropriately rejected by 26 June. • Warfarin / Anti-coagulation information – Nattie to add warfarin/anticoagulation information to the Snapshot report available in the MAAT by 26 June.
	Successes	• ICU Engagement - The ICU team reflect positively on having a dedicated workgroup during implementation. This acted as a clear and accessible feedback path and resulted in the Clin Doc team more effectively aligning the ICU workspace with ICU needs. • Cross-Devon ICU collaboration was valued and productive and increased buy-in for cross-trust governance. We recommend regular collaboration of clinical teams across trusts to align expectations and requests.
	Action Items	• NEWS2 Score - Users expressed confusion around how to generate a NEWS2 score and safety leads expressed concern over incomplete observation documentation. Clin Doc team met to discuss configuration options to improve workflow clarity for vitals documentation. CMs will bring the proposed changes to the appropriate teams for approval. • Quick Release Report - ICU staff note that the Quick Release Report should be reviewed for efficiency improvements. Clin Doc to continue working with the ICU team via Service Desk (IN3239179) to streamline the report. • Pharmacy Med Verification - Several meds required pharmacy verification before printing labels (IN3238199), which is not appropriate in ICU. Clin Doc team to work with Willow to ensure there is a process for evaluating similar issues globally rather than per-medication.

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					N/A		



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RESEARCH	Optimisation	• ICNARC abstraction data accuracy – The ICU team noted inaccuracies in ICNARC chart abstraction, acknowledging that this is due to inaccurate documentation rather than configuration issues in Epic. The Clin Doc team to explore guardrails to reduce inaccuracies and work with IOs to reinforce the importance of accurate documentation. • Fluid Documentation - Knowledge gaps around ongoing fluid documentation results in inaccuracies on patient's charts. The Clin Doc team are working with IOs and trainers to share tipsheets and eLearnings to improve workflow adoption, and heavily impacted teams (such as ICU) have received additional support.
	Successes	• Recruitment Tools: Research Data Managers personalised reports to aid recruitment for studies with challenging recruitment targets. Increasing usage of these tools will increase satisfaction with Epic long-term. • Research Digital Role: During the implementation, Torbay received a grant to create a Research digital lead role that will facilitate study content build to increase recruitment and facilitate study start up within the 30-day national requirement. This will enable One Devon to take advantage of more research functionality and implement strong governance and clinical standards.
	Action Items	• Research Result Review: Principal Investigators (PIs) need to review results to remain GCP compliant. Michelle Vershoren will configure research results review by 19 June so that PIs can review results and indicate the significance for the study (Sherlock 1128064). • Workflow Clarification and Adherence: Research teams raised questions about Snapboard personalisation, cancelling blood tests, SlicerDicer, and scheduling. Gemma Williams will follow up with research super users by 12 June to provide answers and build confidence in these workflows.
OPHTHALMOLOGY	Optimisation	• Data Capture Forms: After UHP goes live, the research EPR team will begin building research data capture forms so that research nurses can complete these electronically. • Interface with EDGE: Torbay should consider an interface with EDGE and Epic for studies and enrollments to avoid double documentation.
	Successes	• Integrated Patient Record – Users are appreciative of access to the full patient record, reducing documentation time and sparing the patient from having to re-answer the same questions.
	Action Items	• Code Capture – Stuart Marks to review OPCS codes linked to Ophthalmology procedures and ensure that all procedures are capturing services by 5 June. • Virtual Review –TSD will move to a more streamlined one-visit workflow for Virtual Reviews, Stu Marks will work to update outpatients related build along with the Springboard team by 12 June.
	Optimisation	• LogMAR v. Snellen – Stuart to review settings for Visual Acuity (VA) print groups in ophthalmology reports to ensure that these depict the graphs in the most useful manner to the clinicians by 26 June.

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					N/A		



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		Injection Laterality – Stuart will review iProc build to identify situations where injection laterality can be defaulted in, reducing clicks in the administration workflow by 26 June.
DERMATOLOGY 	Successes	SmartTools and macros – Users report that SmartTools and procedure documentation macros have saved them time during documentation.
	Action Items	Patient Filtering - Nattie Maynard to add an order-specific question to the dermatology procedure orders to improve the quality of filtering at risk patients in Waiting List Workqueues. Natalya will also work with the Dermatology team to outline what other criteria they would like to filter patients on. Outcome Selection – Natalya to work with the Springboard team to provide education around selecting outcomes by 26 June.
	Optimisation	Risk Scores – Nattie to work with David Wilson to explore the possibility of adding a risk score for patients, based on expected date, type of diagnosis, and a variety of other patient related factors. This risk score can be displayed as a column in the Workqueue to improve the filtering.
OMFS / ORTHODONTICS 	Successes	Documentation efficiency – Users are proficiently using SmartTools, letter templates, and macros to simplify and streamline their documentation and are sharing them amongst each other. We even build a few of these together during the session. Schedule customisation – We showed users how to add clinical comments to their provider schedule, saving them up to an hour a day of searching through the chart for the information.
	Action Items	Streamlining cross-specialty short-notice appointment requests – Abdul – Manan Alhassan to ensure that the appt request/follow-up orders for OFMS, orthodontics, and restorative dentistry are available to each other to simplify the process of quickly scheduling a visit with another specialist in the department by 19 June. Additionally, these appointment requests should be enabled for Order Up to XXXX. Update middle-grade orders authorising security – Abdul to work with the Users and Security EPR team to ensure middle-grades can authorise x-rays so that they can properly receive and review results for these orders by 12 June.
	Optimisation	Recipient button for letters sent to General Dental Practitioner (GDP) – Abdul will investigate whether it's possible to deploy a button for the patient's GDP in the Communication navigator so that letters can easily be routed to these providers by 26 June.

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					N/A		



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ANCILLARY, PROCEDURAL, COMMUNITY

ROLE		SUCCESSIONS & ACTION ITEMS					
ANAESTHESIA 	Successes	Pre-op, intra-op and ordering workflows are running well — Mary Stocker explicitly called out these three areas as smooth, which is a meaningful endorsement from the Anaesthesia MIO at the 6-week mark.					
	Action Items	PAIN1 outpatient ordering - Order is missing from outpatient preference lists, forcing users to navigate outside the clinic navigator to place the request.-Ali Phillips will update the preference list by 30 June (Sherlock 11298617). POA build - A handful of related behaviors are eroding POA satisfaction - the Prep for Surgery order is not on the facility preference list, the perioperative Clinician does not display on the POA Status Tracking report, POA site suitability selection should be single-select, and the hospital number is missing from POA Tracking Dashboard reports. Ali Phillips will update all by 30 June (Sherlock 10753850). Isolated Clinician Happiness – Mark Human, an anaesthetist, is unhappy coming into work since go-live due to lack of comfort with the system. Mike Potter will shadow Mark's pain or dental clinic list and deliver workflow personalisation, navigator reorganisation, and train Mark to personalise using SmartTools by 30 June.					
	Optimisation	NELA chart abstraction toolkit - Anaesthetists are documenting in fields that surgeons are responsible for. Ocean informed Greg Warren of the Chart Abstraction Toolkit to reduce duplicative data entry by auto populating from the surgical chart. Mike Potter to determine which workflow changes are required by 31 July (Sherlock 11298747). Work Effort: Medium. Remove visit taskbar from POA appointments - POA appointments don't require signing the encounter and appointments auto-check-out overnight. Sophie Bonner will remove the Sign Encounter button for POA appointments by 30 June (Sherlock 11298781).					
THEATRES 	Successes	Device integration in general recovery - Recovery staff report spending more time with patients because device integration removes manual vitals entry. Use this team as a peer-coaching reference for the other recovery areas still adjusting.					
	Action Items	IR / CRIS admission workflow- Patients arrived in CRIS are not being admitted in Epic, creating patient movement issues in theatre areas. Ali Phillips to evaluate system build and training improvements by 31 July (Sherlock 11298840). Procedure file gaps - Surgeons are struggling to request procedures because Epic procedure names use more technical terminology than they used previously. Mike will coordinate with surgeon leads to request aliases for high-impact procedures by 30 June.					
	Optimisation	Specimens shadow-charting - The intra-op specimen workflow was challenging at go-live due to unclear role expectations for nurses and surgeons. Katy Griffiths will encourage surgeons to participate in shadow charting prior to Plymouth's go live to identify specimen issues early. Work Effort: Medium. Perioperative and patient movement training – Theatres training did not include patient movement education. Ali McDonald and Katy Griffiths to					
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		incorporate patient movement workflows into theatres shadow charting readiness by 15 June. Work Effort: Low • Adult VENT ETCO2 – Recovery staff must manually document adult vent ETCO2. Harrison Kirwin to work with Claire-Marie Hunt to add the missing flowsheet row to the adult vitals group (Sherlock 11249151). Work Effort: Low
ENDOSCOPY	Successes	• Floor Support - Mark Eggar had positive feedback that week 1 floor support coverage was "spot on" and a significant help to the service.
	Action Items	• Endoscopy WAL auto-completion fix - 395 referral scans were imported as results, which completed the orders and linked waiting lists. Jo Loader and Chantal Caton will identify orders to re-import and the One Devon teams will complete the updates by 30 June (Sherlock 1120304) • Pre-procedure volume recovery (~80% of baseline) - Pre-procedure nurses have absorbed data entry that patients previously completed on paper in the waiting room. Josh Ford, Nick Mathieu, Jo Blackler, Chloe Gardner, and Maria Patterson are reviewing a proposal for admin staff to transcribe patient information from DCCR into Epic to relieve the burden during pre-procedure by 30 June.
	Optimisation	• Implement Pre-Procedure Patient Questionnaire – A patient-entered questionnaire can reduce clinician documentation during patient interactions and identify patients requiring specialised care prior to their procedure. Work Effort: High
RADIOLOGY	Successes	• CRIS Integration - Overall, the integration with CRIS has been stable and the end users are pleased with how quickly most tickets and concerns are resolved, but they continue to have issues that need to be fixed.
	Action Items	• In Basket Adoption - In Basket is being used to contact medical secretaries for scheduling requests. We can help by providing education to end users to explain this is not the appropriate workflow, or we can see if there's a way to prevent messaging these users. The radiology team will continue to monitor these messages and will reach out to the Orders team if they need support. • Nurses aren't completing MRI screening forms consistently. James Reed and Anthony George are bringing this to the Radiology Cross-Trust workgroups to determine next steps.
	Optimisation	• Cross Site Requesting - The ability to place orders across sites would be a big win for end users – not just in radiology. The radiology team would like to be able to have doctors place orders in one location for another hospital.
PHARMACY	Successes	• Improved safety in outpatient pharmacy dispensing: Simon Gardner (OP Pharmacy manager) appreciates the improved safety gained from scanning barcodes on prescription fills • Improved safety and efficiency in aseptics pharmacy: Having barcoded products, inventory control, and Epic-generate worksheets and labels has made dispensing more efficient for Aseptics pharmacy users and safer for the patients receiving the treatments
	Action Items	• Late closing time in main dispensary: Tom Moody provided Jane Pyle and Seb Wright with metrics showing a large proportion of TTO fills are arriving in

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Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



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		pharmacy late in the day, causing pharmacy staff to stay late to complete the fills. Jane and Seb are working with prescribing and nursing leads to implement a "cutoff" time by which orders are expected to be sent to pharmacy. • End of month pharmacy finance reports: Dave Blake and Stacey Muscott identified several issues with end-of-month pharmacy reports. Zack DeLand is working with Dave and the Jamie Lynde (Cogito) to make sure the appropriate reports are available. Zack is also working with Sandra Fitzell and Ahmad Tabesh from the Willow team to make sure the correct cost codes are assigned to each financial transactions
	Optimisation	• Aseptics meds and packages: Creating bespoke medication and package records for each batch and patient-specific strength of aseptic medication will allow users to find the appropriate packages much more quickly • OP Pharmacy courier workflow: Updates to work queues and prescription fill flagging will make the workflow smoother for fills being delivered to patients by courier • Disabling negative balances in Main Dispensary: Negative balances are often allowed during go-live while stock control is still stabilising. Going forward, negative balances should be prevented, and Epic stock counts should be reconciled with physical stock in cases where negative balances had occurred in the past
CARDIOLOGY 	Successes	• Cross-Trust Medical Records - End users like that they can see cross-site what they've implanted. • Secure Chat is loved by staff/clinical teams • Supply Scanning - Physios called out that supply scanning saves lots of time. • Cath Lab Workflows - Nurses & physios reported that their cath lab workflows are smooth and they love having all documentation in one spot. • Ultracardiac Workflow - Feedback from end users is that ultracardiac workflows are much nicer, and charging is better than previous workflows.
	Action Items	• Results routing logic to suppress unnecessary messages: End users reported that they're receiving unwanted result reports in In Basket. This most often occurs when the user who places an order also results that order, and therefore does not need to receive the result report. Additionally, they would prefer to use Secure Chat to communicate abnormal device checks and otherwise not receive result reports for these studies. Changing this process needs to be a joint decision from the workgroup. • Various patient movement issues: There were a few different issues related to documentation of patient movement (ex. patients being marked as in recovery rather than pre-procedure when they are placed in a bed, patients who move to the wards still showing on Cath Lab status board). (Sherlock #11285228) • Open access echos: This was identified as a new workflow, for which the analyst team has begun configuration. The team will complete build updates and communicate to the end users. • Planned ECG workflow: Users provided feedback to Steven Cox & Rui Oliveira-Sousa that there is confusion regarding the planned ECG workflow. The Cupid IS

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		& TS will set up time with Rui and Steven to discuss the specific challenges and identify next steps. • Cardiologists reporting efficiency: Currently, there is a split of cardiologists who are regularly using structured reporting (which saves cardiologists time when completing their documentation), and others who are using it less than half of the time. Additionally, Cardiologists want a way to more easily create a GP report letter, as they are now copying and pasting the result information into a letter. • Referral triage: Cupid team to set up a debrief with Springboard on the difficulties with all subspecialty referrals going into General Cardiology and discuss/agree on next steps to improve the workflow.
	Optimisation	• Further NICOR form improvements to streamline completion • Refinement and reorganisation of print groups in Chart Review for Cath Lab reports to ensure the most important information can be easily accessed • Login workflow for PACs: Cardiologists reported that when they launch PACs from Hyperspace, they need to log in with their PACs credentials. Ideally, we would have a single sign-on / pass-through integration for PACs so that they don't need to enter credentials separately. (Sherlock 11269631)
	Successes	• Reception workflows – Users in central specimen reception gave feedback that the system was easy to use and performing specimen add-ons is easier than before • Access of information – Several lab consultants reported that they like the amount of information now accessible in the patient chart when performing validation workflows.
	Action Items	GP Collect Workflows • Urgent GP collect workflow – the GP collect workflow is not designed for samples urgently requested by secondary care to be collected by GPs as the workflow requires 5-10 days to allow for time to post to the patient. Main technical solution would require GPs to utilise EpicCare Link, which is not viable in the short term. Michelle Collins engaging Joanne Watson to confirm clinical requirements and agree operational process. • Clinician training - the GP collect workflow is still not widely understood by outpatient clinicians who are performing the ordering and should be having conversations with their patients. This is leading to unnecessary GP collect letters being printed and posted to patients as the patients present regularly to community or hospital phlebotomy locations. Michelle Collins to engage Joanne Watson to determine best way to reach all clinicians and ensure the implications of each order class. • Printing team – the GP collect printing team is unable to manage the delivery of ~300 letters per week due to staffing vacancies. Michelle Collins and Liz Procter are escalating the long-standing staffing gap due to the impact on GP Collect workflows. Reporting – Clare Sellick will work with the lab to update volume reports with the new trust-specific reporting filters. The primary focus is on the send away volumes

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		reports (Samples sent from TSD to RDUH) and the annualised volume reports for TSD billing, like the one RDUH has.
	Optimisation	• Microbiology Consultant Workflows – Micro consultants receive emails from GPs and clinicians with additional patient and specimen information. They expect their secretaries to document this information in the system, so a new note type should be created, and micro secretaries need the ability to write these notes to document the information received in emails into the system. Work Effort: Medium
PHLEBOTOMY & DAs 	Successes	• Phlebotomy staff are happy and has adjusted well to the new system. They've seen increased phlebotomy volumes in the past months due to a decreasing number of GPs collecting bloods, but have been able to keep up with the increased volume of draws on their new worklists.
	Action Items	• Task Lists - The doctor assistants requested a patient list to see all tasks (both hospital out-of-hours and draw list tasks) so they can perform both tasks on a patient at once, instead of having to switch between multiple lists and potentially missing work (Sherlock 11274580)
	Optimisation	•
BLOOD TRANSFUSION LAB 	Successes	• Blood workflows are possible with the Epic-SafeTrace integration. The team considers the build stabilised, but they still need support to feel confident in the workflows.
	Action Items	• Transfusion Workflow Compliance - The Orders EPR team will continue to work with the blood transfusion team to understand their concerns and work with end users to provide adequate education. • There is a planned downtime coming for Safetrace – we need to help the lab prepare for this downtime and ensure end users understand the workflows they'll need to take during this time.
	Optimisation	• Group and Save collection workflows – Lab users and DA staff expressed interest in transitioning Group and Save sample collection into Epic. This was deferred during the implementation, but combining with the SafeTrace version 5.1 upgrade would be a good opportunity to re-assess the decision across Devon. Work Effort: High
VIRTUAL WARD 	Successes	• Updating Access for Virtual Ward Roles: In the virtual ward, users may be completing work that normally wouldn't fall to their role. The Orders EPR team gave some users additional access to ensure they can complete their workflows, which has increased end user happiness. In SLG 11214012, the Orders team is continuing to review if other roles should have increased access in the future.
	Action Items	• SDEC Encounters in Virtual Wards: The Medical Admission Avoidance Team (MAAT) was created as an SDEC, but also covers virtual ward workflows. There have been some issues with MAAT workflows which are being worked by the Orders, ASAP, and Willow teams in SLG 11285242.
	Optimisation	• Education on Virtual Ward Workflows: With virtual wards, often users are working in multiple workspaces and working outside the bounds of "normal" roles. Users might be switching roles or logging in and out of departments to

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		complete their work, which can increase the risk of making a mistake. The Orders team will work to update tip sheets to cover any common mistakes that are causing problems.

COMMUNITY		
ROLE	SUCCESSIONS & ACTION ITEMS	
SLT 	<i>Successes</i>	• Super Superusers: Greg Hatfield stepped up as an effective super user, providing a stable point of support for the team during stabilisation. • Referral Triage Holding Pool: A functional depot for patients awaiting allocation was established soon after go-live and has greatly helped the team in their referral triage process.
	<i>Action Items</i>	• Appointment Address in MyCare: MyChart appointments are showing the department address instead of the address of the clinic. Lucy Murley to investigate solutions to ensure patients arrive at the correct location. (Sherlock 11285328). • Letters and Leaflets: Resources are not currently available in Epic, impacting the team's ability to communicate with patients. Amanda Harris to begin working with her team to build these resources as SmartPhrases.
	<i>Optimisation</i>	• Peer Learning: Consider setting up sessions with RDUH SLT teams to share learning and identify potential workflow improvements. Work effort: Low • HomeCare Onsite Support: The SLT team is geographically spread out, making it difficult for the HomeCare team to provide at-the-elbow support. Amanda Harris and Lucy Murley will consider ways to engage teams for additional training and in-person support. Work effort: Low • Results Notifications: The service is receiving unnecessary notifications for all abnormal results across the patient's care spectrum. Turn off care team result notifications for the episode type so that clinicians aren't flooded with unnecessary notifications. Build effort: Low
COMMUNITY NURSING 	<i>Successes</i>	• Rover Adoption: Staff have embraced Rover and prefer it to Hyperspace. Teams report significant time savings, with most visit documentation completed in the field. They also enjoy the ability to easily capture patient photos. • Map It: Teams report that the feature has been transformative for operational oversight, giving coordinators real-time visibility of staff locations and progress through home visits. • Admission Visibility: Clinicians have saved time and resources by being able to easily see when a patient is admitted, so visits to the home are not wasted.
	<i>Action Items</i>	• Urgent Care Workflow: The current UCR referral and episode management process is creating significant confusion and clinical and administrative burden. Simon Hasnip and Nerissa Mauro will demo an improved and simplified workflow and agree on a plan by 6 June • Medication Administration: Teams document insulin administration in a flowsheet for easier tracking, but all other medications are currently tracked on

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COMMUNITY THERAPY 		the paper MAR kept in the patient's home which is causing confusion. Clinicians want the ability to document more medications in flowsheets, but that introduces double documentation. Discussion with the CXIOs resulted in the decision to remove the Insulin admin flowsheet by 8 June. • Visit List in Rover: Home visits are typically TBD but can be allocated to a specific time. The order of visits appears differently between Hyperspace and Rover, which can cause confusion for clinicians. Epic is investigating this to determine if the workflow can be improved with a standardly developed solution. Julia Richard will coordinate a meeting between the service and Epic R&D. (Sherlock 11285294)					
	Optimisation	• Care Plan Interventions: Teams are struggling with using care plan interventions and tasks appropriately. Nerissa Mauro should work with the service to update care plan templates, so they are relevant to clinical workflows. Work effort: High • Peer Learning: Some teams are struggling with workflows that other teams are successfully completing. Consider collaboration between teams to facilitate learning and system confidence. Work effort: Low					
	Successes	• Coordination and Communication with Acute: ○ Teams shared that secure chat and media upload have improved coordination with acute colleagues, particularly when managing complex equipment for patients. ○ Users are easily able to see who completed a Discharge-to-Assessment and follow up directly with that clinician.					
	Action Items	• Caseload Visibility: The service cannot easily see their caseload or identify longest waits between OT and PT. Jonathan Widdowson to build caseload reports for additional specialties and separate waitlist reports between OT and PT specialties. • Admin Access: Some admins had additional clinical security that is being revoked, shifting referral and scheduling work onto clinicians. James Fellows raised this with the CXIOs and will facilitate conversations across all trusts to identify an appropriate resolution. • Referral Information: Internal Epic referrals contain less clinical detail than previous referral forms, increasing clinical triage time. Jonathan Widdowson will work with the service to identify critical information and coordinate with Cath Goatcher and the IOs across trusts for larger community referral quality and process discussion. (Sherlock 11285366) • Snapboard Scheduling: Clinicians across the service are following different scheduling workflows. Jonathan Widdowson to work with service leads to encourage proper workflows with refresher training or tipsheets.					
	Optimisation	• Morning Huddle Reports: Teams are struggling to easily identify patients that need review in morning huddle meetings. Jonathan Widdowson will investigate building a report to surface patients from the overall caseload report that are flagged for review. Work effort: Medium					
	Successes	• MDT Meeting Efficiency: The service moved from daily morning huddles to proper MDT meetings twice a week, with leads only needing to check in on					
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COMMUNITY IC / UCR 		patients with no future care. This represents a significant time saving in daily operations. • Visibility Across Care Settings: Community and inpatient staff report significant benefit from real-time visibility into each other's workflows. Staff can access a complete view of the patient's care regardless of setting, eliminating the need to request duplicate information from patients during calls and preventing unnecessary home visits where admissions are visible in real time.					
	Action Items	• Referral Process: Other teams find it difficult to refer to IC/UCR teams, and when IC/UCR receives the referral, they have to look through the chart for the clinical reason for referral. Cath Goatcher is coordinating discussions with the IOs across all trusts for an improved workflow. (Sherlock 11285366) • Weekend Snapboard Depot: The service needs a way to identify patients with weekend appointments to streamline allocation and coverage. Julie Walden has built a new Snapboard depot and is working through testing. She will push it to the live environment by end of May. • Reporting Gaps: UCR visits completed by community nursing services are not currently being captured in activity reporting for Torbay UCR. James Fellows has a fix in progress and will follow up with Reporting to close this gap. • Appointment Times on MyCare: Patients have raised complaints that MyCare shows a specific appointment time for home visits, but the clinician may not arrive at that time. HomeCare team to collaborate across trusts and update visit types to prevent the appointment time from showing in MyCare.					
	Optimisation	• IC Nurse Transfers: IC nurses are taking on visits from community nursing, but there is no easy way to transfer visits and responsibility between services. Cath Goatcher will work with IOs to ensure that UCR referral process updates also streamline this portion of the workflow. Work Effort: Medium • Communication with Acute: Referrals may not have enough information, so the service needs to reach out to the acute clinicians. Consider building pools for acute discharge teams to streamline communication. This is also being investigated for North and East teams. Build effort: Low • Reporting Training: The service is struggling to find the information they need and needs additional guidance on self-service reporting functionality. Julie Walden to work with service leads to ensure appropriate reports exist or are built out. Build effort: Low					
0-19 TORBAY 	Successes	• Cross-Service Visibility: On the shared system, the service can now see when referrals to other services have been picked up in real-time. The Growth Chart is also collaborative, so they can see updates from other clinicians. • Media Upload: Users shared that uploading media to the patient's chart is very easy. • Streamlined Documentation: Teams highlighted that flowsheet assessments have greatly reduced lengthy free-text note writing					
	Action Items	• Antenatal Referrals: Midwifery is not submitting referrals to the Health Visiting service, meaning they have to track down pregnant mums and place the referral to themselves. Oscar Fisher-Smith will follow up with Midwifery teams to enforce the appropriate referral process.					
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		• Reporting Readiness: The first KPI submission is due in June, but the service is lacking necessary assessments and reports. Lucy Murley will build missing assessments, and service leadership will identify and share reporting gaps with Lucy and the Reporting team.
	Optimisation	• Specialty Allocation: The team accepts referrals for Action for Children but struggles to identify who to allocate visits to. Lucy Murley will work with the service to better understand the allocation process and propose a solution. Work effort: Medium • Miscarriage Visibility: Miscarriage information is not easily identifiable to community staff but has a high impact on how the service provides care. Lucy Murley will work with the Stork team to ensure this information is visible. Work effort: Low
	Successes	• Region-Based Teams: Service leads are using Map It to visualise patient locations and understand demand across areas, actively informing team restructuring decisions for improved region-based scheduling. This is a strong example of Epic driving operational change beyond basic system use. • Note and Letter Workflows: The team highlighted the ease of adding clinical assessment information to notes and letters using SmartTools.
	Action Items	• Additional Visit Types: The service needs additional visit types to appropriately track activity and have correct documentation available. Matt Doyle is working with Cadence to create Exercise Specialist and Community Care Worker visit types. • Gym Clinic Locations: The service books clinics to gyms in various locations and need that structure reflected in system. Patients need accurate addresses so they arrive to the right place, and clinicians need flexible scheduling workflows. Matt Doyle to follow up with Amy Davey for additional information to start new department and workflow build.
	Optimisation	• Simplify Columns: The caseload reports and Snapboard depots have columns that are not beneficial for the service and are making information hard to find. Amy Davey will identify the unnecessary columns and follow up with Matt Doyle to have them removed. Build effort: Low • MyCare Integration: The service wants to send patients questionnaires and pre-visit assessments to encourage patient engagement and reduce in-clinic documentation. Victoria Wicks is linking with other services to understand how teams are utilising MyCare. Matt Doyle will coordinate with the MyChart team. Build effort: Medium • Documentation Standardisation: Staff are writing similar notes across encounters and would benefit from SmartPhrases to reduce repetitive work and standardise documentation. Amy Davey will draft the content and follow up with Matt Doyle to create SmartPhrases. Build effort: Low
	Successes	• Admission information visibility: Teams find it easier to manage home care patients post-discharge because there is greater visibility of patient admission information on a shared system.

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COMMUNITY PHARMACY 	Action Items	Care Home Patients: Patients who are in a care home (Jack Sears and Mapleton) need to be separated from patients receiving care at home. Nerissa Mauro will create separate caseload reports and scheduling depots to streamline workflows. (Sherlock 11285307) Social Care Information Gap: Pharmacists are currently logging into Paris to access care package information. Nerissa Mauro will add the appropriate flowsheet assessment to the community pharmacy workspace. Work with Alex Pleace and Sarah Bradley to establish a process for coordinators to complete the assessment.
	Optimisation	SmartTools: Teams can standardise and streamline documentation with SmartTools. Work effort: Low Role Access: Community pharmacists have a HC Clinician role and a Pharmacist role with different access. Consider consolidating to one role so that users are not having to switch context to access information or activities. Work effort: High Medication List Attribution: The medication list does not show who updated it or when, creating audit and traceability concerns. Nerissa Mauro to investigate potential solutions. Work Effort: Medium

ACCESS, ACTIVITY, AND OPERATIONS

ROLE	SUCCESSES & ACTION ITEMS	
HOSPITAL LOGISTICS (HOUSEKEEPING AND PORTERING) 	Successes	Reduced Delays - In May, you saw a 3% decrease in delayed portering jobs from April System Usage - Porters and Housekeepers are successfully completing requests entered within Epic
	Action Items	Discharge Lounge portering requests are automatically placed on hold and need to be manually removed before they can be assigned. Brendan will work with Richard to update build to prevent Discharge Lounge moves from being held automatically when generated by 10/6.
	Optimisation	ED Portering Support - occasionally, porters are pulled from their current assignments to help in the ED during busy times. Reporting and managing porters helping in the ED is challenging. Consider exploring the use of secondary sector assignments to help with ED requests during busy times.
PATIENT FLOW & DISCHARGE 	Successes	Use of Dashboards - SiteOps are driving patient flow and their daily operations off dashboard built in Epic Cross Trust Engagement - You stood up a cross-location SiteOps meeting to continue engagement post go-live, share learnings and pain points across trusts
	Action Items	Patient Flow Dashboards – Patient Flow Dashboards are not consistently filtered based on location dashboard parameter selection. Brendan Haugh will

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BOOKING 		work with Grand Central team to review patient flow dashboard components and make updates to components not linked to parameters by 20/6.
	Optimisation	• Patient Flow Expeditor Dashboard - EDDs and understanding the next steps before a patient can be discharged are critical elements to supporting patient flow. The Patient Flow Expeditor dashboard can be used to get visibility into patients with outstanding milestones and EDD status. This tool should be reviewed with the Stie Ops team to ensure the data is meaningful and can be used to support patient flow
	Successes	• Letter Generation: Multiple specialties (Physio, Dermatology, PAS Validators) confirmed letters now generate at point of outcoming rather than waiting on secretarial transcription, cutting days out of patient communication cycles. • Time Savings: Physio, Dermatology, and PAC teams noted workflows have become smoother, citing two MSK physiotherapists now finishing admin on time despite previously taking work home
BOOKING 	Action Items	• Ophthalmology: Future-state workflow is still being determined; there is currently a 40% reduction in bookings from legacy. Outpatients and Cadence are scoping out appointment scenarios to inform workflow. (Sherlock 11131430) • Cross-Trust Referrals: Investigation is ongoing into an appropriate workflow for referring between trusts. Epic and Devon IT working to identify volume of referrals to understand current impact. (Sherlock 11125399) • Oncology: Currently run Bookwise and Epic in parallel for SACT/Day Unit chemo scheduling at a cost of 1 FTE/day in reconciliation. Plan is underway to transition appointment booking to be fully in Epic. (Sherlock 11280578)
	Optimisation	• Workqueues: Multiple specialties cited workqueue volume and filtering as a common friction. User-saved workqueue filters will be available in the autumn Epic upgrade; in the near-term, teams can raise tickets for IT to create filters on their behalf. <i>Work Effort: Low</i> • Scheduling Instructions: Consultants are inconsistently populating scheduling instructions across specialties, forcing PACs to make clinical judgement calls on follow-up timing. Mia Jones to sit with Clinical IOs to define a standard set of subspecialty scheduling instructions by 13 June. <i>Work Effort: Medium</i> • Dermatology: A move from OP visits to Day Case admit/discharge model is pending ICB sign-off on coding and reimbursement. This would impact clinician workflows. <i>Work Effort: High</i>
REPORTING 	Successes	• Go-Live Critical Submissions – All CDS data, RTT, Cancer Wait Time, and Diagnostics submissions are being successfully submitted. • Radiotherapy Feed – Richard Walker has built a Mosaiq feed into the month-end SUS process, with Dave Sturdy supporting on technical queries. • SUS Submission Cadence – The monthly SUS submission remains on track, with a data refresh planned ahead of the next return. • Dashboard Usage – Operational leadership and executives use Epic dashboards to determine prioritisation in meetings

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ACTIVITY & FINANCE 	Action Items	• Missing Clinic Codes – Activity without clinic codes is complicating like-for-like comparisons. Chantel Biddle will share examples via Sherlock for Epic investigation. • High-Cost Drugs Report – The report was not usable in the first month. Mark Tucker will follow up with Helen Avgherinos to confirm whether corrective action has been delivered or remains outstanding. • Mosaic Epic ID Inclusion – Epic IDs need to be included in the Mosaic radiotherapy feed so financial reconciliation links cleanly through to SUS. Chantel Biddle will coordinate with Dave Sturdy and Richard Walker. • Outpatient Mapping Review – Paul Procter and Mark Tucker will arrange a session with Deren Westcot and Helen Avgherinos to walk through the detailed clinic mapping work and confirm required fields.
	Optimisation	• Treatment Function Code Mapping – Mapping treatment function codes and capturing activity currently without clinic codes would sharpen like-for-like comparisons between PAS and Epic. <i>Work Effort: Medium</i> • Dashboard to SUS Workflow – A defined route from dashboard anomaly to forensic review to SUS-ready output would reduce manual chase-down each submission cycle. <i>Work Effort: Medium</i> • Reporting Forum Standardisation – Standardising the forum and accountability path for prioritising and developing reporting content would shorten the loop between insight and action. <i>Work Effort: Low</i>
	Successes	• Activity Stabilisation Process – The process is well-embedded, with active engagement from operational and specialty teams. • Anomaly-Level Focus – The team is transitioning from high-level monitoring to anomaly-level focus at the specialty level, supporting more targeted resolution. • Programme Maturity – The programme is maturing toward customer ownership, with operational leads taking on greater accountability for running the cadence.
	Action Items	• SDEC Longer Attendances – A system issue has been identified with SDEC longer attendances that should be considered Inpatient. Matt Thumser will follow up with Francis Mimmack. • Cardiology Baseline Updates – Chantel Biddle will send baseline update requests to Martin Davis, ensuring all known Cardiology issues are addressed, with support from Zach Birney and Scott Powers. • Procedure Review Support – Justin Chapman will work with Vishal Patel and Jason Bernheimer to manage the cross-specialty procedure and clinic setup reviews.
	Optimisation	• Dashboard to Action Conversion – Convert dashboard findings into specific, owned actions for operational managers on Activity Stabilisation meetings, with a maintained action log to track progress and accountability. <i>Work Effort: Medium</i> • Baseline Refresh – Update baselines where midwifery/obstetrics or other previously-excluded activity is now being captured, so variance reporting reflects genuine change rather than scope shifts. <i>Work Effort: Medium</i>

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		• Anomaly Playbook – Develop a playbook for the most common specialty-level anomalies, covering both technical drivers and human factors such as clinician workload and system usability. <i>Work Effort: Medium</i> • Workflow Streamlining – Ambulatory to take point in exploring opportunities such as packaging multiple orders and standardising advice and guidance flows, building on best practice already in place in some specialties. <i>Work Effort: Medium</i>
CODING 	Successes	• Comfortable in System – Users are feeling comfortable in Epic & SimpleCode. • Relationship with Epic – Coders from TSD are meshing in with existing strategic relationship structures well and feel comfortable speaking up about their needs and wants in the system. Phenomenal to see and a great start to a long, positive relationship which can help them get the most out of Epic.
	Action Items	• Endoscopy – Procedures are not being finalised as coders expect. Coders are reaching up to clinical staff to clarify expected workflows are being completed. Glenda (TSD coding manager) and Anael (IT) own this in progress action. • Admitted Diagnosis and Problem List – Similar to Endoscopy, but for low data quality of admitted diagnosis and problem list usage. Coding managers are communicating with clinical staff to ensure data is being corrected appropriately. Glenda (TSD coding manager) and Sapph (IT) own this in progress action item.
	Optimisation	• Doc Review – Minor updates could go a long way in doc review, especially for Cardiology and OpNotes. TSD coders are putting together lists of improvements they would like to see for IT to action.
MEDICAL RECORDS 	Successes	• Chart Misfiles – The concept of a misfiled chart has been nearly entirely eliminated since moving to Epic. • Scanning – So far scanning is going well and upcoming quality review plan is in place to gather data and ramp down quality review from 100% to 10% over the coming months.
	Action Items	• Security & BTG – Medical records has some discrepancies in their user's experience, likely around different staff having a different variety of templates and preferences for login options. Ideally, all Medical Records staff have the same experience and access. This includes Medical Records being required to BTG, when they are currently set up as exempt. Matt Jackson will be point on owning this in progress action item. (Sherlock 11304195) • SARs - Overall low volume needed in Epic so far, but is likely to increase overtime. Keep watching volume and content as SARs are fulfilled via Epic tools, speak up about desired optimisations.
	Optimisation	• Employee Access of Own Record – Looking for additional configuration options to take action on inappropriate self-access.
PERFORMANCE / VALIDATION 	Successes	• Single source of truth for patient story: Validators and Med Secs appreciate being able to see a patient's full story within Epic and no longer needing to log into multiple systems.
	Action Items	• Clinician outcoming: Clinicians are selecting incorrect outcomes and overusing Route to Validator because they aren't familiar with outcome wording in Epic. Ambulatory team to deliver IHCS-to-Epic outcome mapping grid to Clinical IO

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CANCER PERFORMANCE		team. Springboard TS to ensure we can report on Route to Validator outcome usage by specialty and provider for targeted intervention. • Med Sec Pathway Validation: Medical secretaries continue to push back against and struggle with validation workflows. There is no formal communication channel between PAS Validators and Med Secs and an unclear division of responsibility. Mia Jones will share the Med Sec validation training with the PAS Validator team. TSD (organised by Kevin Pirie) need to make an operational decision to define the organisational chain of command, training plans and communication channels to facilitate better pathway management by Med Secs and Validators.
	Optimisation	• Tip sheet organisation and DQ report guidance: Validators have a hard time finding the correct tipsheets and don't know how to resolve DQ errors. Tipsheets should be reviewed by Anthony Jackson with additional information on what each DQ error means and how to fix it. • Waiting List Visibility in Pathways: Display waiting list removal information and WAL "seen-by date" in more places on pathways. Rosie Maino is working with Sapphire Urwick to update the waiting list LPG used in Admin Pathway Management to display these columns. • Pathway Tasks: PAS Validators requested a way for users to flag pathways as needing validator review. This could be accomplished with pathway tasks functionality coming with our upgrade to vMay26 in November. Ownership will be determined closer to development release.
	Successes	• Reporting: Cancer team expressed satisfaction with BI and submission workflows. • Shift to PTL Management in Epic: Cancer services are now able to focus on PTL management in Epic and reporting April's data out of Epic rather than being consumed by MDT administration and legacy March reporting.
	Action Items	• 31D treatment clock starts: 31d treatment pathway volume is at 33% of expected. Springboard TS will support Alex Atkins and CWT work on reporting on 62d pathways that are missing a linked 31d treatment pathway. Springboard TS will investigate why the 31d treatment pathways are not being created automatically. • Duplicate cancer pathways from internal referrals: Internal referrals create duplicate pathways when clinicians incorrectly check the 'New Condition' box. Alex Atkins is working on communications to cancer leads for specialties with a high volume of this issue. Alex Atkins to review which referral orders (e.g. Oncology, Dietetics, Speech, Plastics) should have the new condition question removed.
	Optimisation	• Cancer Wait Times (CWT) Dashboard Filters: Overall management and identification of areas that need focus would benefit from summary level filters by suspected tumour site and managing tumour type on CWT dashboards. • IPT Table: Information from the IPT table is referenced throughout the system and for national submissions. This table can be confusing to users and may not be entered appropriately. Users would benefit from additional in-system guidance or clearer layout.

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Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



Torbay South Devon NHS Foundation Trust

Post Live Summary

		• Touchless 31d Treatment Pathways: Since going live with Beacon, pathway creation can occur when orders are placed for treatment procedures. (Sherlock 11187641) <i>Work Effort: Medium</i>

PATIENT EXPERIENCE AND ONGOING TRAINING

ROLE	SUCCESSSES & ACTION ITEMS	
PATIENT EXPERIENCE 	<i>Successes</i>	• MyChart Activation Over 18,000 Torbay patients have activated a MY CARE account, with 31% of patients seen since go-live now active. • For All Usage Torbay patients have used For All workflows 22,000+ times to directly access visit details, eSignatures, messaging, and questionnaire workflows, even without an active account.
	<i>Action Items</i>	• Expand Patient Messaging Mia Jones to identify a timeline for Dermatology and Rheumatology to move towards patient messaging by 19 June. • NHS App Integration NHSE plans to enable displaying Torbay encounters in the NHS App on 23 June, in alignment with enabling NHS Login in MY CARE.
	<i>Optimisation</i>	• Activation Engagement Elisenda McCutcheon to encourage service line managers to promote MY CARE activation across services. Focus on areas such as Emergency Department and community services. • Patient Scheduling Torbay departments are not currently live for patient scheduling tickets or Fast Pass. MY CARE and Cadence teams to re-evaluate onboarding departments onto these services following UHP go-live.
TRAINING 	<i>Successes</i>	• 97% of TSD staff (4418 individuals) fully completed training requirements prior to go-live. • Principle Trainers and Credentialed Trainers taught Just in Time Training during go-live to ensure all TSD staff had training prior to Epic use.
	<i>Action Items</i>	• New Starter Training - Andy Kerslake and Joanne Blackler to finalise the TSD BAU schedule and communicate plan to support new staff inductions 3 July. • Thrive Registration - Joanne and Andy will publish and advertise the TSD Thrive registration starting 8 June prior to the 17 August Thrive start date. Thrive training gives staff focused guidance on personalising their Epic workflows for greater efficiency. It's an important programme for improving both productivity and system satisfaction.

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		

Appendix 2		One Devon EPR Programme	
Submitted to	Care Group Directors		
Document Name:	TSD Epic Benefits Realisation Plan		
Author:	Guy Boosey		
Executive Summary			
We are approximately three weeks post go live following the deployment of Epic across acute and community services. This immediate post implementation period is recognised as disruptive and resource intensive. Evidence from UK Epic Trusts, alongside local experience, consistently demonstrates that benefits do not materialise at go live. Instead, they are realised through a structured progression of stabilisation, standardisation, and optimisation. Meaningful operational, quality, and financial benefits typically begin to emerge when staff confidence increases, workflows stabilise, data quality becomes reliable, and unwarranted variation in processes becomes visible. TSDFT is currently in the stabilisation phase, where patient safety, clinical confidence, and business continuity are paramount. This phase lays the essential foundations for sustainable benefits realisation. This Benefits Realisation Plan sets out how TSDFT will transition from programme led ownership of benefits to organisation wide operational delivery, embedding Epic-enabled change into business-as-usual processes. The plan describes how benefits will be mobilised, governed, delivered, measured, and assured, ensuring alignment with existing Trust transformation, performance, and financial management arrangements.			
Purpose and Scope			
The purpose of this plan is to: • Define how Epic-enabled benefits will be realised following go-live • Describe how ownership and accountability for benefits will transfer from the EPR Programme to operational teams • Confirm how benefits will be delivered through existing governance and transformation processes • Provide assurance over measurement, reporting, and escalation The scope of this plan covers all cash-releasing and non-cash-releasing benefits agreed within the NHSE-approved Epic business case, alongside emergent benefits identified post go-live.			
Mobilising the Organisation for Benefits Realisation			
Benefits realisation will be achieved by embedding Epic-enabled change into core operational management, rather than through standalone programme activity. Pre go-live, the EPR Programme team owned the development, profiling, and assurance of the benefits register. Post go-live, delivery of these benefits must transition to Care Groups, supported by enabling functions. This represents a deliberate shift: • From <i>programme ownership</i> → <i>operational accountability</i> • From <i>implementation focus</i> → <i>performance, productivity, and quality improvement</i>			

- From *using Epic operationally* → *using Epic transformationally*

Epic should be regarded as a continuous improvement platform, not a completed project. Benefits realisation will therefore be delivered through:

- Existing operational management structures
- Established transformation programmes
- Routine performance and financial oversight
- Cultural change focused on optimisation and learning

Benefits Delivery Operating Model

Epic benefits will be delivered through a consistent, auditable operating model aligned to Trust processes:

- 1. Benefit Definition and Baseline**
 - Benefits derived from the NHSE-approved business case, with established baseline values
- 2. Ownership Confirmation**
 - Each benefit assigned an accountable operational owner
 - Owners confirmed by Care Group Directors
- 3. Delivery Mechanism Agreed**
 - Cash releasing and non-cash releasing benefits translated into approved POD's via the PMO
- 4. Change Delivered**
 - Optimisation and service redesign implemented
 - Supported by the EPR programme, Information Officers, Improvement & Innovation, Finance, and PMO
- 5. Measurement and Assurance**
 - Progress and delivery tracked through agreed metrics
 - Validation provided by PMO, Finance, and Information functions
- 6. Reporting and Escalation**
 - Reported through Care Group and Trust governance
 - Risks escalated in line with CIP Status Definitions

This ensures Epic benefits are delivered through business-as-usual mechanisms, not parallel programme structures.

Governance and Assurance

Ownership Transition

- Pre go-live: Benefits developed and managed by the EPR Programme
- Post go-live: Benefits owned and delivered by operational and corporate teams

POD's and CIP Alignment

- Cash releasing and non-cash releasing benefits will be managed via the existing PMO process
- The PMO CIP Status Definition provides transparency regarding risk to delivery

Measurement and Evidence

- Benefits validated using activity, productivity, quality, and financial data

- Evidence retained to support internal and external assurance

Current Position and Next Steps

To date:

- Benefits profiles have begun to be translated into approved PODs
- Approximately £800k of transactional benefits now have a defined route to cash
- Care Group capacity has, appropriately, been focused on go-live delivery and safety. As TSDFT moves towards stabilisation, benefits realisation activity can now scale.

Immediate Next Steps

- EPR Benefits Analyst to support PMO in completing POD development for remaining benefits
- Care Group Directors to review benefit lists and confirm ownership
- Joint sessions with benefit owners to agree delivery plans and alignment with:
 - Outpatient Transformation
 - Admin Review
 - Other service improvement programmes
- PMO to establish routine reporting and escalation

Roles and Responsibilities

Care Group Directors

- Champion Epic-enabled benefits realisation
- Confirm appropriate and accountable benefit owners
- Ensure benefits delivery is prioritised within Care Group objectives
- Provide clear routes for escalation
- Lead cultural change from “system go-live” to “value realisation”
- Actively promote optimisation opportunities

Benefit Owners

- Accountable for delivery of assigned benefits
- Agree delivery plans, timelines, and success measures
- Escalate risks and dependencies appropriately
- Report progress through PMO and Care Group structures

Enabling Functions

- EPR Team: optimisation support and system expertise
- Information Officers: system expertise, and operational insight
- Improvement & Innovation Team: service redesign support
- PMO: governance, reporting, and financial assurance

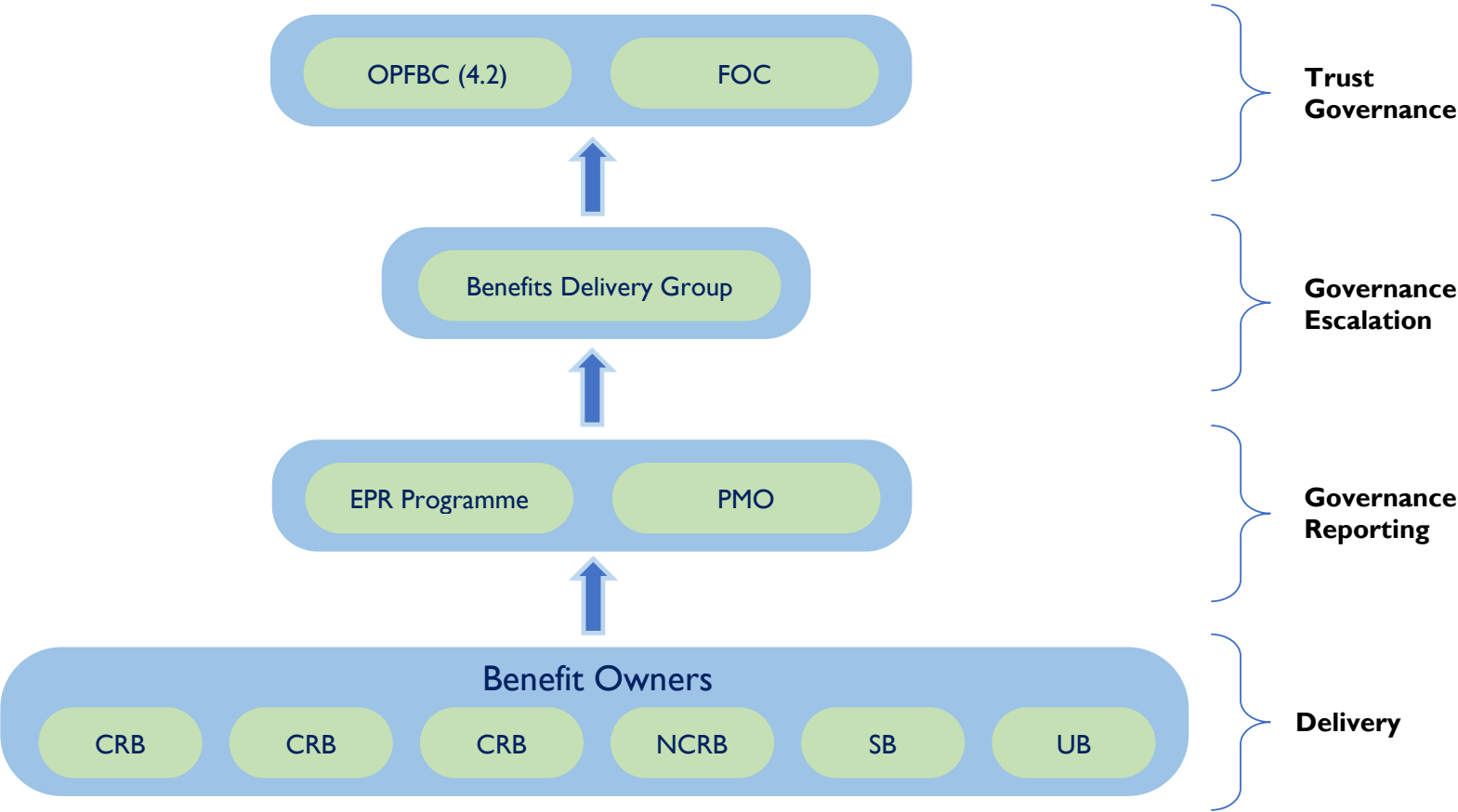
Summary

Epic benefits will not be realised through the EPR programme alone, but through operational leadership, sustained optimisation, transformation, and cultural change. This plan provides a structured, realistic, and auditable approach to transition from system implementation to lasting value, ensuring Epic delivers meaningful improvements for patients, staff, and the organisation.

PMO - CIP Status Definition

Category	Meets four tests	Aligned development risk adjustment	Summarised definition	Criteria to meet the category
Pre-pipeline	X	N/A – 0%	High level idea, requires validation, could be from benchmarking / ideas generation workshops.	- Initial idea identified and recorded on ICB / provider tracker with potential indicative value, and reported on CIP template. - Plan (with target dates) in place to develop respective scheme to meet the '4 tests' criteria and validate savings. - Movement into 'Opportunity' dictated by approval mechanism within local governance structure, to ensure that scheme meets the '4 tests' criteria.
Opportunity	✓	High risk – 25%	Validated, costed opportunity with stakeholder buy in that meets the four tests	Scheme satisfies '4 tests' criteria and target date to transition scheme to 'Plans in progress' – key areas: - There is basic outline costing (not just a number from a benchmarking tool); - There is a basic calculation of WTE impact where relevant; - There is evidence that the idea has been reviewed by relevant operational and/or clinical colleagues who agree that it is potentially feasible; and - There is a target implementation date and evidence that relevant operational and/or clinical colleagues agree this is feasible. Project Initiation Document (PID) initiated to capture the key information within all parts of the '4 tests' - Movement into 'Plans in place' dictated by approval mechanism within local governance structures.
Plans in progress	✓	Medium risk – 50%	Validated, costed opportunity with stakeholder buy in that meets the four tests and has a PID in development	As per the criteria above plus: - Clear scheme scope & ownership - Detailed activity plan with milestones / actions and supporting ownership - Risk and issues captured with supporting mitigation measures - Check, challenge & phasing of non-financial KPIs to enhance monitoring - Check, challenge & phasing of financial benefits Completed & signed off QIA/EIA (when moving to 'Fully developed') Movement into 'Fully developed' dictated by signed off QIA and fully approved PID reviewed through local governance structures.
Fully developed	✓	Low risk – 75%	Validated, costed robust plan with stakeholder buy in that has been fully signed off by all scheme stakeholders with a fully signed off QIA / EIA (as applicable)	As per the criteria above plus: - The PID is highly robust with a clear, detailed, and comprehensive project scope that is easy to understand and follow. - The opportunity is fully supported by comprehensive activity and financial analysis, demonstrating clear and substantial benefits and feasibility. - The financial opportunity is fully phased and accurately mapped to all relevant budgetary lines, ensuring clear alignment and transparency. - KPIs are clearly defined, regularly tracked, and effectively support comprehensive benefit monitoring and reporting. - Clear, specific milestones with detailed action plans and timelines are identified, ensuring the opportunity can be effectively realised. - Potential risks have been thoroughly identified and documented, ensuring comprehensive understanding and mitigation strategies are in place. - QIA / EIA completed and fully agreed upon by all relevant stakeholders, ensuring compliance and alignment with project objectives.
Implemented	✓	Low risk – 100%	As per the above for 'Fully developed', but the scheme is now into the anticipated delivery start month and is delivering as planned	As per the criteria above, the key differential between 'Fully developed' and 'Implemented' is that a scheme will remain in 'Fully developed' until it is into delivery. For instance, if a scheme is fully signed off in M1 but not due to deliver until M3, it would remain in 'Fully developed' for M1 and M2 and move into 'Implemented' in M3.

Benefits Realisation – Architecture



Quality and People Committee

Medicines Optimisation Annual Report

Date of meeting	Date report produced
26 May 2026	14 May 2026

Author(s)		Report approved by	
Name and title:	Jane Pyle Kate Wormald Stacey Muscott Ann Hogan Simon Gardner	Name and title:	Paul Foster Director of Pharmacy, Kate Lissett CMO

Date: 19 May 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 intended to provide assurance to the committee on how Medicines Optimisation processes are implemented across the Trust. The report describes what achievements have been made over the past 12 months, current concerns and what future work is planned to be undertaken. 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
Governance	Limited	Satisfactory
Clinical Pharmacy	Limited	Satisfactory
Operations	Limited	Satisfactory
Aseptic Services	Limited	Limited
CQC	Satisfactory	Satisfactory
Workforce	Limited	Limited
Outpatient Pharmacy (SDH Developments Ltd)	Limited	Limited

Appendices

N/A

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

Pharmacy Management Group with representation from all parts of the Pharmacy service have had an input into the report. In addition, the report will be presented to the Trust's Medicines Governance Committee.

Key recommendations and actions requested

The committee is requested to approve this report and support the risk mitigations/ actions under risk below.

How does this report further our Trust strategy?

Improve the quality and range of Medicines Optimisation services within the Trust. Ensuring that prescribing decisions are evidence based, medicines are used as safely as possible, patients are involved in the decision-making process and that medicines optimisation is part of routine practice.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Identifies that medicines optimisation continues to support this aim.
Quality of services provided	Identifies quality achievements, concerns that require improvement and future work that will improve quality of services.
Sustainable and efficient use of resources	Identifies the role of medicines optimisation in effective use of medicines and services.

Impact on BAF Objectives	
BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Patients receive individualized medicines optimisation.
Leadership and Governance	Timely provision of medicines.
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	Effective use of medicines.
Risk	

Risks lodged on Datix:	
SDH Staff Vacancies – awaiting outcome via new vacancy escalation process.	4034
Aseptic Services Risk to Provision of Systemic Anti-Cancer Treatments – to support the recommendations of the ongoing options appraisal when complete.	4001

External Standards affected by this report and associated risks
The Medicines Act 1968 The Human Medicines Regulations 2012 The Misuse of Drugs Act 1971 Care Quality Commission GPhC standards

Medicines Optimisation Annual Report

Introduction and background

Medicines optimisation is the process to ensure that: -

1. Prescribing decisions are evidence based
2. Medicines are used as safely as possible
3. Patients are involved in the decision-making process
4. Medicines optimisation is part of routine practice

This report provides an account of pharmacy led activities in the past year which support medicines optimisation across the organisation. The report is intended to update the Committee, outlining the achievements, areas of concern and the plans going forward for the next year.

The current groups which oversee the use of medicines across the Trust are: -

- Medicines Governance Committee (TSDFT)
- Controlled Drugs Governance Committee (TSDFT)
- Medicines Approval Committee (TSDFT)
- Clinical Policy Recommendations Committee (Devon)
- Formulary Interface Group (Devon)
- Non-Medical Prescribing Management Group (TSDFT)
- Cancer & Clinical Support Services Care Group Governance Committee
- SDH Developments Ltd Board of Directors (Outpatient Pharmacy)
- Systemic Anti-Cancer Therapy Committee (TSDFT)

Assurance and Recommendations

Pharmacy Operations

Achievements:

- Successful implementation of a replacement automated dispensing system (pharmacy robot) – handed over to the Trust December 2025
- Ongoing support for the implementation of Epic which features a replacement Pharmacy Stock Control System
- Continued support has been provided for the Covid and Flu vaccination programme.
- Continued appropriate response to OPEL levels to support patient flow.
- Proactive management of medicines shortages which have become increasingly common.

Concerns:

- The impact of Epic upon pharmacy procurement, finance systems and supply functions is at an early stage.

Future work:

- Take forward work via the Pharmacy Management Group to invest in staff support and wellbeing, to reduce staff turnover and to improve recruitment and retention. This is unlikely to be initiated before June 2026.

Clinical Pharmacy

Recruitment and retention of pharmacists and pharmacy technicians, continues to be challenging. The clinical pharmacy team has worked flexibly to safeguard patients as well as supporting team members' wellbeing and job satisfaction. Prioritisation of activities which are of greatest value to patients and the system remains key. Clinical activities include:

- Medicines reconciliation and prescription review for patients on high-risk medicines and/or restricted antibiotics.
- Ward-based facilitation of discharge prescriptions to support patient flow.
- Dispensing and supply of medicines, including ward stocks, outpatient prescriptions, aseptic products/chemotherapy, trials, and homecare
- Weekend and weekday on call services
- Management of medicines shortages
- Management of high-cost drugs

Achievements:

- Provision of support for the medicines related aspects of the One Devon Epic implementation. Successful collaborative working with colleagues from RDUH and UHP.
- Support for QI/Audit projects by trainee pharmacists, including development of post operative "Just in Case" analgesic service for Day Surgery patients.
- Development and provision of training support for increased numbers of pharmacy prescribing students and undergraduate pharmacists
- Maintain team cohesion/morale under challenging circumstances, including vacancies and physical relocation of team members during the replacement of the pharmacy robot.

Concerns:

- With the further development of virtual wards and other initiatives to support patient flow, it is recognised that pharmacy support is required. However, despite national and local evidence demonstrating the patient care and financial benefits of this support, new resources remain unavailable.
- Foundation level vacancies and the need for senior staff to support baseline inpatient and outpatient pharmacy services has hampered the development of new and more specialist clinical pharmacy services.

Future work:

- Develop a business case for the appointment of clinical pharmacists to support Virtual Ward teams.
- Develop new ways of working to maximise the potential medicines related benefits of Epic, including those related to antimicrobial stewardship
- Review and develop the clinical pharmacy team structure and processes.
- Development of a strategy for the most appropriate utilisation and support for the increasing numbers of pharmacist prescribers

Aseptic Services

Achievements:

- A full service to patients has been maintained whilst working with a 24-hour expiry on all aseptically prepared in-house products as required by our external auditor.
- A regulatory compliant radiopharmacy labelling system has been funded and sourced - when put into use this will address a major non-compliance identified in an external audit.
- A QA Lead has been appointed, from existing staff to a development post. They are currently undertaking the PTQA qualification hosted by Manchester University.
- The team have effectively managed regular medicine shortages and fragile outsourced supplies.
- R&D-support for haematology and oncology clinical trials has been maintained whilst carrying a long-term vacancy for a Clinical Trials Lead Pharmacist.
- Relevant training opportunities have been utilised for a range of staff within the team, particularly NHSE regional events.

Concerns:

- Our NHSE risk rating following external audit has moved from Medium to High.
- Maintaining and managing our current aseptic service in the existing non-compliant facility is challenging. The fabric of the Aseptic Services unit continues to visibly deteriorate and urgently requires major investment to meet regulatory standards. Investment in a new unit has been approved by ExCo.
- Contingency for SACT provision is required. Acquisition of an isolator to be sited in an unused cleanroom in radiopharmacy is currently being implemented.
- A renewed staffing plan is to be developed in response to the report from our external auditors.
- Medicine shortages continue to present significant challenges to service continuity.

Future work:

- To take forward the procurement of a new Aseptics facility.
- Review current staffing structure in aseptic services and consider what improvements to the skill mix could be made.

Locality Services

A locality pharmacy team (made up of Pharmacists and Pharmacy Technicians) provides clinical pharmacy services to Intermediate Care Teams, the Community Hospitals and Care Homes across South Devon.

Achievements:

- Providing clinical pharmacy support to high-risk patients being maintained in the community by one of the Intermediate Care teams.
- Providing a point of contact for Care Homes where medicines/pharmacy advice is required.
- Clinical pharmacy support for block intermediate care placements within Jack Sears and Mapleton care homes.
- Providing clinical pharmacy support to an increasingly acute population of patients in our Community Hospitals.

- The ongoing rationalisation of polypharmacy prescriptions in patients with multiple long-term conditions who are receiving a range of medicines.
- Supporting primary care with difficult to manage patients

Concerns:

- Lack of resources to support new out of hospital care pathways
- Difficulties in recruiting and retaining staff
- Maternity leave cover within a small team
- Moor to Sea pharmacist on a fixed term contract until end of March 26.
- With Epic implementation the team will lose access to System One Community which will impede communications with primary care.

Future work:

- To develop a business plan to provide Clinical Pharmacy support for out of hospital care pathways such as the Harbour initiative.

Outpatient Pharmacy (SDH Developments Ltd)

SDH Developments Ltd is a Wholly Owned Subsidiary company which provides the Outpatient dispensary service. It is registered with Companies House and has its own Board of Directors. The reasons for establishing SDH was threefold; firstly, to separate inpatient and outpatient dispensing activity and thereby increase efficiency and capacity, secondly, to improve patient experience for outpatients and thirdly to reduce the Trust's, tax liability.

Achievements:

- Continued provision of an outpatient dispensing service issuing approximately 100,000 prescription items per annum.
- Continued to provide a home delivery service to approximately 40% of patients
- 60% of patients receive their medicines within 30 minutes
- SDH Developments has been audited by our external auditors – Bishop Flemming and given a positive appraisal.
- Presentation made to the Trust Board in November 25.

Concerns:

- There are significant staffing issues with a vacancy rate of over 20%. Cover from the Inpatient Pharmacy is being provided daily which is compromising some inpatient services.
- Recruitment processes for SDH are not fit for purpose and don't allow the company to be responsive to recruitment opportunities. All recruitment decisions are approved by the SDH Management Group which includes finance representation. No further Trust scrutiny of these decisions is useful or helpful.

Current Situation:

- Activity is increasing year on year and expected to increase by 20% over the next 3 years
- The implementation of EPIC is challenging
- A review of patient delivery criteria will be completed following the implementation of EPIC.

Medicines Governance

All medicines incidents are sent to the Governance Pharmacist / Medication Safety Officer (MSO) and the Director of Pharmacy. The Medicines Governance team work

with the Clinical Governance Co-ordinators, incident owners and the Patient Safety and Quality Team. All moderate and serious incidents or those of particular concern, where no harm occurred, are discussed with the Director of Pharmacy. There is quarterly reporting on incidents to the ADN&PPs and the Medicines Governance Committee.

Achievements:

- Active support for critical Patient Safety Incident Investigations
- Formulary adherence of 97% demonstrates that medicines are prescribed with a good evidence base.
- Our no harm rate for medication incidents this year was 73% compared with an all incidents no-harm rate of 64%
- There were no 'never events' involving medicines reported this year.
- A quality improvement project in ED around time critical medicines which links in with the recently published HSSIB report is ongoing.
- The Trust has signed up for the Parkinson's UK Pledge on time critical medication.
- Working with the Epic team is ongoing to ensure risks associated with medicines are minimised.

Concerns:

- Due to staffing issues, there has been a reduction in audit work. For example, Safe & Secure Audit work is currently on hold and not all controlled drug audits have been completed.
- Care Group engagement and capacity within the team mean that some medicines related issues have not been reviewed or actioned.
- High risk medicines accounted for 61% of all medicine's incidents reported in the period Oct 24 – Sep 25. Of all medicine's incidents reported the top 3 were: controlled drugs 21% (20% last year), antibiotics 11.5% (11% last year) and insulin 9% (7.8% last year).

Future work:

- To ensure one complete Trust wide controlled drugs audit is completed prior to the implementation of Epic.
- To look at how pharmacists can further assist ward managers with their Medicines Round Competencies and support the safe administration of medicines.
- To implement a medicines safety training dashboard for ward and department managers to provide oversight on compliance.
- To investigate how we can support Agency and Bank staff to improve the safe use of medicines across the organisation.
- To review how the Medicines Governance Team works to ensure digital processes are used rather than manual ones to improve capacity, efficiency and accessibility.

Conclusion

It has been a challenging year for pharmacy, mainly driven by the planned implementation of EPIC and the replacement of the Automated Dispensing System in the Inpatient Pharmacy.

SDH Developments operates in an environment where the recruitment and retention of staff is challenging due to there being a competitive market and a shortage of qualified staff. To optimise the recruitment of staff and make the most of

opportunities there needs to be a more flexible recruitment process which is controlled by the SDH Management Group. The request is that SDH become exempt from the current recruitment approval processes.

The clinical pharmacy service is being recurrently requested to support out of hospital/virtual ward care pathways. It is known from experience and from published data that clinical pharmacy services within these care pathways improves efficiency, safety, quality and achieve a cost-saving. The service is currently not in a position to provide this support without investment.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Governance	Limited	Satisfactory
Clinical Pharmacy	Limited	Satisfactory
Operations	Limited	Satisfactory
Aseptic Services	Limited	Limited
CQC	Satisfactory	Satisfactory
Workforce	Limited	Limited
Outpatient Pharmacy (SDH Developments Ltd)	Limited	Limited

The Committee is requested to approve this report and support the actions described below: -

- SDH Staff Vacancies – an alternative process needs to be approved by the Trust so that the recruitment approval process is delegated to the SDH Management Group.
- To support the development of a business case for Clinical Pharmacists to be part of Virtual Ward care pathways including the Harbour project.



Quality Assurance Committee

Adults End-of-Life (EoL) Annual Report 2024/2025

Date of meeting	Date report produced
26 May 2026	13 May 2026

Author(s)		Report approved by	
Name and title:	Natalie Herring, Deputy Chief Nurse	Name and title:	Nicola MCMINN, Chief Nurse and DIPC
		Date:	19 May 2026

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

Executive summary
This annual report provides the Quality Assurance Committee with satisfactory assurance that End-of-Life Care across Torbay and South Devon NHS Foundation Trust continues to improve, supported by strengthened governance, enhanced multidisciplinary working and targeted quality improvement activity. The report covers the period 1 April 2024 to 31 March 2025 and summarises performance and quality metrics, compliance with national and local standards, incident trends and learning, patient, family and carer experience, workforce capability and training, and key risks and mitigations. Overall assurance is satisfactory, with credible improvement plans in place. Areas requiring continued focus are patient and family feedback, staff feedback, training compliance in specific areas, audit capacity, emotional needs assessment and advance care planning.

Appendices
Not applicable

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

The report has been reviewed and discussed by members of the Trust's End-of-Life Integrated Care Organisation (ICO) meeting, and all relevant contributors have provided input to the updates it contains.

Key recommendations and actions requested

The Committee is asked to:

- Receive the report and note the progress made in strengthening End-of-Life Care across the Trust.
- Take satisfactory assurance that improvement work is progressing in line with national and local priorities.
- Note the areas of limited assurance, specifically:
 - Patient, family and carer feedback arrangements
 - Staff feedback mechanisms
 - Training compliance in specific areas
 - Audit capacity and completion
 - Variability in emotional needs assessment and advance care planning
- Support the 2025/26 improvement priorities, including strengthening advanced care planning, emotional needs assessment, audit processes, family feedback arrangements and staff feedback mechanisms.
- Support the continued development of e-TEP and progress toward sustainable seven-day specialist palliative care cover.

How does this report further our Trust strategy?

This report supports the Trust's strategic aims by:

- Improving quality and safety of care for people approaching End-of-Life Care
- Strengthening integrated working across acute, community and hospice services
- Enhancing patient and family experience
- Supporting workforce capability and compassionate care
- Ensuring compliance with national standards and regulatory expectations

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Improved recognition of patients in last year of life; strengthened ACP and TEP

	processes; enhanced community-based support.
Quality of services provided	Improved documentation, symptom management, communication, and governance.
Sustainable and efficient use of resources	Increased outpatient capacity; reduced avoidable admissions; more efficient pathways.

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Strengthened assurance through NACEL, incident learning, and improved documentation.
Leadership and Governance	Clear governance structure; improved oversight through the EoL ICO Group and One Devon collaboration.
Performance	Increased outpatient activity; improved monitoring of key metrics.
People and Culture	Workforce training expanded; ambassador programme strengthened.
Strategy and Business Intelligence	Data-driven improvement through NACEL, local audits, and dashboard reporting.
Finance	Efficient use of resources through improved pathways and reduced delays.
Risk	

Key risks:

- Limited and uneven availability of faith-community representatives across the Trust. Therefore, patients with faith-specific needs may experience delays in accessing appropriate spiritual support, impacting the quality and responsiveness of care.
- Limited staff training compliance (MCA, VoED, SCSP)
- Capacity constraints affecting audit completion
- Variability in emotional needs assessment and ACP

Mitigations:

- Bespoke training and targeted support
- Strengthened governance oversight
- Quality Improvement Plan monitored jointly with One Devon

Risks lodged on Datix:

Risk 3500: Potential delay to appropriate spiritual support at End-of-Life

Cause: Limited and uneven availability of faith-community representatives across the Trust.

Effect: Patients with faith-specific needs may experience delays in accessing appropriate spiritual support, impacting the quality and responsiveness of care.

Mitigation:

- ✓ Annual review of faith-community contacts — The directory of faith representatives is updated on an annual basis to ensure accuracy and accessibility.
- ✓ Subscription to the Devon Faith and Belief Forum — Ongoing membership provides access to wider community networks, expertise, and inter-faith support.
- ✓ Spiritual care and cultural-needs guidance on ICON — Staff have access to up-to-date information on spiritual, cultural, and religious considerations via the ICON platform.
- ✓ On-call chaplaincy provision — A 24/7 on-call chaplain is available to provide general pastoral and spiritual support when required.
- ✓ These are monitored through the EoL Trust Group and escalated where required.
- ✓

External Standards affected by this report and associated risks

Care Quality Commission

End-of-Life (EoL) Annual Report 2024/2025

1. Introduction and Background

The Trust continues to deliver End-of-Life Care across acute, community and home-based settings through a multidisciplinary workforce, working in partnership with external providers such as Rowcroft Hospice.

Bringing together these services and professionals enables a truly person-centred, multidisciplinary approach.

This report provides assurance on achievements, challenges, quality standards and improvement priorities for the period 1 April 2024 to 31 March 2025.

Key themes include:

- Increased demand due to an ageing population
- Strengthened multidisciplinary collaboration
- Improved documentation and governance
- Continued focus on patient and family experience
- Workforce development and training
- System-wide partnership working

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1. Section 1- Introduction		N/A

2. Context of End-of-Life Care

As the organisation moves beyond the post-pandemic period, the End-of-Life Care Team has been able to refocus on key priorities that were constrained between 2020 and 2023. This renewed focus is evident throughout the report and provides assurance that the programme is operating on a stronger and more sustainable footing.

Key contextual factors:

- Increased complexity of patients approaching end of life
- Greater emphasis on personalised care and advance care planning
- System-wide collaboration through One Devon
- Continued pressure on workforce capacity
- Growing demand for community-based EoL care

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
2. Section 2 - Context of End-of-Life Care	Satisfactory	N/A

3. The National Strategic, Regional and Local Priorities

Torbay and South Devon NHS Foundation Trust's End-of-Life Strategy remains aligned with national and regional ambitions and continues to provide a clear framework for delivery. A full review is planned for 2026/27 to support development of a refreshed strategy to 2030. This provides assurance that the Trust remains strategically aligned and forward looking.

The Trust's strategic goals for End-of-Life Care are to:

- Provide high-quality care for people approaching end of life within the Trust's geographic area.
- Work in partnership to identify and support individual care preferences for those nearing end of life.
- Promote living well and maintaining independence for as long as possible.
- Support those important to each patient throughout the end-of-life journey.
- Ensure equitable access to end-of-life care regardless of diagnosis, care setting, social circumstances, life choices, culture, or religion.
- Work collaboratively across specialist, acute, primary and community services to deliver seamless patient journeys.
- Provide education and support to all staff delivering EoL care to ensure competence and confidence across the workforce.
- Review and refresh the End-of-Life Strategy with One Devon and local community, presenting a new strategy to the EoL Board covering the period to 2030.

The Trust has established clear priorities to deliver national and regional End-of-Life ambitions. Although some areas have been affected by operational pressures and vacancies, oversight remains strong and delivery continues to progress.

The priorities for 2025/2026 are:

- Promote high-quality care for people approaching the end of life, working in partnership to identify and support individual preferences for all EoL patients.
- Review and implement updated EoL documentation across community hospitals and community teams, ensuring it meets the current needs of staff and patients.
- Develop a structured EoL audit programme, incorporating participation in national and locally driven audits to strengthen learning and improve outcomes for local communities.
- Improve recognition of patients likely to be in their last year of life and ensure these discussions are consistently recorded within patient records.
- Understand the experiences of patients, carers and families receiving EoL care within the ICO.
- Capture the perspectives of staff delivering EoL care to inform workforce development and service improvement.
- Increase the use and accessibility of e-TEP across Devon to support consistent, high-quality advance care planning.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
3. Section 3 - The National Strategic, Regional and Local Priorities	Satisfactory	On Track

4. Governance and Leadership

Strategic leadership of the End-of-Life (EoL) agenda is provided by the Deputy Chief Nurse, with operational delivery supported by the Consultant in Palliative Medicine and the EoL Lead Nurse. This structure ensures clear accountability, clinical oversight and sustained focus on quality improvement.

The EoL ICO Trust Group is made up of internal and external stakeholders, all of whom have an interest in End-of-Life Care. The Chair of the meeting provides structured updates to the Safety and Quality Assurance Group and subsequently to the Quality and People Committee. Membership is multidisciplinary and ICO-wide, ensuring comprehensive oversight and robust challenge. Externally, the Deputy Chief Nurse reports to the EoL Oversight Group, chaired by One Devon. Membership includes representation from acute and community services across the system, ensuring alignment with wider local needs. This governance structure enables shared learning, coordinated planning and a collaborative approach to delivering national and regional priorities. It provides assurance that the Trust maintains strong leadership, clear lines of accountability and effective partnership working.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
4. Section 4 - Governance and Leadership	Satisfactory	On Track

5. End-of-Life Activity

End-of-Life Care is delivered across a range of appropriate settings, including a person's own home (which may be a care home), the local hospice, Rowcroft Hospice as the specialist EoL unit, and within both acute and community hospital environments. This breadth of provision ensures that patients receive care in the most suitable setting for their needs.

Between 1 April 2024 and 31 March 2025, the Torbay Hospital Palliative Care Team (HPCT) received 1,473 new referrals and undertook 5,789 face-to-face patient reviews, demonstrating sustained demand and continued responsiveness across the service.

Significant work undertaken in 2023/24 to clarify and strengthen the support the HPCT provides to wider hospital teams has contributed to a notable increase in referrals. This upward trend has continued into 2024/25, with corresponding growth in outpatient activity. New referrals to the Palliative Care outpatient clinic increased

by 35, and an additional 235 follow-up appointments were delivered during the reporting period. To accommodate this increased activity, additional clinic space was secured at Rowcroft Hospice, enabling weekly consultant-led reviews.

In 2024, the Trust launched an initiative to train and upskill a Palliative Care Specialist Nurse to undertake independent outpatient reviews. Following completion of the Clinical Skills course and preparatory training, weekly nurse-led clinics commenced at Torbay Hospital in June 2025. This development has expanded clinical capacity, improved access and enhanced the resilience of the service. These developments provide assurance that the Trust is strengthening its End-of-Life service model, responding to rising demand and investing in workforce capability.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
5. Section 5 - End-of-Life Activity	Satisfactory	Improved Trajectory

6. Performance and Quality

6.1 Community End-of-Life Care

The most recent Care Quality Commission (CQC) inspection of community and acute end-of-life services took place in 2018. Community End-of-Life Care was rated Requires Improvement overall, with ratings of Requires Improvement for Safe, Effective and Well-Led, and Good for Caring and Responsive. The inspection highlighted several areas requiring improvement, including:

- Insufficient evidence of training records
- Gaps in documentation and decision-making for patients lacking capacity
- Mobile phones not fit for purpose, with potential impact on patient care
- Generic rather than personalised care plans
- Insufficient information on EoL governance processes

The Trust has maintained a comprehensive End-of-Life CQC Action Plan, overseen by the End-of-Life Trust Group, and all actions arising from the 2018 inspection have now been completed. This provides assurance that the identified issues have been addressed and that monitoring arrangements remain in place.

The Trust awaits its next CQC inspection with an aim to achieve an at least 'Good' rating, reflecting the significant progress made, strengthened governance, and the assurance mechanisms now embedded across the service.

6.2 Acute End-of-Life Care

Acute EoL Care was rated "Good" overall in the 2018 Care Quality Commission (CQC) inspection. Across the five key lines of enquiry, acute services were rated Requires Improvement for Safe, and Good for Effective, Caring, Responsive and Well-Led. Two 'Must Do' requirements were identified:

- Ensure consistent use of care-planning documentation to assess and plan the needs of palliative and EoL patients.

- Ensure full compliance with the Mental Capacity Act (MCA) 2005, including improving staff training and ensuring MCA principles are enacted in practice.

Actions Taken

- Monthly audits of Butterfly Packs demonstrate improved completion of key elements, including EoL decision-making, individualised plans, symptom control and spiritual needs. Remaining issues such as missed signatures and personal identifiers will be fully resolved through the transition to the Patient Electronic Record.
- The number of Butterfly patients admitted, discharged and deceased continues to be monitored monthly via the palliative care team, providing ongoing assurance of oversight and quality.
- MCA monitoring and compliance continues to be reviewed through a structured update process.

Figure 1. MCA compliance figures 2025

Levels 5 and 6 MCA training have not yet met target but show improvement compared with 2024. The number of staff requiring this training is small (fewer than 5–6 individuals), and targeted support is in place.

Ongoing actions include monthly review of Level 3 training compliance, ensuring staff are mapped to the correct training level, and provision of bespoke MCA training for preceptorship nurses, students, new starters, international nurses, doctors and dental staff. Compliance is monitored monthly through the Education Governance Meeting.

Planned Actions

- Review and action plan following external audit outcomes
- Review of systems and processes relating to MCA/DoLS pathways
- Review of trajectory targets for 2026

Completed actions, strengthened monitoring and targeted training provide assurance that the Trust has responded effectively to the CQC's 'Must Do' requirements and continues to improve the safety and consistency of acute End-of-Life Care.

6.3 End-of-Life Care Quality Standards

6.3.1 National Audit of Care at the End of Life (NACEL)

Torbay and South Devon NHS Foundation Trust participated in the NACEL 2024 audit between July and December 2024. As NACEL data is reported a year in arrears, this 2025/26 annual report reflects 2024/25 data.

Due to capacity constraints within the Palliative Care Team, case note reviews for Rounds 1 and 2 of the bereavement survey were deferred following approval through the Chief Medical Officer and End-of-Life governance routes. Although this element of the audit is not mandated and does not provide benchmarking, it remains important for local quality assurance. A revised process is now in place with Medical Examiner Officers asking next of kin whether they wish to participate in future NACEL audits, providing a more robust approach for 2025 onwards.

The NACEL process includes an online survey completed by a bereaved relative or friend several weeks after a patient's death, following consent discussions with Medical Examiner Officers. Results are currently shared only with participating

organisations, but from August 2026 national publication through the Healthcare Quality Improvement Platform will enable public reporting and benchmarking. The Trust's Palliative Care Lead Consultant will oversee the communications required to support this change.

2024/25 Q3 and Q4 Survey Response Overview:

- 51 responses relating to Torbay Hospital (Torbay) deaths
- 5 responses relating to Community Hospital deaths

Positive Findings – Areas of Strong Assurance

Across multiple domains, the Trust performed at or above national averages, demonstrating compassionate and person-centred care.

1. Care and support for the dying person

Rated higher than national averages across both acute and community settings.

- Quality of care for dying patients rated Excellent/Good:
 - National: 76%
 - Torbay: 84%
 - Community Hospitals: 80%

2. Support for those important to the dying person

- Excellent/Good:
 - National: 72%
 - Torbay: 78%
 - Community Hospitals: 80%

3. Sensitive communication with dying patients

- Strongly agree/Agree:
 - National: 75%
 - Torbay: 80%
 - Community Hospitals: 80%

4. Planning care around needs and wishes

- Strongly agree/Agree:
 - National: 61%
 - Torbay: 74%
 - Community Hospitals: 80%

5. Involving patients in decisions

- Involved as much as they wanted:
 - National: 39%
 - Torbay: 46%
 - Community Hospitals: 60%

6. Symptom management

- Pain relief (Strongly agree/Agree):
 - National: 72%
 - Torbay: 74%
 - Community Hospitals: 60%

7. Honest conversations about prognosis

- Yes, appropriately:
 - National: 36%
 - Torbay: 44%
 - Community Hospitals: 40%

These findings provide good assurance that the Trust is delivering compassionate, well-communicated and person-centred care at the end of life.

Areas for Improvement

The audit also highlighted areas requiring focused improvement:

1. Support with drinking and fluids

Torbay scored below national averages, though community hospitals performed well.

- Strongly agree/Agree:
 - National: 54%
 - Torbay: 51%
 - Community Hospitals: 60%

2. Assessing emotional needs

- Strongly agree/Agree:
 - National: 42%
 - Torbay: 36%
 - Community Hospitals: 20%

3. Checking and addressing patient needs

Community hospitals scored below national averages.

- Strongly agree/Agree:
 - National: 53%
 - Torbay: 53%
 - Community Hospitals: 40%

4. Advance care planning (ACP)

A consistent theme across previous NACEL audits.

- No ACP in place:
 - National: 50%
 - Torbay: 56%
 - Community Hospitals: 40%

These findings align with known improvement priorities and are being actively addressed.

Actions Taken and Ongoing Quality Improvement

The Trust has responded to the NACEL findings through a focused programme of improvement:

- Results shared with all Trust doctors and nursing staff, with invitations for improvement suggestions.
- Teaching session on fluids at the end of life arranged for resident doctors (April 2026).
- Planned teaching for FY1 and FY2 doctors on assessing emotional needs using “softer skills” (Spring 2026).
- As part of the Mortality Surveillance Group, the team is conducting an audit of patients who died in Torbay, including ACP and preferred place of death.
- All findings and actions are incorporated into the EoL Quality Improvement Action Plan, shared with the EoL Oversight Group meeting and managed through the joint EoL ICO meeting.

Forward Look – NACEL 2025

The Trust is participating in NACEL 2025, a 12-month programme including bereavement surveys and case note reviews. Results are expected in mid-2026 and will inform future improvement priorities.

Overall, the NACEL 2024 results provide satisfactory assurance, with performance above national averages in several key domains. The identified gaps are understood, improvement actions are in place, and governance arrangements provide ongoing oversight.

The table below summarises progress against the 2024/25 recommendations.

No	Recommendation	TSDFT Status	RAG Rating
1	Oversight of Hospital Improvement Plans	One Devon is an integral part of our ICO and One Devon committees and has access to our QIP.	
	Integrated Care Boards should ensure system level oversight of provider quality improvement plans (QIP)		
2	Access to Specialist Palliative Care Services	Please see section 9 of the report for a full description of the services offered within the Trust	
	Integrated Care Boards should ensure that services provide specialist palliative care services 8 hours a day, 7 days a week with 24-hour advice available		
3	Improve personalised care and support planning	The NACEL survey findings and the evidence in this report show that the Trust is performing well in this area.	

		Further improvement is required in assessing emotional needs and advance care planning, both of which remain priorities within the QIP.	
	Integrated Care Boards should lead on collaborative improvement initiatives to increase the number of personalised care and support planning conversations offered to patients and shared across the system		
4	Equitable care delivered for all dying people	The care provided at TSDFT was equitable and, with the launch of the new Electronic Patient Record, quality data on protected characteristics will be more readily available.	
	Integrated Care Boards should ensure that high quality EoL care is equitable and tailored to the needs of our local population		
5	Training and Support	The availability of training, coupled with Trust initiatives such as Ambassador training and syringe pump training, is supported through ICO and One Devon oversight.	
	Integrated Care Boards should consider system level initiatives aimed at increasing the uptake and quality of EoL training		

Table 1. RAG ratings against actions, 2024/25

6.3.2 Performance from family and carer feedback

The Trust developed a local Next-of-Kin Experience of End-of-Life Care Survey in response to the 2018 CQC report to capture meaningful feedback and support continuous improvement.

During 2024/25, the survey was not progressed because of long-term staff absence and limited capacity. As a result, no additional family feedback was collected beyond NACEL.

From 2025/26, the Professional Standards Lead Nurse will provide renewed leadership and capacity to re-establish this feedback mechanism and support a more sustainable approach from 2026/27.

The Trust will:

- Review and improve consent processes for next-of-kin participation to enhance response rates.
- Secure digital capacity to support survey administration and analysis through dashboard reporting as a priority for 2026/27.
- Ensure that insights from the survey feed directly into the End-of-Life Quality Improvement Programme, supporting continuous learning and service development.

These actions demonstrate a clear commitment to strengthening patient and family voice within End-of-Life Care improvement, although assurance in this area remains limited until a sustainable feedback process is fully in place.

6.3.3 Performance from staff feedback

The Trust recognises the importance of staff feedback in informing service development, supporting workforce wellbeing and improving the quality of End-of-Life Care.

During 2024/25, a formal staff feedback process was not introduced because of capacity constraints within the Palliative Care Team and competing priorities. As a result, staff experience was not captured systematically.

From 2025/26, the Professional Standards Lead Nurse will provide capacity to design and implement a more structured staff feedback approach for 2026/27.

The Trust will now:

- Develop and implement a formal staff feedback process, including surveys, reflective forums and facilitated discussions.
- Review best practice to ensure the approach is meaningful, accessible and representative across acute, community and hospice-linked teams.
- Secure digital capacity to support administration, analysis and dashboard reporting of staff feedback as a priority for 2026/27.
- Ensure staff insights feed directly into the End-of-Life Quality Improvement Action Plan, strengthening learning, safety and service development.

6.3.4 Local audit of EoL care

The documents reviewed as part of this audit are the individualised EoL care plans (Butterfly Packs) and syringe pump administration checklists. In 2023/24, these audits were completed monthly.

Key themes from 2023/24 include:

- Documentation: multi-professional communication pages were not being used. This was highlighted to medical colleagues and ward managers as an area for improvement during 2023/24. The success of this focused work has been demonstrated in recent audits, where this has no longer been identified as an issue.
- Documentation: the current Community Hospital Syringe Pump Administration Record is now consistent with those used in the acute setting. When a care plan or syringe pump checklist is found to be incomplete, this is brought to the attention of the practitioner immediately to support real-time learning.
- Spirituality: it was noted that the quality of care plans continues to improve; however, this remained a focus for 2024/25. Ward staff and managers now receive real-time feedback on the quality of the care plans reviewed, with support and bespoke training provided as needed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
6. Section 6.3.1 - Audit	Satisfactory	On track
Section 6.3.1 – Audit	Section 6.3.2–6.3.3 – Family and Staff Feedback	Regression

7. Incidents

Between 1 April 2024 and 31 March 2025, the Trust reported 139 End-of-Life (EoL) incidents (Table 3), representing a 2% decrease from the previous year. This overall downward trend provides assurance that the system remains stable, with no indication of increased risk or harm.

Despite the small overall decline, there were modest increases in incidents relating to care during and after death and delays in issuing Medical Certificates of Cause of Death (MCCD). These delays were influenced by national changes to timescales, doctor availability, and vacancies within the Medical Examiner Officer (MEO) team. Recruitment challenges contributed to the vacancy period; however, a successful appointment was made in Autumn 2024, with the postholder commencing on 30 December 2024, which has improved capacity and timeliness.

Figure 2. EoL incidents reported by severity, 1 April 2024 to 31 March 2025, TSDFT

MCCD delays are anticipated to reduce further in 2025/26 because of revised national timescales. However, the team’s workload has doubled following the expansion of scrutiny responsibilities to include all acute and community deaths. Capacity will continue to be monitored closely and escalated to the National Medical Examiner team if required.

A proportion of incidents related to symptom management at the end of life, particularly prescribing and administration issues involving subcutaneous syringe pumps, reduced by more than 50%. This improvement reflects targeted work undertaken during the reporting year. Collaborative work with system partners will continue into 2025/26 to strengthen communication and processes supporting community teams and to prevent recurrence.

All incidents were reviewed, with in-depth investigations undertaken where appropriate, leading to clear actions and shared learning. Importantly, 91% of reported incidents were categorised as no or low harm, providing strong assurance that patients receiving EoL care are not experiencing significant harm and that the Trust maintains effective oversight and responsive governance.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 7 - Incidents	Satisfactory	On track

8. Education and Training

From April 2024, the Hospital Palliative Care Education Team significantly expanded the delivery of Palliative and End-of-Life Care (PEoLC) education to a wider cohort of staff. Teaching has been provided through both 1-hour workshops and bespoke training sessions, tailored to the needs of specific teams. This is in addition to established training on syringe pump use and Verification of Expected Adult Death (VoEAD).

Staff groups supported through this enhanced education programme include:

- Internationally educated nurses and doctors
- Haematology medical teams
- Pharmacy teams
- Preceptorship programmes
- Chaplaincy volunteers
- Acute medical teams
- Resident doctors and medical students
- Emergency Department induction cohorts
- Acute and community staff across all levels

There has also been a small but growing uptake of training offered to care homes, supporting system-wide capability and consistency in End-of-Life Care delivery. This expanded education programme provides assurance that the Trust is strengthening staff competence and confidence in delivering high-quality, safe and compassionate End-of-Life Care. The breadth of staff groups reached demonstrates a proactive approach to embedding core skills across the workforce and supporting continuous improvement.

8.1 Staff syringe pump training and Verification of Expected Adult Death (VoED) training and compliance

Acute Services

For the period 1 April 2024 to 31 March 2025, 488 Registered Nurses employed within acute services were required to complete Syringe Pump (SCSP) training as part of their role. 287 nurses were compliant (59%) by year-end. This represents a 63% improvement on the previous year, providing assurance that targeted efforts are having a measurable impact.

However, ongoing compliance challenges remain due to:

- High staff movement, which continually changes the training denominator
- Inability to release staff from clinical areas because of operational pressures

Despite these constraints, clinical areas retain responsibility for ensuring that adequately trained and competent staff are rostered on each shift to maintain safe care. The Palliative Care Education Team continues to provide ad hoc bespoke training to areas with low compliance, which has proven effective in improving uptake.

Regarding Verification of Expected Death (VoED), only a small number of acute nurses are required to complete this training. Of the seven registered nurses who provide the VoED service for the acute site, 71.4% are compliant, and focused work is underway to improve this further. The number of staff required on the acute site to undertake this training is low, as general acute site nurses are not routinely expected to undertake VoED training because this responsibility sits with the Clinical Site Team.

Community Services

During the same reporting period, 209 Registered Nurses employed as Community Nurses were required to complete both VoED and SCSP training as essential components of their role.

- 72% compliance in SCSP training – a 4% reduction from the previous year, primarily due to capacity to release staff. This remains a focus.
- 54% compliance in VoED training – a 4% improvement, though uptake remains below expected levels. This remains a focus.

These figures remain subject to variation due to staff movement. Nevertheless, the Trust continues to strengthen capability by offering bespoke ward-based and community-based training and through training resources available via the HIVE.

The Trust has demonstrated clear improvement in acute SCSP compliance and continues to take targeted action to address the remaining gaps across both acute and community settings. The provision of bespoke training, strengthened oversight and local responsibility for ensuring competent staffing provide assurance that safe and effective End-of-Life Care is being maintained. Ongoing work will focus on improving attendance, engagement and access to training to further strengthen compliance and service quality.

8.2 Ambassadors

The End-of-Life (EoL) Ambassadors Programme continues to develop positively and remains a key component of the Trust’s approach to embedding high-quality EoL practice across clinical areas. The Trust now has 65 active graduates, with a further 25 staff members confirmed for the next cohort commencing in September 2025. This demonstrates sustained engagement and growing organisational capability.

An EoL Ambassador is a member of the nursing or allied health professional workforce who has completed the structured training programme jointly delivered by Rowcroft Hospice and the Hospital Palliative Care Team Leads. Ambassadors act as local champions, supporting the successful implementation of the Trust’s End-of-Life Care Strategic Board Plan and promoting best practice within their clinical areas.

The continued growth of the programme provides assurance that:

- The Trust is building internal expertise and strengthening frontline leadership in EoL care.
- Staff across acute and community settings are being equipped with the skills, confidence and knowledge to support high-quality, compassionate care.
- The organisation is embedding a sustainable model of improvement, with Ambassadors acting as a bridge between strategic priorities and day-to-day clinical practice.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 8 – Education and Training	Satisfactory	On track

9. Projects and Initiatives

9.1 Hospital Specialist Palliative Care Team 7 day working

National NICE guidance and CQC expectations recommend seven-day face-to-face Hospital Specialist Palliative Care Team cover. The Trust demonstrated this model

during the Covid-19 period in 2020, when temporary seven-day working was positively received and associated with improved patient support. Seven-day working was reintroduced in July 2022 using the existing workforce but became unsustainable by April 2023 because of rising demand and staffing constraints. Weekend cover by a single Clinical Nurse Specialist was not manageable, while using two created unacceptable weekday gaps. The service therefore reverted to a six-day model, with Saturday cover from 09:00 to 17:00 and Sunday and out-of-hours advice provided by the palliative care consultant or specialty doctor on call via Rowcroft Hospice.

Despite these constraints, the team remains committed to achieving a sustainable seven-day model. Work is underway to:

- Develop a business case in partnership with Cancer Services
- Benchmark against regional services through visits to other hospital palliative care teams
- Identify innovative workforce and rota solutions to support safe, effective seven-day delivery

9.2 TEP (Treatment Escalation Plan) Action and Delivery Group

The Trust introduced the latest version of the Treatment Escalation Plan in 2021/22, including GMC and NMC registration numbers to support nurse-led completion and strengthen accountability.

A multidisciplinary TEP Task and Finish Group was established in 2022 to improve TEP completion, support sensitive conversations and strengthen documentation and compliance oversight.

In October 2023, six senior nurses were trained to undertake TEP conversations and complete TEP forms as part of a pilot. By mid-2024, all six had been signed off as independent practitioners and the outcomes had been reported through relevant committees.

A register of competent practitioners is maintained via HIVE, and the relevant TEP policies are available on the Trust website. The TEP Action and Delivery Group continues to work closely with the Resuscitation Committee Steering Group to align policy, training and governance.

Following the success of the pilot, the programme was expanded to include Allied Health Professionals. After updating the relevant documentation, a second cohort of 10 senior nurses and AHPs was identified for training in May 2025.

Overall, the Trust has strengthened TEP practice, expanded the pool of competent practitioners and maintained clear governance. The planned inclusion of AHPs further supports consistent, person-centred escalation planning.

9.3 Movement to electronic TEP forms – e-TEP

Electronic Treatment Escalation Plan forms were developed by One Devon in 2023, with Derriford Hospital going live in early 2024. Torbay's implementation has been supported through a regional e-TEP group, with the system accessed via the Clinical Portal and linked to the Devon and Cornwall Care Record to support interoperability with GP systems.

Progress was significantly affected by the Trust's commitment to implementing EPIC by April 2025, which reduced IT capacity for additional digital developments. Despite this, strong clinical leadership and cross-departmental collaboration enabled the work to continue.

With support from the Palliative Care Consultant, Medical Directorate, Deputy Chief Nurse, Resuscitation clinical lead and additional project and IT support from March 2025, a confirmed go-live date of June 2025 was agreed.

The Trust Resuscitation Policy has been updated to reflect the introduction of e-TEP and published on EOLAS to support staff readiness and governance compliance. Despite digital capacity pressures, the Trust has maintained momentum through strong leadership, clear governance and coordinated delivery. The confirmed June 2025 go-live provides satisfactory assurance that implementation remains on track.

9.4 Research

The Trust's Palliative Care Team expressed interest in participating in a University of Surrey cluster randomised trial examining the use of intravenous or subcutaneous fluids in the last days of life. Following an online meeting with the University in March 2024, the Trust was successfully selected as a study site. Torbay was randomised to the arm involving administration of IV or subcutaneous fluids for recruited and consented patients.

A dedicated local research team was assigned to support delivery, and a site visit confirmed readiness to proceed. The study went live in July 2024 for data input, marking a significant contribution to national research in End-of-Life Care; outcomes are yet to be shared.

Participation in this trial provides assurance that the Trust is:

- Actively contributing to the national evidence base for best practice in the last days of life
- Supporting ethical, high-quality research that may influence future clinical guidance
- Strengthening its profile as a research-engaged organisation committed to improving patient outcomes

9.5 Dying Matters campaign

Each year, organisations across the country participate in Dying Matters Awareness Week, a national initiative encouraging communities to engage in open conversations about death, dying and bereavement. In May 2025, the theme focused on "The Culture in Dying Matters – The Way We Talk About Dying Matters", emphasising the importance of breaking down barriers to conversations about death and grief, and promoting open, honest communication between the public, families and healthcare professionals.

To support this, the Trust hosted a Dying Matters engagement stand in the main entrance at Torbay Hospital. Staff and members of the public were invited to share experiences, access information and take away supportive resources. Feedback indicated that the stand was well received, generating meaningful conversations and effective signposting to further support.

Community hospitals also contributed by hosting information stalls, displaying materials in staff areas and organising awareness-raising coffee mornings. These activities helped extend the reach of the campaign across the wider system.

EoL Ambassadors undertaking the programme at the time were encouraged to participate in ways meaningful to their roles. Their contributions included:

- Joining the main entrance stand to initiate conversations with staff and visitors
- Encouraging discussions within teams during breaks and meetings
- Using conversation-prompt cards with patients to explore their lives, values and wishes
- Supporting local awareness events such as coffee mornings and noticeboard displays

This multi-site, multi-professional involvement provides assurance that the Trust is fostering a culture in which conversations about dying are normalised, compassionate and well supported. The engagement demonstrated strong staff commitment and alignment with national priorities to improve openness and communication around end-of-life care.

9.6 Patient, Family and Carer Experience

The voice of patients, carers and loved ones remains a central focus of the Trust's End-of-Life quality improvement approach. Listening to lived experience is essential to shaping compassionate, person-centred care and ensuring that services reflect what matters most to those we support.

Although capacity to collect family feedback has been limited over the past two years, as outlined in section 6, the Trust has continued to refine its improvement work in response to the needs of patients and those close to them. This provides assurance that patient, carer and family voice remains central to the Trust's End-of-Life improvement work.

9.7 Complaints, Concerns 1st April 2024 to 31st March 2025

The Trust transitioned from Datix to DCIQ for complaints and concerns reporting in January 2024. As a result, data for April 2023 to March 2024 was drawn from both systems. The transition has strengthened reporting and improved the quality of information available for oversight and learning.

Between April 2024 and March 2025, the Trust received 137 contacts relating to End-of-Life (EoL) care (Figure 1), representing a 15% reduction compared with the previous year. This downward trend provides early assurance that concerns are not increasing and that improvement work may be positively influencing experience.

The run chart highlights several peak periods of activity, reflecting times when higher numbers of complaints or concerns were raised. These peaks have been reviewed through established governance processes to ensure themes are understood, learning is captured and actions are taken where required. Some correlation is seen with delays in medication, which was already identified in section 7 as a concern and is being addressed.

Overall, the data provides assurance that:

- Reporting systems are functioning effectively following the transition to DCIQ
- The volume of EoL-related contacts has reduced year-on-year
- Variations in activity are being monitored and addressed through routine governance
- The Trust remains committed to learning from patient and family feedback to strengthen the quality and compassion of EoL care

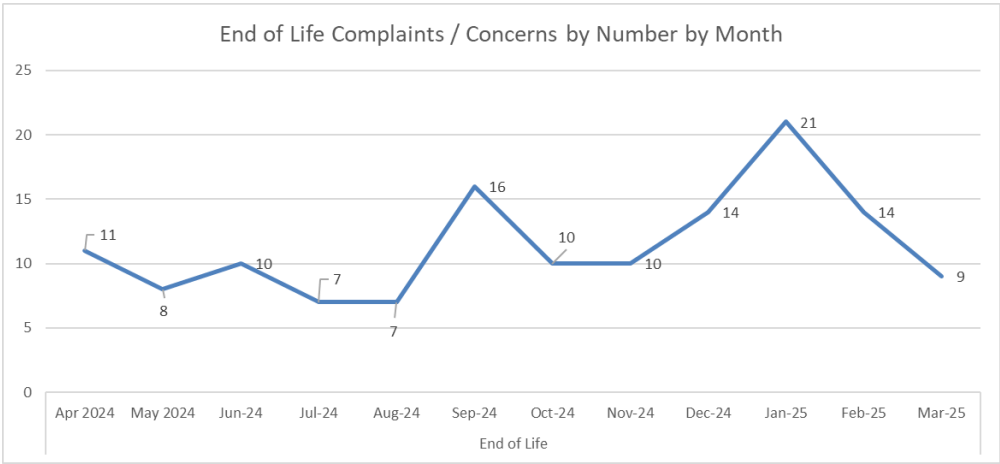


Figure 3. EoL feedback received, April 2024 to March 2025

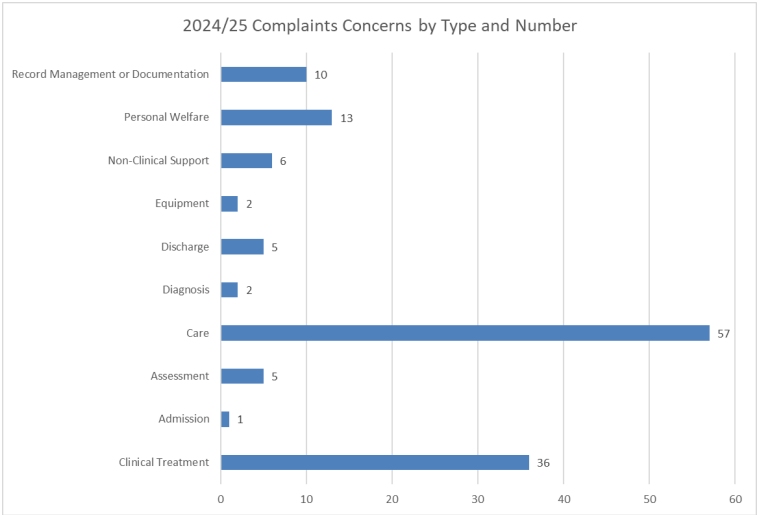


Figure 4. Themes arising from EoL complaints and concerns, April 2024 to March 2025

A detailed breakdown of the data highlights the key themes arising from complaints and concerns. The predominant themes continue to relate to clinical treatment and patient care, consistent with the pattern seen in the previous year. This stability provides assurance that no new or emerging areas of risk have been identified.

All complaints and concerns have been investigated, with learning captured and shared through established governance processes. This supports meaningful improvement and continued focus on the quality and safety of EoL Care.

9.8 Family and loved one support

The Trust recognises that talking about dying, death and bereavement can be challenging for patients, families and staff. In response, we continue to provide a wide range of resources to support conversations, helping patients and those important to them to begin discussions in a safe and supported way.

The Trust’s annual Dying Matters event further strengthens this commitment by encouraging open, honest dialogue between patients, families, loved ones and staff. These activities promote a culture in which conversations about dying are normalised, compassionate and aligned with individual wishes.

This work provides assurance that the organisation remains focused on supportive communication, reducing barriers to difficult conversations and ensuring that people approaching the end of life, and those close to them, feel heard, informed and supported.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 9 – Projects, initiatives, feedback and engagement	Satisfactory	Improvement

10. Spiritual Care

The Chaplaincy and Pastoral Care Department continues to provide vital spiritual and emotional support for patients approaching the end of life and for their families. The team operates a 24/7 service, including an out-of-hours on-call rota that also supports community hospitals, ensuring that spiritual care is available whenever required.

Between April 2024 and March 2025, the service recorded 406 visits to patients on an End-of-Life Care Plan, representing 26% of all chaplaincy activity. The majority of these visits took place at Torbay Hospital, with a smaller number delivered across community sites. This activity demonstrates the Trust's commitment to providing holistic, person-centred care that recognises the importance of spiritual and emotional wellbeing at the end of life.

The Chaplaincy and Pastoral Care service continues to play a vital role in supporting patients and families at the end of life. Although there remains an open risk relating to the limited availability of faith-community representatives, mitigations and governance arrangements are in place. This provides assurance that the organisation remains committed to compassionate, responsive and holistic End-of-Life Care.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 10 - Spiritual Care	Satisfactory	Same

11. Staff feedback and experience on End-of-Life Care

Staff feedback remains important to understanding the experience of delivering End-of-Life Care and informing service improvement.

However, response rates to the traditional postcard-based process have remained low, limiting the volume of timely and reliable feedback available.

To improve engagement, the Trust is exploring more accessible digital options, including QR feedback forms, use of existing staff platforms and rapid anonymous online surveys.

- Digital quick-response (QR) feedback forms accessible via mobile devices
- Integration with existing platforms such as HIVE or staff intranet pages

- Anonymous online surveys that can be completed rapidly after an EoL episode
- Push-notification prompts following key clinical interactions

These changes are intended to improve response rates, strengthen insight and support more timely learning.

Assurance in this area remains limited until a more robust and sustainable feedback process is established, but improvement work is underway.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 11 - Staff feedback and experience on End-of-Life Care	Limited	Regression

12. Conclusion

This report demonstrates the breadth of work undertaken across the Trust to support high-quality End-of-Life Care and the value of collaborative working across services, teams and partner organisations.

Despite a challenging year, the Trust has continued to make measurable progress against its End-of-Life quality improvement priorities, with strengthened governance, improved oversight and clear evidence of learning being translated into practice.

At the heart of this work is a commitment to ensuring that each person's end-of-life experience, and that of their family and loved ones, is delivered with compassion, dignity and respect.

Learning from the National Audit of Care at the End of Life across acute and community settings continues to inform improvement and supports equitable access to good-quality End-of-Life Care.

Partnership working across the system has continued to strengthen during 2024/25, improving coordination, support and quality of care for people at the end of life and those close to them.

Overall, the report provides satisfactory assurance that the Trust remains focused on delivering consistent, compassionate and high-quality End-of-Life Care, underpinned by robust governance, meaningful collaboration and a clear commitment to continuous improvement.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 12 - Conclusion	Satisfactory	N/A

13. Key Learning

The report has provided insight into the positive work currently taking place across the Trust, including:

Key learning from 2024/25 includes:

- Staff confidence, communication skills and role flexibility directly influence the quality of EoL care. Expanding competencies (e.g., nurse- and AHP-led TEPs) strengthens resilience and improves consistency.

- Despite capacity challenges, listening to lived experience continues to shape improvements. Digital methods will strengthen feedback collection going forward.
- e-TEP implementation highlighted the need for early IT engagement, dedicated project support and alignment with wider digital programmes.
- Enhanced oversight (TEP governance, DCIQ reporting, audit participation) ensures learning is captured and acted upon.
- Partnerships with hospices, community services, One Devon and academic institutions improve coordination and support system-wide learning.
- Variability in spiritual support, emotional needs assessment and staffing capacity highlight areas needing continued focus.

This learning has directly informed the ongoing plan for 2025/26.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 13 - Key learning	Satisfactory	On track

14. Recommendations

The Committee is asked to:

- Receive the report and note the breadth of End-of-Life work undertaken across the Trust.
- Note the strength of partnership working across the health and social care system.
- Endorse the continued focus on workforce development, digital capability, governance strengthening and system collaboration to support consistent, compassionate and equitable End-of-Life Care across all settings.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Section 14 – Recommendations	Satisfactory	N/A

Quality and People Committee

Cultural Insights Review Group (CIRG)

Date of meeting	Date report produced
23rd June 2026	15 th June 2026

Author(s)		Report approved by	
Name and title:	Laura Fuller, Deputy Director of People Development	Name and title:	Jess Piper, CPO.
		Date:	15 th June 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 an overview of key themes arising from the Cultural Insights Review Group (CIRG) during May–June 2026, alongside progress against targeted interventions, with a particular focus on the Enhanced Care for Staff pilot.

CIRG is currently overseeing targeted interventions across a number of teams and services, reflecting increasing demand and the scale of workforce and cultural challenges emerging across the organisation.

Demand for Organisational Development (OD) support remains high and predominantly reactive, with issues often escalating late and reducing opportunities for early, preventative intervention. Persistent themes continue to emerge, including psychological safety, inclusion, bullying and overall staff experience, alongside evidence of under-reporting of concerns, particularly among international staff.

The Enhanced Care for Staff pilot is demonstrating early positive impact, improving staff voice, supporting wellbeing and enabling service-level improvements through a more structured and proactive model of engagement. This represents a shift from reactive support to earlier, preventative intervention, although risks remain in relation to capacity and the ability to scale delivery consistently.

The report highlights systemic organisational risks, including recurring cultural issues across multiple teams, sustained late escalation, and the absence of a

consistent, organisation-wide approach to change management. Collectively, these factors are increasing workforce pressure and limiting the organisation's ability to respond early and effectively.

Overall assurance is assessed as **Limited** reflecting sustained demand, recurring cultural themes and a continued reactive position.

Delivery of the People and Education Strategy, Culture Plan, Freedom to Speak Up (FTSU) model and the People & Education restructure will be critical to strengthening early intervention, improving staff voice and enabling a more proactive and coordinated organisational response.

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
Workforce Culture & Escalation	Limited	Static
Enhanced Care for Staff Intervention	Satisfactory	
Change Management Approach	Limited	

Appendices

N/A

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

People And Education Governance Group (PEGG)

Key recommendations and actions requested

The Committee is asked to:

- **Agree** the overall assurance rating of *Limited*
- Support the consideration of adoption and scaling of the Enhanced Care for Staff model as a core organisational intervention
- Approve the development of a consistent organisation-wide change management framework
- **Note** the emerging systemic cultural risks and endorse strengthened escalation and early intervention mechanisms

How does this report further our Trust strategy?

Aligned to our strategic people priorities and restorative just and learn culture (RJLC).

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Yes- Improved staff wellbeing supports delivery of better patient outcomes. CIRG is monitoring insights to understand & supporting actions to mitigate & remedy
Quality of services provided	Yes- Earlier intervention improves team functioning and care quality
Sustainable and efficient use of resources	Yes Reduces escalation costs and reactive interventions

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Direct link between staff experience and care quality
Leadership and Governance	Highlights need for improved oversight and frameworks
Performance	Workforce issues impacting delivery
People and Culture	Core area of focus
Strategy and Business Intelligence	Requires improved data integration
Finance	Reactive interventions carry increased cost

Risk

Key Risks Identified

- Continued late escalation of workforce concerns
- Persistent cultural issues (bullying, inclusion, psychological safety)
- Under-reporting limiting organisational visibility of risk
- Insufficient capacity to deliver timely interventions
- Lack of structured change management approach

Mitigation

- Proposal for scaling Enhanced Care for Staff model
- Strengthening governance and escalation triggers
- Leadership development focused on culture and inclusion
- Integration of workforce, safety and experience data

Risks lodged on Datix:

N/A

External Standards affected by this report and associated risksNHSE
CQC

1. Introduction and background

This report summarises insight and intelligence gathered through CIRG, which reviews organisational culture, workforce experience, and emerging risks requiring OD and leadership intervention.

Recent months have shown increasing demand from services experiencing workforce challenges, often escalated at a late stage. These pressures are compounded by ongoing operational and organisational change.

In response, targeted interventions have been deployed, most notably the Enhanced Care for Staff pilot, designed as a proactive, preventative model to improve staff experience and reduce escalation risk. CIRG is currently overseeing targeted interventions across a number of teams and services, reflecting the scale of emerging cultural risks and the need for coordinated organisational development support.

2. Purpose of report

To provide:

- Assurance on current cultural themes and workforce risks
- An update on interventions, with a focus on Enhanced Care for Staff
- Recommendations for organisational action to strengthen early intervention and change management

3. Key Themes and Risks Emerging

1. Workforce Culture and Escalation

- Continued pattern of late escalation leading to complex and resource-intensive interventions
- Persistent concerns relating to:
 - Bullying and incivility
 - Inclusion and belonging
 - Psychological safety
- Under-reporting of concerns, particularly among international staff, reflecting reduced confidence in speaking up

Assurance Recommendation:

The Committee should note that current approaches are not consistently identifying or addressing cultural risks early enough, with issues often escalating late and recurring. Strengthening governance and escalation processes, alongside delivery of the People and Education Strategy, Culture Plan and revised FTSU model, will support earlier intervention, improved staff voice and a more proactive organisational response.

2. Enhanced Care for Staff Intervention

The Enhanced Care for Staff pilot has been developed in response to increasing workforce complexity and the need for earlier, structured intervention.

Model Overview

The model provides:

- Proactive, structured engagement with teams at risk
- A focus on staff voice, psychological safety and wellbeing
- Integration of OD, improvement and leadership support
- Data-informed identification of risk and targeted intervention

Early Impact

Initial evidence indicates:

- Improved staff engagement and openness in supported teams
- Earlier identification of workforce concerns
- Positive feedback regarding visibility and responsiveness of support
- Emerging links to service improvement outcomes

Strategic Value

The model represents a shift from:

- Reactive to Preventative and proactive intervention
- Isolated support to Integrated workforce and service improvement approach

Risks / Challenges

- Current delivery is constrained by capacity limitations
- Not yet consistently embedded across all services
- Requires alignment with wider change and leadership frameworks

Assurance Recommendation:

It is recommended the Committee take **satisfactory assurance** that the Enhanced Care for Staff pilot is demonstrating early positive impact and represents an effective model for proactive workforce intervention. However, there are ongoing risks related to capacity and the ability to scale delivery.

Further assurance will be provided through formal evaluation and the development of a proposal to strengthen delivery, which will be progressed as part of the People and Education restructure, including the establishment of delivery teams and a phased rollout plan.

3. Change Management Approach

The organisation's current approach to change is largely reactive and inconsistently applied, with limited use of structured diagnostic assessment at the outset of change programmes. As a result, the impact of change on staff experience, team functioning and organisational culture is not always fully understood or actively managed.

A change management approach in this context refers to a consistent, organisation-wide method for planning, implementing and embedding change that:

- Assesses workforce and cultural impact early (before implementation)
- Ensures staff engagement and involvement throughout the change process
- Supports leaders to manage change confidently and consistently
- Tracks the impact of change on culture, wellbeing and performance
- Integrates organisational development (OD), improvement and education into a single, coherent approach

This is increasingly important given the scale and pace of organisational change, alongside ongoing operational pressures, which are collectively:

- Increasing workforce stress and fatigue
- Contributing to declines in psychological safety and engagement
- Leading to unintended negative cultural consequences when change is not well managed

Lack of a standardised framework results in:

- Variable leadership capability
- Inconsistent staff engagement
- Limited tracking of workforce impact
- Organisational change and operational pressures are:
- Increasing workforce stress
- Contributing to cultural challenges

Assurance Recommendation:

It is recommended the Committee take Limited assurance that current change management approaches are sufficient to mitigate workforce risks, noting the absence of a consistent framework. Further assurance should follow Executive agreement on a proposed model which is being reviewed for implementation

4. Assurance recommendations and summary

It is recommended that the Committee:

- **AGREE** the overarching assurance rating of **Limited**

- **NOTE** the early positive impact of the Enhanced Care for Staff intervention pilot
- **SUPPORT** its further development and scaling as a core organisational model through a proposal being developed from pilot evidence
- **ENDORSE** the need for a standardised change management framework and strengthened early intervention approach
- **SUPPORT** the alignment of this work through the People and Education Strategy, Culture Plan, FTSU model and P&E restructure
- **NOTE** the recurring cultural themes (including psychological safety, inclusion and staff experience) and the risk of continued late escalation if not addressed systematically
- **ENDORSE** the strengthening of governance and escalation mechanisms to improve early identification and response to workforce risks
- **RECOGNISE** the capacity risks within OD and improvement functions and the potential impact on pace and sustainability of delivery that will be addressed within P&E restructure

Quality and People Committee

Cultural Insights review Group (CIRG) update (information only)

Date of meeting	Date report produced
26 th May 2026	15 th May 2026

Author(s)		Report approved by	
Name and title:	Laura Fuller, Acting Deputy Director of People and Education	Name and title:	Jess Piper, CPO
		Date:	18 th May 2026

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

Executive summary
Triangulated insight from the Staff Survey, Freedom to Speak Up (FTSU), Employee Relations (ER) and Information Governance (IG) demonstrate persistent challenges within the Well-led domain, particularly in relation to culture, inclusive leadership, and staff voice. There is evidence of progress in openness and transparency, reflected in increased speaking up, indicating growing staff confidence in raising concerns. However, this is not yet underpinned by consistently psychologically safe environments at team level. Variability in leadership capability, local culture and clarity of escalation processes continues to impact staff experience. Themes relating to bullying and incivility, discrimination and inclusion remain evident across multiple data sources, indicating that cultural improvement is not yet embedded or consistently experienced across the organisation. This presents a risk to the delivery of a compassionate, inclusive and high-performing workforce, as required under the Well-led framework. Workforce engagement presents an emerging concern, with reduced National Staff Survey response rates suggesting fragility in staff voice and involvement. This limits the organisation's ability to demonstrate that it is listening to and acting on

staff feedback, a key component of effective leadership and continuous improvement.

The increase in IG incidents, while largely non-malicious, highlights gaps in training, behavioural expectations and system adoption, particularly in relation to Epic. This reflects the need for stronger governance, clearer accountability and consistent leadership oversight to ensure safe and effective practice.

Key risks relate to:

- Inconsistent leadership and management capability
- Lack of clear ownership of cross-organisational cultural priorities
- Fragmented approaches to improvement, reducing overall impact

These factors indicate that, while governance structures are strengthening, organisational grip and pace of improvement require further development.

CIRG is now established as a central mechanism for triangulation, oversight and escalation, supporting improved organisational insight within the Well-led domain. However, assurance is currently moderate, with further work required to embed coordinated action, clear accountability and measurable impact.

Priority areas for strengthening assurance include:

- Developing visible, consistent and inclusive leadership at all levels
- Developing ownership and accountability for cultural improvement at all levels
- Strengthening manager capability and behavioural expectations
- Embedding a coherent, organisation-wide approach to staff experience and support
- Enhancing data-driven oversight and learning through the CIRG dashboard

In summary, while there are early indicators of progress, continued focus is required to ensure the organisation is consistently well-led, inclusive and responsive to staff voice, thereby supporting improvements in staff experience, patient safety and quality of care.

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
Workforce Culture (Bullying, Incivility, Inclusion)	Limited	No significant change – persistent themes across datasets
Staff Voice & Psychological Safety	Satisfactory	Improving – increased speaking up, but variable local experience
Management Capability & Escalation	Limited	Static – ongoing variability in practice and clarity

Information Governance	Satisfactory	Deteriorating – increase in breaches, mitigations in progress
Organisational Coordination & Ownership	Limited	No improvement
Overall Assurance Position	Satisfactory	Static – progress evident but not yet embedded or consistent

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 note the latest CIRG report summary and assurance ratings and ongoing action.

How does this report further our Trust strategy?

This update report supports delivery of the Trust's strategy by strengthening Well-led governance, culture and staff experience, ensuring risks are identified, triangulated and acted upon cohesively.

It enables a more coordinated, accountable approach to improvement, directly underpinning safer care, better staff engagement and sustainable organisational performance.

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	Yes
Performance	Yes
People and Culture	Yes
Strategy and Business Intelligence	Yes
Finance	Yes

Risk

There is a risk that without clear shared ownership and coordinated action, persistent cultural and workforce issues will continue to impact staff wellbeing, engagement and retention.

This may lead to downstream risks to patient safety, quality of care and organisational performance, particularly where psychological safety and effective escalation are not consistently embedded.

Risks lodged on Datix:

External Standards affected by this report and associated risks

Overview

Data triangulated within the Cultural Insights Review Group (CIRG) with intelligence from Staff Survey, FTSU, ER and IG continues to identify persistent cultural and behavioural risks relating to incivility, inclusion and staff voice.

Whilst there are early indicators of improvement (increased speaking up), this is not yet consistently translating into improved staff experience or psychological safety at team level.

Overall assurance is moderate, with clear actions in place, but risk remains unless coordination, ownership and management capability are strengthened.

What This Means for Patient Care & Quality

- Psychological safety and incivility:
 - Environments where staff feel unable to speak up or challenge behaviours are associated with increased risk of avoidable harm, poorer teamworking and reduced quality of care
- Variation in manager capability:
 - Inconsistent handling of concerns can lead to delayed escalation of safety issues and inequitable staff experience, directly impacting service reliability
- Engagement fragility (low NSS response):
 - Reduced engagement limits organisational insight, increasing the risk that emerging safety or quality concerns are not identified early
- IG breaches and Epic-related issues:

- While largely non-malicious, these present risks to patient confidentiality, data integrity and safe system use, particularly during digital transformation

Key Risks to Quality & Safety

- Cultural risk: Persistent bullying, incivility and inclusion concerns : impact on teamwork, communication and safe care delivery
- System risk: Fragmented and siloed responses : reduced organisational ability to address cross-cutting safety issues effectively
- Workforce risk: Increasing employment tribunal activity (notably disability-related) : indicates potential systemic inequities and risk to staff wellbeing and retention
- Digital risk: IG breaches linked to Epic adoption : potential compromise of safe and effective use of clinical systems

Controls & Mitigation

- CIRG operating as central oversight forum, improving triangulation and escalation
- Targeted IG actions including training and local accountability
- Enhanced Care for Staff pilot supporting workforce wellbeing and early intervention
- Agreement to actively track NSS metrics through CIRG to strengthen engagement oversight
- Planned review of Epic-related behavioural and training issues
- Wellbeing group established to improve oversight and governance of offer, visibility and impact

Gaps in Assurance

- Lack of clear shared ownership for cross-cutting cultural themes
- Inconsistent management capability in responding to staff concerns
- Limited coordination of interventions across organisational functions
- CIRG dashboard (to strengthen visibility and assurance) not yet fully implemented

Next Steps / Focus for QPC Awareness

- Strengthening clear executive and operational ownership of culture-related risks
- Delivering coordinated, organisation-wide interventions aligned to patient safety priorities
- Embedding consistent expectations and capability for line managers
- Completing and utilising the CIRG dashboard to support proactive risk management
- Undertaking formal review of Epic-related issues with a focus on safe practice and our people's well-being.

Overall Assurance Statement

There is increasing visibility of key cultural and workforce risks, and appropriate actions are being developed. However, delivery risk remains due to fragmentation and variability in local implementation. Sustained focus on culture, leadership capability and coordinated action is required to mitigate downstream risks to patient safety, experience and quality of care.

Quality and People Committee

Clinical Audit Forward Plan

Date of meeting	Date report produced
23 rd June 2026	09 th June 2026

Author(s)		Report approved by	
Name and title:	Katie Hooper, Head of Compliance and Assurance	Name and title:	Nicola McMinn, Chief Nurse
		Date:	15 th July 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 seeks QPC approval of the proposed assurance ratings for the 2026/27 Clinical Audit Forward Plan. National mandatory clinical audit is rated as satisfactory, with relevant audit requirements identified, monitoring arrangements in place and no current concerns regarding participation or contractual compliance. Local clinical audit is rated as limited. The programme is developing following EPIC implementation and requires a clearer delivery plan, stronger divisional ownership, defined reporting expectations, action tracking, re-audit and timescales for demonstrating impact.		
Section	Assurance (Limited/Satisfactory/Significant)	Trend from previous report
National Mandatory Clinical Audit	Satisfactory	Same
Local Clinical Audit	Limited	Same
The key issue for QPC scrutiny is therefore the pace and governance of the local clinical audit programme. The Committee is asked to approve the assurance ratings and request that future reports demonstrate completed improvement actions and impact, rather than audit registration or participation alone. The key actions for QPC scrutiny are to seek confirmation of divisional audit priorities, delivery timescales, action tracking arrangements, re-audit expectations, escalation routes and how future reports will evidence measurable improvement.		

Appendices

N/A

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

Clinical audit performance is reported annually through the Quality Account. The 2026/27 forward plan has been developed by the Clinical Effectiveness Team and will be monitored through established quality governance routes, with escalation to the Safety and Quality Assurance Group and Risk Group where non-participation, delivery risk or lack of improvement action is identified.

Key recommendations and actions requested

The Committee is asked to APPROVE the proposed SATISFACTORY assurance rating for national mandatory clinical audit, on the basis that the Trust has identified the relevant 2026/27 national audit requirements, has monitoring arrangements in place, and has no current concerns regarding participation or contractual compliance.

The Committee is asked to APPROVE the proposed LIMITED assurance rating for local clinical audit and REQUEST a strengthened delivery plan that confirms divisional priorities, reporting expectations, action tracking, re-audit arrangements and timescales for demonstrating impact.

The Committee is also asked to NOTE that future assurance should focus on evidence of completed improvement actions and impact, rather than audit registration or participation alone.

How does this report further our Trust strategy?

The forward plan supports the Trust strategy by directing clinical audit activity towards areas with the greatest potential to improve quality, safety, patient experience and outcomes. It also supports better use of EPIC data to identify variation, evidence improvement and focus resources on the areas of greatest clinical and organisational priority.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Clinical audit assesses whether care is delivered in line with agreed evidence-based standards, identifies variation and supports targeted improvement. National audit enables benchmarking with peers, while local clinical audit provides a mechanism to respond to Trust priorities, quality risks and service-level improvement opportunities. This supports all three aims by improving
Quality of services provided	
Sustainable and efficient use of resources	

outcomes, reducing unwarranted variation and focusing resources on interventions most likely to improve care.

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Clinical audit supports the Quality, Safety and Patient Experience objective by evidencing compliance with clinical standards, identifying variation and driving improvement. It also supports Leadership and Governance through oversight of national requirements and local priorities, and Performance and Strategy by enabling services to use audit findings and EPIC-derived data to inform improvement, prioritisation and assurance.
Leadership and Governance	
Performance	
People and Culture	
Strategy and Business Intelligence	
Finance	
Risk	
There are no risks requiring escalation in relation to national mandatory clinical audit participation at this stage. The limited assurance rating for local clinical audit reflects a recognised governance and delivery risk if the programme is not sufficiently prioritised, monitored and linked to improvement actions. This will be mitigated through clearer divisional ownership, routine monitoring via established quality governance routes, and escalation where audit delivery or action completion is off trajectory.	
Risks lodged on Datix:	
There is no active Datix risk at present. The position will be kept under review as the local clinical audit programme is strengthened; escalation will be considered if delivery risks, repeated non-participation or failure to complete agreed improvement actions are identified.	
External Standards affected by this report and associated risks	
Care Quality Commission: clinical audit provides evidence of quality governance, learning and improvement.	
NHS Standard Contract: participation in relevant national clinical audit programmes supports contractual compliance.	
Healthcare Quality Improvement Partnership best practice: audit should be prioritised, governed, acted upon and re-audited to demonstrate impact.	

Clinical Audit Forward Plan

1. Introduction and background

Clinical audit priorities are agreed to:

- support delivery of Trust objectives and priorities;
- comply with contractual and external regulatory requirements; and
- focus resources on higher-priority projects with the greatest potential to improve quality, safety and patient outcomes.

2. Purpose of report

This report provides QPC with assurance on the Trust's participation in national mandatory clinical audits for 2026/27 and sets out the current position on the local clinical audit programme. It identifies where assurance is satisfactory, where assurance remains limited, and the actions required to strengthen oversight, prioritisation and evidence of improvement.

3. National Mandatory Clinical Audits 2026/27

The Trust is contracted to undertake the following national audits during 2026/27. There are currently no identified concerns regarding participation. This provides satisfactory assurance that the Trust has identified the relevant national audit requirements and has arrangements in place to monitor participation throughout the year.

Audit of Bladder Cancer Transurethral Laser Ablation Treatment and Evaluation (ABLATE) (BAUS)
Male Bladder Outflow Obstruction Audit (BOO) (BAUS)
Stent Time in Endourology; a National Treatment Survey (STENTS) Audit (BAUS)
BTS Endobronchial Ultrasound (EBUS) National Audit 2025
BTS National Tobacco Dependency Audit 2026
BTS UK Interstitial Lung Disease (ILD) Registry
(ICNARC) Case Mix Programme (CMP)
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People
MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
National Audit of Cardiac Rehabilitation
National Audit of Care at the End of Life (NACEL)
FFFAP National Audit of Inpatient Falls (NAIF)
FFFAP National Hip Fracture Database (NHFD)
National Audit of Dementia (NAD) a) Dementia Diagnostic Services Audit
National Audit of Dementia (NAD) b) Dementia Hospital Care Audit
(NATCAN) National Audit of Metastatic Breast Cancer (NAoMe)
(NATCAN) National Audit of Primary Breast Cancer (NAoPri)
(NATCAN) National Bowel Cancer Audit Report (NBOCA)
(NATCAN) National Kidney Cancer Audit (NKCA)

(NATCAN) National Lung Cancer Audit (NLCA)
(NATCAN) National Non-Hodgkin Lymphoma Audit (NNHLA)
(NATCAN) National Oesophago-Gastric Cancer Audit Report
(NATCAN) National Ovarian Cancer Audit (NOCA)
(NATCAN) National Pancreatic Cancer Audit (NPaCA)
(NATCAN) National Prostate Cancer Audit
National Cardiac Arrest Audit (NCAA)
(MINAP) Acute Coronary Syndrome or Acute Myocardial Infarction
(NCAP) Cardiac Rhythm Management Audit
(NCAP) National audit of Percutaneous Coronary Interventions (NAPCI)
(NCAP) National Heart Failure Audit (NHFA)
National Child Mortality Database (NCMD)
National Clinical Audit of Perioperative Care (NCAPC)
National Comparative Audit of NICE Quality Standard QA138)
National Comparative Audit of Platelet use
NCA of the use of Anti-D Immunoglobulin Prophylaxis
(NDA) National Diabetes Foot Care Audit (NDFA)
(NDA) National Diabetes Inpatient Safety Audit (NDISA)
(NDA) National Pregnancy in Diabetes Audit (NPID)
National Early Inflammatory Arthritis Audit (NEIAA)
National Emergency Laparotomy Audit (NELA) (NoLap)
National Joint Registry
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP)
National Ophthalmology Database (NOD) - Age-related Macular Degeneration (AMD) Audit
National Ophthalmology Database (NOD) - Cataract Audit
National Paediatrics Diabetes Audit (NPDA)
National Perinatal Mortality Review Tool (PRMT)
NRAP COPD Secondary Care
NRAP Pulmonary Rehabilitation
NRAP Adult Asthma Secondary Care
NRAP Children and Young People's Asthma Secondary Care
Perioperative Quality Improvement Programme (PQIP)
Sentinel Stroke National Audit Programme (SSNAP)
Child Health Outcome Review Programme (NCEPOD)
National Emergency Laparotomy Audit (NELA) (Laparotomy)

Participation is monitored by the Clinical Effectiveness Team throughout the year. Concerns relating to non-participation, incomplete data submission or emerging outlier status will be escalated through the Safety and Quality Assurance Group and Risk Group as required. Outcomes from national audit participation will be reported through the annual Quality Account, with services expected to translate relevant findings into improvement actions and, where appropriate, undertake re-audit to evidence impact.

4. Local Clinical Audit 2026/27

Local clinical audit projects are registered throughout the year by individual services in response to service priorities, quality risks, external standards or identified

improvement needs. Central team small-scale audits may also be undertaken where organisation-wide concerns require baseline intelligence or where a consistent Trust-wide approach is required.

Following implementation of EPIC, the 2026/27 local audit programme will need to move beyond traditional record-keeping compliance audits and place greater emphasis on the quality, completeness and clinical usefulness of information within the electronic patient record. This is an opportunity to strengthen assurance, but it requires a clearer programme of work and stronger divisional ownership.

There is potential to use EPIC reporting functionality to extract more timely quality information as the system becomes more established. For example, this could support baseline assessment against NICE quality standards, identify variation between services and enable more targeted audit activity. The limited assurance rating reflects that the local programme is not yet sufficiently mature to demonstrate consistent prioritisation, action tracking, re-audit and impact.

For local clinical audit, the governance expectation is that each audit is prioritised against quality risks and strategic objectives, has clear divisional ownership, is reported through established quality governance routes, and is translated into tracked actions with named owners and timescales. Where audit findings identify significant variation, repeated non-compliance, overdue actions or lack of improvement, these should be escalated through the relevant quality and risk governance routes. Future assurance should therefore demonstrate not only that audits have been undertaken, but that actions have been completed, re-audit has taken place where appropriate, and measurable impact has been achieved. Escalation for overdue local audit actions should follow a clear stepped approach: first, review by the responsible audit lead and divisional governance group to confirm the cause of delay, revised timescale and any support required; second, escalation to the divisional quality and performance route where actions remain overdue or delivery risk is increasing; third, escalation to the Safety and Quality Assurance Group where overdue actions relate to significant quality, safety, compliance or variation concerns; and fourth, escalation to Risk Group, and consideration of Datix risk entry, where actions remain off trajectory, present a material risk to quality or safety, or require executive oversight.

The proposed strengthening actions for 2026/27 are to confirm divisional audit priorities linked to quality risks and strategic objectives; agree a standard reporting framework for local audit outcomes, actions and re-audit; use EPIC data to support more timely intelligence where feasible; and provide QPC with future assurance on delivery, impact and any areas requiring escalation.

5. Assurance recommendations and summary

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
National Mandatory Clinical Audit	Satisfactory	Same
Local Clinical Audit	Limited	Same

The Committee is asked to APPROVE the proposed SATISFACTORY assurance rating for national mandatory clinical audit, noting that the Trust has identified the relevant 2026/27 national audit requirements, has monitoring arrangements in place, and has no current concerns regarding participation or contractual compliance.

The Committee is asked to APPROVE the proposed LIMITED assurance rating for local clinical audit and REQUEST a strengthened delivery plan that confirms divisional priorities, reporting expectations, action tracking, re-audit arrangements and timescales for demonstrating impact.

The Committee is asked to NOTE that future reports should provide assurance on completed improvement actions and evidence of impact, rather than audit registration or participation alone.

In summary, QPC should expect the local clinical audit programme to demonstrate clear prioritisation against quality risks and strategic objectives, divisional ownership, reporting through established quality governance routes, tracked actions with named owners and timescales, escalation of significant variation or overdue improvement, and evidence of re-audit and measurable impact.

For scrutiny, QPC should seek assurance that the strengthened local clinical audit delivery plan includes: agreed divisional priorities linked to quality risks; named owners and timescales for audit actions; clear reporting and escalation routes; planned re-audit where required; and evidence that completed actions have improved care, reduced variation or strengthened compliance with standards. QPC should also expect overdue audit actions to be escalated through a stepped route from audit lead and divisional governance review, to divisional quality and performance oversight, then to Safety and Quality Assurance Group, with escalation to Risk Group and consideration of Datix risk entry where actions remain off trajectory or present a material quality or safety risk.



Torbay and South Devon
NHS Foundation Trust

Quality and People Committee

2025 National Staff Survey Results Report (revised)

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

Author(s)		Report approved by	
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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

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

Appendices are 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).

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 were shared with colleagues through communications from the Chief Executive Officer and Chief People Officer. Following this, results have been cascaded to Directorates and Staff Networks, with all survey reports made available on ICON.

The Trust is now 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 may be influenced by the EPIC launch, substantive action planning taking place in May/ June 2026.

The Cultural Insights Review Group (CIRG) will act as the central governance mechanism for Staff Survey action planning. All Directorates will develop their action plans and present these to CIRG in July.

Care Groups will develop local action plans informed directly by their survey insights, ensuring these reflect local cultural drivers, strengths and risks. Completed Care Group action plans will be submitted by the end of June 2026. CIRG will then review, challenge and track delivery, ensuring alignment with Trust-wide cultural priorities.

CIRG will consolidate all outputs into a single, coherent Trust-wide plan, monitor delivery through its monthly assurance cycle, and support a consistent “You Said – We Did – We Will” communication approach.

At Trust level, the CEO and Executive Team will host a programme of “listening and dialogue” events to share results and focus on key organisational priorities.

In addition, action planning will be undertaken at the May Board Development Day and incorporated into the overarching Trust Action Plan.

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

Appendix 1 TSD NSS 2025 Results and Analysis Background



Torbay and South Devon
NHS Foundation Trust

- The NHS National Staff Survey (NSS) is one of the largest workforce surveys in the world and is carried out every year to understand and improve staff experiences across the NHS
- The survey is aligned to the [NHS People Promise](#)
- All NHS organisations are required to participate
- Link: [Working together to improve NHS staff experiences | NHS Staff Survey](#)

Methodology



Torbay and South Devon
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- An external contractor (IQVIA) was used to process the survey, provide results tables and protect respondent anonymity
- The survey was run on paper and online between September and November 2025
- Two reminders were sent to staff who didn't respond to the paper survey and six reminders for online respondents
- The comparative group was made-up of 71 acute and acute & community trusts who work with the same contractor

Key Insights



Torbay and South Devon
NHS Foundation Trust

TSD Response rate: 35.55 (↓ 39.15)

1. 'Stable' response with little variation on previous year
2. Largely below comparator organisations
3. Flexible working (where the employee's role allows) seen as positive
4. Involvement is mixed; uneven experiences across staff groups
5. Safety, violence and discrimination remain a concern especially for clinical staff
6. Health and wellbeing – contradictory results. Increase in MSK is high.

Headlines



Torbay and South Devon
NHS Foundation Trust

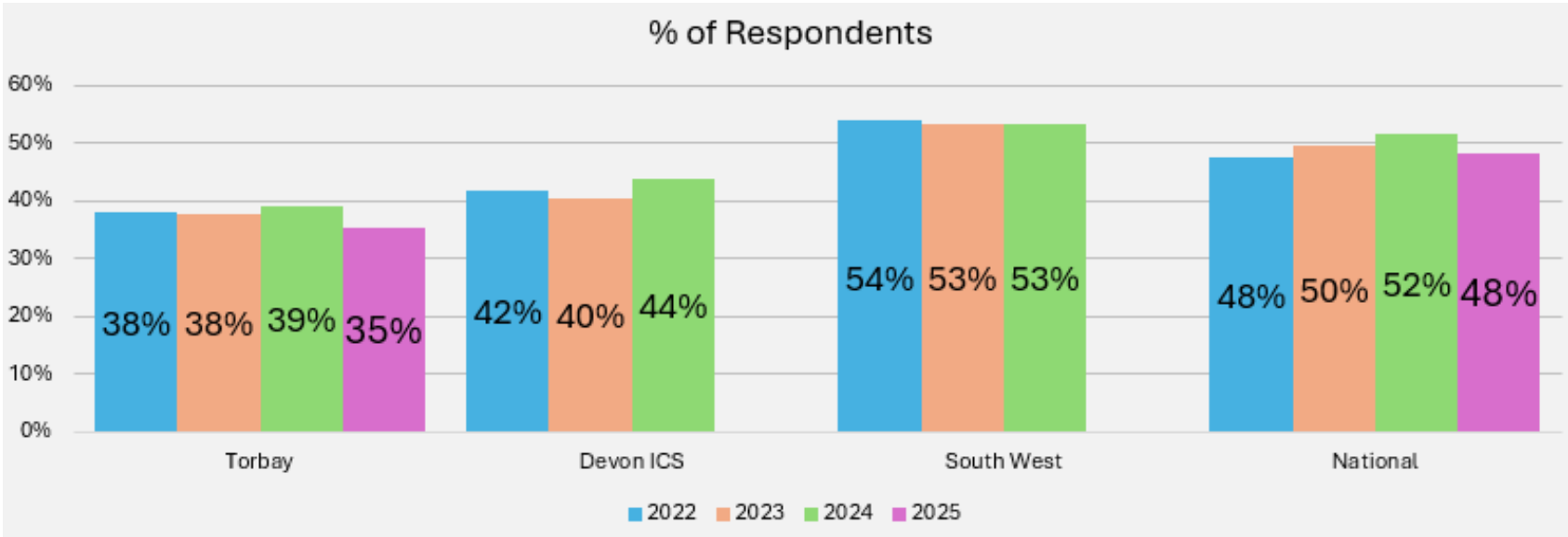
 Staff Survey at a Glance • Response rate: 35.55% • Down from 39.15% in 2024 • Highest score: Diversity & Equality (8.15) • Lowest score: Appraisals (4.33) • Overall message: Workforce experience 'stable' but 'fragile'	 Workforce Experience • Engagement and morale slightly improved • Results remain below comparator trusts • Health & wellbeing results mixed • Musculoskeletal concerns increasing • Frontline staff report greatest pressure
 Culture Signals • Flexible working viewed positively where available • 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
 Work Pressure • Only 41% can meet work demands on time • Around half report insufficient staffing • Materials generally available • Frontline workload remains very high	→ What Happens Next • Trust communications on results • Care Group and team reports shared • Listening sessions with staff • Local and Trust action plans to embed development • 'You Said – We Did – We Will' approach

Response Rates: TSD and Comparison



Torbay and South Devon
NHS Foundation Trust

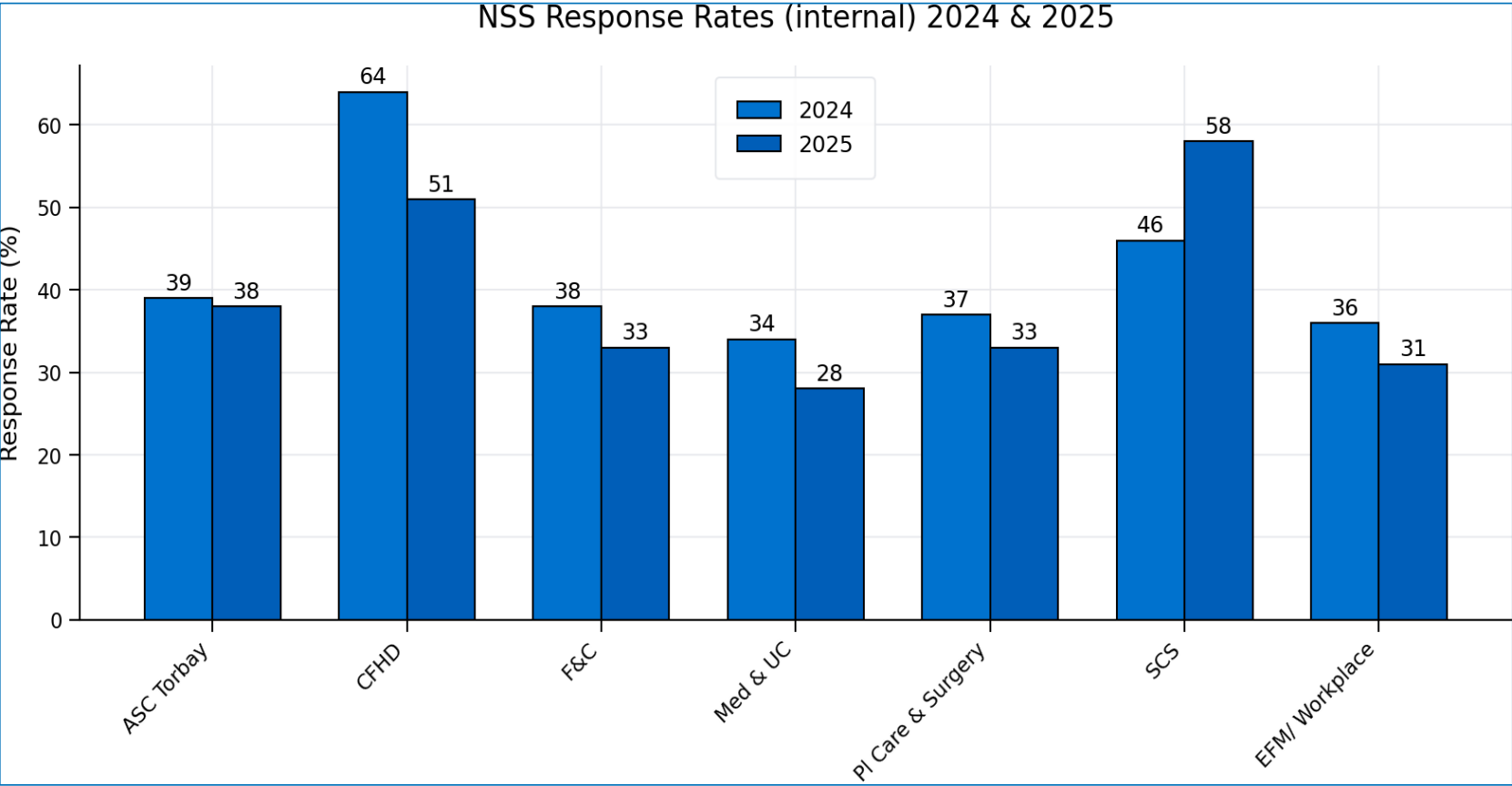
Narrative



Response Rates: TSD Internal



Torbay and South Devon
NHS Foundation Trust



Narrative

Response Rates by Profession



Torbay and South Devon
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Description	contributes to Theme Sub- score	Results					
		2024		2025		Comparator	
		n	value	n	value	n	value
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Occupational Therapy	N/A	75	2.7%	80	3.1%	4,220	1.3%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Physiotherapy	N/A	87	3.1%	82	3.2%	8,931	2.8%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Radiography	N/A	45	1.6%	55	2.2%	8,229	2.5%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Pharmacy	N/A	56	2.0%	50	2.0%	9,214	2.9%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Clinical Psychology	N/A	8	0.3%	18	0.7%	1,022	0.3%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Psychotherapy	N/A	1	0.0%	3	0.1%	274	0.1%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Operating Department Practitioner	N/A	19	0.7%	15	0.6%	2,750	0.9%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Speech and Language Therapy	N/A	51	1.8%	47	1.8%	2,398	0.7%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Other qualified Allied Health Professionals (e.g. dietetics, podiatry, osteop	N/A	83	3.0%	74	2.9%	6,689	2.1%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Support to Allied Health Professionals (e.g. support worker, therapy help	N/A	84	3.0%	70	2.7%	8,355	2.6%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Other qualified Scientific and Technical or Healthcare Scientists (e.g. hae	N/A	56	2.0%	56	2.2%	10,637	3.3%
Allied Health Professionals / Healthcare Scientists / Scientific and Technical: Support to healthcare scientists (e.g. technicians, assistants or students)	N/A	35	1.3%	26	1.0%	4,440	1.4%
Medical and Dental: Medical / Dental - Consultant	N/A	113	4.1%	107	4.2%	16,318	5.1%
Medical and Dental: Medical / Dental - In Training (e.g. Foundation Y1, Foundation Y2, Core Trainees, Specialty Trainees (including GPs))	N/A	52	1.9%	40	1.6%	5,505	1.7%
Medical and Dental: Medical / Dental - SAS doctor (Specialty Doctor, Specialist, Staff Grade or Associate Specialist)	N/A	15	0.5%	16	0.6%	2,771	0.9%
Medical and Dental: Medical / Dental - Other (e.g. Locally Employed Doctor, Trust Grade Doctor, Clinical Fellow, etc)	N/A	17	0.6%	14	0.5%	3,089	1.0%
Medical and Dental: Salaried Primary Care Dentists	N/A	4	0.1%	4	0.2%	76	0.0%
Ambulance (operational): Paramedic	N/A	1	0.0%	1	0.0%	99	0.0%
Ambulance (operational): Emergency Care Assistant	N/A	3	0.1%	3	0.1%	179	0.1%
Ambulance (operational): Patient Transport Service (e.g. ambulance drivers, support staff)	N/A	11	0.4%	11	0.4%	352	0.1%
Public Health: Public Health / Health Improvement	N/A	24	0.9%	26	1.0%	938	0.3%
Commissioning: Commissioning managers / support staff	N/A	6	0.2%	4	0.2%	290	0.1%
Registered Nurses and Midwives: Adult / General	N/A	446	16.1%	359	14.1%	73,984	22.9%
Registered Nurses and Midwives: Mental health	N/A	7	0.3%	6	0.2%	398	0.1%
Registered Nurses and Midwives: Learning disabilities	N/A	11	0.4%	7	0.3%	249	0.1%
Registered Nurses and Midwives: Children	N/A	59	2.1%	56	2.2%	9,351	2.9%
Registered Nurses and Midwives: Midwives	N/A	55	2.0%	44	1.7%	8,252	2.6%
Registered Nurses and Midwives: Health Visitors	N/A	18	0.7%	15	0.6%	1,283	0.4%
Registered Nurses and Midwives: District / Community	N/A	28	1.0%	22	0.9%	2,151	0.7%
Registered Nurses and Midwives: Other Registered Nurses	N/A	24	0.9%	28	1.1%	4,339	1.3%
Nursing or Healthcare Assistants: Nursing auxiliary / Nursing assistant / Healthcare assistant (including Health / Clinical / Nursing Support Worker)	N/A	204	7.4%	151	5.9%	25,416	7.9%
Social Care: Social workers	N/A	20	0.7%	31	1.2%	344	0.1%
Social Care: Social care managers	N/A	11	0.4%	6	0.2%	35	0.0%
Social Care: Social care support staff	N/A	34	1.2%	41	1.6%	490	0.2%
Wider Healthcare Team: Admin & Clerical (including Medical Secretary)	N/A	475	17.2%	476	18.6%	47,826	14.8%
Wider Healthcare Team: Central Functions / Corporate Services (e.g. HR, Finance, Information Systems, Information Technology)	N/A	157	5.7%	194	7.6%	17,557	5.4%
Wider Healthcare Team: Maintenance / Ancillary (e.g. housekeeping, domestic staff, maintenance, facilities, estates)	N/A	177	6.4%	145	5.7%	14,867	4.6%
General Management: General Management	N/A	78	2.8%	80	3.1%	8,796	2.7%
Other: Other occupational group	N/A	116	4.2%	90	3.5%	10,736	3.3%
Missing	N/A	50		55		7,639	

Response Rates by Ethnic Group



Torbay and South Devon
NHS Foundation Trust

Description	Results					
	2024		2025		Comparator	
	n	value	n	value	n	value
White: English / Welsh / Scottish / Northern Irish / British	2,364	85.2%	2,234	86.9%	198,730	61.3%
White: Irish	13	0.5%	12	0.5%	3,293	1.0%
White: Gypsy or Irish Traveller	3	0.1%	1	0.0%	196	0.1%
White: Any other White background	123	4.4%	108	4.2%	17,443	5.4%
Mixed/Multiple ethnic background: White and Black Caribbean	9	0.3%	5	0.2%	1,782	0.5%
Mixed/Multiple ethnic background: White and Black African	4	0.1%	2	0.1%	1,371	0.4%
Mixed/Multiple ethnic background: White and Asian	14	0.5%	10	0.4%	2,120	0.7%
Mixed/Multiple ethnic background: Any other Mixed / Multiple ethnic background	17	0.6%	12	0.5%	3,135	1.0%
Asian/Asian British: Indian	94	3.4%	81	3.2%	32,445	10.0%
Asian/Asian British: Pakistani	5	0.2%	6	0.2%	5,742	1.8%
Asian/Asian British: Bangladeshi	1	0.0%	2	0.1%	2,290	0.7%
Asian/Asian British: Chinese	10	0.4%	7	0.3%	2,502	0.8%
Asian/Asian British: Filipino	-	-	37	1.4%	13,294	4.1%
Asian/Asian British: Any other Asian background	66	2.4%	17	0.7%	8,021	2.5%
Black/African/Caribbean/Black British: African	34	1.2%	24	0.9%	20,835	6.4%
Black/African/Caribbean/Black British: Caribbean	1	0.0%	3	0.1%	4,274	1.3%
Black/African/Caribbean/Black British: Any other Black / African / Caribbean background	3	0.1%	4	0.2%	1,610	0.5%
Other ethnic group: Arab	2	0.1%	0	0.0%	1,740	0.5%
Other ethnic group: Any other ethnic background	13	0.5%	5	0.2%	3,531	1.1%
Missing	40		39		6,245	

Insights to Results

Summary of Scores



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme	2024 Score	Significance	2025 Score	Significance	Sector Score
Theme - Staff engagement	6.68	Not Significant	6.72	Not Significant	6.75
Theme - Morale	5.79	Not Significant	5.82	Not Significant	5.88
People Promise 1 - We are compassionate and inclusive	7.29	Not Significant	7.31	Not Significant	7.28
People Promise 2 - We are recognised and rewarded	5.93	Not Significant	5.96	Significantly Better	5.88
People Promise 3 - We each have a voice that counts	6.52	Not Significant	6.57	Not Significant	6.62
People Promise 4 - We are safe and healthy	5.99	Not Significant	6.01	Significantly Worse	6.09
People Promise 5 - We are always learning	5.32	Not Significant	5.38	Significantly Worse	5.64
People Promise 6 - We work flexibly	6.23	Not Significant	6.33	Significantly Better	6.23
People Promise 7 - We are a team	6.70	Not Significant	6.73	Not Significant	6.75

Appendix 1 TSD NSS 2025 Results and Analysis



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Theme Scores



Torbay and South Devon
NHS Foundation Trust

- Staff engagement
- Morale

Data Type	Metric		Results			TSD vs Comparator
			2024	2025	Comparator	
			value	value	value	
Theme score	E	Staff engagement	6.66	6.68	6.75	below
Theme score	M	Morale	5.79	5.80	5.88	below
Theme sub-score	E_1	Motivation	6.84	6.89	6.86	above
Theme sub-score	E_2	Involvement	6.64	6.74	6.76	below
Theme sub-score	E_3	Advocacy	6.50	6.42	6.61	below
Theme sub-score	M_1	Thinking about leaving	6.12	6.13	6.02	above
Theme sub-score	M_2	Work pressure	4.93	4.91	5.25	below
Theme sub-score	M_3	Stressors	6.32	6.36	6.36	equal

Both measures show slight improvement however there are two declines (slight) which are a concern especially work pressure. Both measures below comparators.

Staff Engagement



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
Theme - Staff engagement	6.68	Not Significant	6.72	Not Significant	6.75
Sub-score 1 - Motivation	6.86	Not Significant	6.93	Not Significant	6.86
2a. I look forward to going to work.	50.5%	Not Significant	52.0%	Not Significant	51.7%
2b. I am enthusiastic about my job.	65.9%	Not Significant	68.0%	Significantly Better	65.4%
2c. Time passes quickly when I am working.	70.9%	Not Significant	72.1%	Significantly Better	69.1%
Sub-score 2 - Involvement	6.68	Not Significant	6.79	Not Significant	6.76
3c. There are frequent opportunities for me to show initiative in my role.	71.6%	Not Significant	73.3%	Not Significant	72.2%
3d. I am able to make suggestions to improve the work of my team / department.	70.6%	Not Significant	72.0%	Significantly Better	69.8%
3f. I am able to make improvements happen in my area of work.	51.5%	Not Significant	53.7%	Not Significant	54.7%

Staff Engagement (continued)



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People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
Sub-score 3 - Advocacy	6.51	Not Significant	6.46	Significantly Worse	6.61
25a. Care of patients / service users is my organisation's top priority.	67.8%	Not Significant	68.5%	Significantly Worse	71.5%
25c. I would recommend my organisation as a place to work.	57.8%	Not Significant	56.6%	Not Significant	57.8%
25d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	60.4%	Not Significant	61.2%	Not Significant	62.2%

Morale



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
Theme - Morale	5.79	Not Significant	5.82	Not Significant	5.88
Sub-score 1 - Thinking about leaving	6.15	Not Significant	6.19	Significantly Better	6.02
26a. I often think about leaving this organisation.	31.3%	Not Significant	31.0%	Significantly Worse	29.0%
26b. I will probably look for a job at a new organisation in the next 12 months.	20.9%	Not Significant	18.9%	Significantly Better	20.9%
26c. As soon as I can find another job, I will leave this organisation.	14.4%	Not Significant	14.3%	Significantly Better	16.7%
Sub-score 2 - Work pressure	4.90	Not Significant	4.90	Significantly Worse	5.25
3g. I am able to meet all the conflicting demands on my time at work.	41.2%	Not Significant	40.6%	Significantly Worse	46.6%
3h. I have adequate materials, supplies and equipment to do my work.	51.2%	Not Significant	52.2%	Not Significant	54.1%
3i. There are enough staff at this organisation for me to do my job properly.	27.6%	Not Significant	26.0%	Significantly Worse	31.8%

Morale (continued)

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
Sub-score 3 - Stressors	6.32	Not Significant	6.37	Not Significant	6.36
3a. I always know what my work responsibilities are.	85.4%	Not Significant	84.2%	Significantly Worse	86.5%
3e. I am involved in deciding on changes introduced that affect my work area / team / department.	47.4%	Significantly Improved	50.3%	Not Significant	49.2%
5a. I have unrealistic time pressures.	24.8%	Not Significant	25.3%	Not Significant	25.5%
5b. I have a choice in deciding how to do my work.	52.7%	Significantly Improved	55.5%	Significantly Better	51.4%
5c. Relationships at work are strained.	46.8%	Not Significant	47.2%	Not Significant	45.3%
7c. I receive the respect I deserve from my colleagues at work.	71.3%	Not Significant	72.5%	Not Significant	70.9%
9a. My immediate manager encourages me at work.	71.0%	Not Significant	72.0%	Not Significant	71.7%

Advocacy scores



Torbay and South Devon
NHS Foundation Trust

Data Type	Metric		Description	c contributes tow	Results			
					Theme Sub-score	2024	2025	Comparator
						value	value	value
Question: score (+ive)	25a	Care of patients / service users is my organisation's top priority.	Staff selecting Agree/Strongly agree	Advocacy	67.8%	67.7%	71.5%	
Question: score (-ive)	25a	Care of patients / service users is my organisation's top priority.	Staff selecting Strongly disagree/Disagree	Advocacy	13.2%	13.5%	11.2%	
Question: score (+ive)	25b	My organisation acts on concerns raised by patients / service users.	Staff selecting Agree/Strongly agree	N/A	63.0%	61.0%	68.2%	
Question: score (-ive)	25b	My organisation acts on concerns raised by patients / service users.	Staff selecting Strongly disagree/Disagree	N/A	7.1%	8.4%	7.1%	
Question: score (+ive)	25c	I would recommend my organisation as a place to work.	Staff selecting Agree/Strongly agree	Advocacy	57.0%	55.0%	57.8%	
Question: score (-ive)	25c	I would recommend my organisation as a place to work.	Staff selecting Strongly disagree/Disagree	Advocacy	17.3%	18.6%	16.8%	
Question: score (+ive)	25d	If a friend or relative needed treatment I would be happy with the stan	Staff selecting Agree/Strongly agree	Advocacy	60.3%	60.4%	62.2%	
Question: score (-ive)	25d	If a friend or relative needed treatment I would be happy with the stan	Staff selecting Strongly disagree/Disagree	Advocacy	13.8%	14.7%	13.3%	

Work Pressure scores



Torbay and South Devon
NHS Foundation Trust

Data Type		Metric	Description	Questionnaire Section	Metric contributes towards:		Results		
					Theme Sub-score		2024	2025	Comparator
							value	value	value
Theme sub-score	M_2	Work pressure	N/A	N/A	M_2	Work pressure	4.93	4.91	5.25
Question: score (+ive)	3g	I am able to meet all the conflicting demands on my time at work.	Staff selecting Agree/Strongly agree	YOUR JOB	M_2	Work pressure	42.0%	41.1%	46.6%
Question: score (-ive)	3g	I am able to meet all the conflicting demands on my time at work.	Staff selecting Strongly disagree/Disagree	YOUR JOB	M_2	Work pressure	32.9%	34.4%	28.1%
Question: score (+ive)	3h	I have adequate materials, supplies and equipment to do my work.	Staff selecting Agree/Strongly agree	YOUR JOB	M_2	Work pressure	51.1%	52.4%	54.1%
Question: score (-ive)	3h	I have adequate materials, supplies and equipment to do my work.	Staff selecting Strongly disagree/Disagree	YOUR JOB	M_2	Work pressure	29.9%	28.2%	25.9%
Question: score (+ive)	3i	There are enough staff at this organisation for me to do my job properly.	Staff selecting Agree/Strongly agree	YOUR JOB	M_2	Work pressure	28.2%	26.2%	31.8%
Question: score (-ive)	3i	There are enough staff at this organisation for me to do my job properly.	Staff selecting Strongly disagree/Disagree	YOUR JOB	M_2	Work pressure	51.1%	52.9%	46.0%

Summary: Top 10



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Top 10 Scores for your organisation

		Score
1	13b In the last 12 months, I have personally experienced physical violence at work from managers.	0.6%
2	13c In the last 12 months, I have personally experienced physical violence at work from other colleagues.	1.4%
3	16c04 Experienced discrimination on grounds of marriage or civil partnership.	1.4%
4	16c03 Experienced discrimination on grounds of gender reassignment.	1.4%
5	16c07 Experienced discrimination on grounds of religion or belief.	3.1%
6	17b In the last 12 months, I have personally been the target of unwanted behaviour of a sexual nature in the workplace from a manager / team leader or other colleagues.	3.7%
7	16c05 Experienced discrimination on grounds of pregnancy or maternity.	3.9%
8	16c09 Experienced discrimination on grounds of sexual orientation.	4.0%
9	16a In the last 12 months, I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	5.8%
10	16b In the last 12 months, I have personally experienced discrimination at work from a manager / team leader or other colleagues.	8.2%

Summary: Bottom 5



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NHS Foundation Trust

Bottom 10 Scores for your organisation

		Score
1	23b The appraisal / review helped me to improve how I do my job.	20.4%
2	5a I never / rarely have unrealistic time pressures.	25.3%
3	3i There are enough staff at this organisation for me to do my job properly.	26.0%
4	23d The appraisal / review left me feeling that my work is valued by my organisation.	29.8%
5	23c The appraisal / review helped me agree clear objectives for my work.	30.8%
6	4c I am satisfied with my level of pay.	33.8%
7	3g I am able to meet all the conflicting demands on my time at work.	40.6%
8	4b I am satisfied with the extent to which my organisation values my work.	40.7%
9	25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	42.5%
10	11d In the last three months I have come to work despite not feeling well enough to perform my duties.	56.3%

Top 5 most improved



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Top 5 Most Improved Breakdown Positive Scores compared to previous year

Question 	Diff Score	Rank 	2025 Score	2024 Score
13d The last time you experienced physical violence at work, did you or a colleague report it (Yes).	8.4%	1	70.2%	61.9%
10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours (0 hours).	4.4%	2	73.6%	69.2%
5b I have a choice in deciding how to do my work (Often/Always).	2.9%	3	55.5%	52.7%
3e I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	2.9%	4	50.3%	47.4%
6c I achieve a good balance between my work life and my home life (Agree/Strongly agree).	2.7%	5	58.8%	56.1%

Top 5 most declined



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Top 5 Most Declined Scores Breakdown Positive Scores compared to previous year

Question	Diff Score	Rank	2025 Score	2024 Score
24b There are opportunities for me to develop my career in this organisation (Agree/Strongly agree).	-1.7%	1	50.3%	52.0%
11a My organisation takes positive action on health and well-being (Agree/Strongly agree).	-1.6%	2	49.5%	51.1%
3i There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	-1.6%	3	26.0%	27.6%
26a I often think about leaving this organisation (Strongly disagree/Disagree).	-1.5%	4	44.4%	45.9%
9b My immediate manager gives me clear feedback on my work (Agree/Strongly agree).	-1.2%	5	62.9%	64.1%

Significant results compared to 2024



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Significantly Better Scores

Question		2024	2025	Difference	
3e	I am involved in deciding on changes introduced that affect my work area / team / department.	47.4%	50.3%		+2.9%
5b	I have a choice in deciding how to do my work.	52.7%	55.5%		+2.9%
6c	I achieve a good balance between my work life and my home life.	56.1%	58.8%		+2.7%
10b	I work additional PAID hours for this organisation, over and above my contracted hours.	30.8%	26.4%		-4.4%
13d	The last time I experienced physical violence at work, myself or a colleague reported it.	61.9%	70.2%		+8.4%

Significantly Worse Scores

Question	2024	2025	Difference

There are no significantly worse scores than the previous year.

Significant results – compared to sector



Torbay and South Devon
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Significantly Better Scores

Question	Your Org.	Sector	Difference
2b I am enthusiastic about my job.	68.0%	65.4%	+2.6%
2c Time passes quickly when I am working.	72.1%	69.1%	+2.9%
3d I am able to make suggestions to improve the work of my team / department.	72.0%	69.8%	+2.2%
4a I am satisfied with the recognition I get for good work.	54.5%	52.1%	+2.3%
4c I am satisfied with my level of pay.	33.8%	31.0%	+2.8%
4d I am satisfied with the opportunities for flexible working patterns.	58.8%	56.4%	+2.4%
5b I have a choice in deciding how to do my work.	55.5%	51.4%	+4.1%
6c I achieve a good balance between my work life and my home life.	58.8%	55.9%	+2.9%

Significant results – compared to sector - worse



Torbay and South Devon
NHS Foundation Trust

Significantly Worse Scores

Question	Your Org.	Sector	Difference
3a I always know what my work responsibilities are.	84.2%	86.5%	-2.4%
3g I am able to meet all the conflicting demands on my time at work.	40.6%	46.6%	-5.9%
3i There are enough staff at this organisation for me to do my job properly.	26.0%	31.8%	-5.8%
8a Teams within this organisation work well together to achieve their objectives.	49.9%	54.4%	-4.5%
9b My immediate manager gives me clear feedback on my work.	62.9%	65.0%	-2.2%
11a My organisation takes positive action on health and well-being.	49.5%	54.5%	-5.0%
12a I often / always find my work emotionally exhausting.	36.8%	34.5%	+2.3%
12c My work often / always frustrates me.	40.4%	36.8%	+3.6%
12e I often / always feel worn out at the end of my working day / shift.	45.4%	43.1%	+2.3%
14b In the last 12 months, I have personally experienced harassment, bullying or abuse at work from managers.	10.6%	9.2%	+1.3%
14d The last time I experienced harassment, bullying or abuse at work, myself or a colleague reported it.	48.2%	52.6%	-4.4%
16c01 Experienced discrimination on grounds of age.	25.1%	17.0%	+8.1%
16c02 Experienced discrimination on grounds of disability.	17.2%	9.9%	+7.3%
16c10 Experienced discrimination on grounds of anything else.	26.3%	21.2%	+5.1%

Significant results – compared to sector - worse



Torbay and South Devon
NHS Foundation Trust

18	In the last month, I have seen an error, near miss, or incident that could have hurt staff and / or patients / service users.	37.8%	35.3%		+2.5%
19c	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	63.1%	67.3%		-4.2%
19d	We are given feedback about changes made in response to reported errors, near misses and incidents.	55.1%	61.0%		-5.9%
20b	I am confident that my organisation would address my concern.	51.4%	54.7%		-3.3%
23a	In the last 12 months, I have had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.	83.6%	86.3%		-2.8%
23b	The appraisal / review helped me to improve how I do my job.	20.4%	27.3%		-6.8%
23c	The appraisal / review helped me agree clear objectives for my work.	30.8%	36.3%		-5.5%
23d	The appraisal / review left me feeling that my work is valued by my organisation.	29.8%	33.2%		-3.3%
25a	Care of patients / service users is my organisation's top priority.	68.5%	71.5%		-3.0%
25b	My organisation acts on concerns raised by patients / service users.	62.5%	68.2%		-5.7%
25f	If I spoke up about something that concerned me I am confident my organisation would address my concern.	42.5%	46.6%		-4.1%
26a	I often think about leaving this organisation.	31.0%	29.0%		+2.0%

People Promise

People Promise Scores



Torbay and South Devon
NHS Foundation Trust

Data Type		Metric	Results			TSD vs Comparator
			2024	2025	Comparator	
			value	value	value	
People promise score	PP1	We are compassionate and inclusive	7.18	7.20	7.20	equal
People promise score	PP2	We are recognised and rewarded	5.92	5.96	5.88	above
People promise score	PP3	We each have a voice that counts	6.50	6.53	6.62	below
People promise score	PP4	We are safe and healthy	6.00	5.99	6.01	below
People promise score	PP5	We are always learning	5.26	5.29	5.64	below
People promise score	PP6	We work flexibly	6.23	6.36	6.23	above
People promise score	PP7	We are a team	6.66	6.71	6.75	below
People promise sub-score	PP1_1	Compassionate culture	6.83	6.76	6.97	below
People promise sub-score	PP1_2	Compassionate leadership	6.93	6.97	6.99	below
People promise sub-score	PP1_3	Diversity and equality	8.11	8.15	8.02	above
People promise sub-score	PP1_4	Inclusion	6.85	6.93	6.81	above
People promise sub-score	PP3_1	Autonomy and control	6.81	6.89	6.91	below
People promise sub-score	PP3_2	Raising concerns	6.20	6.16	6.33	below
People promise sub-score	PP4_1	Health and safety climate	5.17	5.16	5.42	below
People promise sub-score	PP4_2	Burnout	4.96	5.02	4.95	above
People promise sub-score	PP4_3	Negative experiences	7.86	7.79	7.67	above
People promise sub-score	PP5_1	Development	6.25	6.22	6.31	below
People promise sub-score	PP5_2	Appraisals	4.26	4.33	4.95	below
People promise sub-score	PP6_1	Support for work-life balance	6.28	6.37	6.30	above
People promise sub-score	PP6_2	Flexible working	6.19	6.35	6.17	above
People promise sub-score	PP7_1	Team working	6.58	6.62	6.66	below
People promise sub-score	PP7_2	Line management	6.75	6.80	6.84	below

- 6 PP scores show slight increase
- 1 PP score show slight decline
- Highest score on Diversity & equality (8.15)
- Lowest score on Appraisals (4.33)
- Biggest improvement flexible working (+0.13)
- Biggest decline on Compassionate Culture and negative experiences -0.07)

We are compassionate and inclusive



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 1 - We are compassionate and inclusive	7.29	Not Significant	7.31	Not Significant	7.28
People Promise 1, Sub-score 1 - Compassionate culture	6.85	Not Significant	6.82	Significantly Worse	6.97
6a. I feel that my role makes a difference to patients / service users.	87.7%	Not Significant	87.8%	Not Significant	88.0%
25a. Care of patients / service users is my organisation's top priority.	67.8%	Not Significant	68.5%	Significantly Worse	71.5%
25b. My organisation acts on concerns raised by patients / service users.	63.1%	Not Significant	62.5%	Significantly Worse	68.2%
25c. I would recommend my organisation as a place to work.	57.8%	Not Significant	56.6%	Not Significant	57.8%
25d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	60.4%	Not Significant	61.2%	Not Significant	62.2%

We are compassionate and inclusive (continued)

Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 1, Sub-score 2 - Compassionate leadership		6.97	Not Significant	7.00	Not Significant	6.99
9f.	My immediate manager works together with me to come to an understanding of problems.	68.9%	Not Significant	70.2%	Not Significant	68.8%
9g.	My immediate manager is interested in listening to me when I describe challenges I face.	70.9%	Not Significant	72.8%	Not Significant	71.3%
9h.	My immediate manager cares about my concerns.	70.0%	Not Significant	71.2%	Not Significant	69.9%
9i.	My immediate manager takes effective action to help me with any problems I face.	66.2%	Not Significant	67.3%	Not Significant	66.8%
People Promise 1, Sub-score 3 - Diversity and equality		8.45	Not Significant	8.50	Significantly Better	8.35
16a.	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	5.8%	Not Significant	5.8%	Significantly Better	9.4%
16b.	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	9.0%	Not Significant	8.2%	Not Significant	9.1%
21.	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	67.9%	Not Significant	69.6%	Not Significant	69.0%

We are compassionate and inclusive (continued)

Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 1, Sub-score 4 - Inclusion	6.88	Not Significant	6.95	Significantly Better	6.81
7h. I feel valued by my team.	70.2%	Not Significant	71.5%	Significantly Better	69.0%
7i. I feel a strong personal attachment to my team.	64.2%	Not Significant	66.5%	Significantly Better	62.6%
8b. The people I work with are understanding and kind to one another.	70.8%	Not Significant	71.1%	Significantly Better	69.0%
8c. The people I work with are polite and treat each other with respect.	71.9%	Not Significant	72.5%	Significantly Better	70.1%

Additional – Discrimination

Question	2024 Score	Significance	2025 Score	Significance	Sector Score
15. Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation?	-	N/A	52.7%	Not Significant	53.1%
16c01. On what grounds have you experienced discrimination? Age	-	N/A	25.1%	Significantly Worse	17.0%
16c02. On what grounds have you experienced discrimination? Disability	-	N/A	17.2%	Significantly Worse	9.9%
16c03. On what grounds have you experienced discrimination? Gender reassignment	-	N/A	1.4%	Not Significant	1.6%
16c04. On what grounds have you experienced discrimination? Marriage and civil partnership	-	N/A	1.4%	Not Significant	1.3%
16c05. On what grounds have you experienced discrimination? Pregnancy and maternity	-	N/A	3.9%	Not Significant	2.8%
16c06. On what grounds have you experienced discrimination? Race	-	N/A	27.8%	Significantly Better	55.2%
16c07. On what grounds have you experienced discrimination? Religion or belief	-	N/A	3.1%	Significantly Better	8.8%
16c08. On what grounds have you experienced discrimination? Sex	-	N/A	20.1%	Not Significant	15.6%
16c09. On what grounds have you experienced discrimination? Sexual orientation	-	N/A	4.0%	Not Significant	3.3%
16c10. On what grounds have you experienced discrimination? Other	-	N/A	26.3%	Significantly Worse	21.2%

Appendix 1 TSD NSS 29025 Results and Analysis

We are recognised and rewarded

Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 2 - We are recognised and rewarded	5.93	Not Significant	5.96	Significantly Better	5.88
4a. The recognition I get for good work.	54.1%	Not Significant	54.5%	Significantly Better	52.1%
4b. The extent to which my organisation values my work.	40.6%	Not Significant	40.7%	Not Significant	42.2%
4c. My level of pay.	32.9%	Not Significant	33.8%	Significantly Better	31.0%
8d. The people I work with show appreciation to one another.	67.8%	Not Significant	68.2%	Significantly Better	66.0%
9e. My immediate manager values my work.	72.7%	Not Significant	73.7%	Significantly Better	71.7%

We each have a voice that counts



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 3 - We each have a voice that counts	6.52	Not Significant	6.57	Not Significant	6.62
People Promise 3, Sub-score 1 - Autonomy and control	6.83	Not Significant	6.93	Not Significant	6.91
3a. I always know what my work responsibilities are.	85.4%	Not Significant	84.2%	Significantly Worse	86.5%
3b. I am trusted to do my job.	88.7%	Not Significant	89.7%	Not Significant	89.8%
3c. There are frequent opportunities for me to show initiative in my role.	71.6%	Not Significant	73.3%	Not Significant	72.2%
3d. I am able to make suggestions to improve the work of my team / department.	70.6%	Not Significant	72.0%	Significantly Better	69.8%
3e. I am involved in deciding on changes introduced that affect my work area / team / department.	47.4%	Significantly Improved	50.3%	Not Significant	49.2%
3f. I am able to make improvements happen in my area of work.	51.5%	Not Significant	53.7%	Not Significant	54.7%
5b. I have a choice in deciding how to do my work.	52.7%	Significantly Improved	55.5%	Significantly Better	51.4%

Appendix 1 TSD NSS 2025 Results and Analysis



We each have a voice that counts (continued)

Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 3, Sub-score 2 - Raising concerns	6.23	Not Significant	6.21	Significantly Worse	6.33
20a. I would feel secure raising concerns about unsafe clinical practice.	69.3%	Not Significant	70.9%	Not Significant	70.1%
20b. I am confident that my organisation would address my concern.	51.1%	Not Significant	51.4%	Significantly Worse	54.7%
25e. I feel safe to speak up about anything that concerns me in this organisation.	58.5%	Not Significant	59.7%	Not Significant	59.1%
25f. If I spoke up about something that concerned me I am confident my organisation would address my concern.	42.3%	Not Significant	42.5%	Significantly Worse	46.6%

Additional – Errors, near misses or incidents

Torbay and South Devon
NHS Foundation Trust

Question		2024 Score	Significance	2025 Score	Significance	Sector Score
18.	In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	36.8%	Not Significant	37.8%	Significantly Worse	35.3%
19a.	My organisation treats staff who are involved in an error, near miss or incident fairly.	59.5%	Not Significant	59.8%	Not Significant	59.9%
19b.	My organisation encourages us to report errors, near misses or incidents.	84.9%	Not Significant	84.8%	Not Significant	85.2%
19c.	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	62.6%	Not Significant	63.1%	Significantly Worse	67.3%
19d.	We are given feedback about changes made in response to reported errors, near misses and incidents.	55.2%	Not Significant	55.1%	Significantly Worse	61.0%

We are safe and healthy



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 4 - We are safe and healthy	5.99	Not Significant	6.01	Significantly Worse	6.09
People Promise 4, Sub-score 1 - Health and safety climate	5.14	Not Significant	5.14	Significantly Worse	5.42
3g. I am able to meet all the conflicting demands on my time at work.	41.2%	Not Significant	40.6%	Significantly Worse	46.6%
3h. I have adequate materials, supplies and equipment to do my work.	51.2%	Not Significant	52.2%	Not Significant	54.1%
3i. There are enough staff at this organisation for me to do my job properly.	27.6%	Not Significant	26.0%	Significantly Worse	31.8%
5a. I have unrealistic time pressures.	24.8%	Not Significant	25.3%	Not Significant	25.5%
11a. My organisation takes positive action on health and well-being.	51.1%	Not Significant	49.5%	Significantly Worse	54.5%
13d. The last time you experienced physical violence at work, did you or a colleague report it?	61.9%	Significantly Improved	70.2%	Not Significant	70.7%
14d. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	48.8%	Not Significant	48.2%	Significantly Worse	52.6%

Appendix 1 TSD NSS 29025 Results and Analysis



We are safe and healthy (continued)

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 4, Sub-score 2 - Burnout	4.92	Not Significant	4.96	Not Significant	4.95
12a. How often, if at all, do you find your work emotionally exhausting?	37.5%	Not Significant	36.8%	Significantly Worse	34.5%
12b. How often, if at all, do you feel burnt out because of your work?	31.2%	Not Significant	30.2%	Not Significant	32.0%
12c. How often, if at all, does your work frustrate you?	40.1%	Not Significant	40.4%	Significantly Worse	36.8%
12d. How often, if at all, are you exhausted at the thought of another day/shift at work?	29.0%	Not Significant	28.5%	Not Significant	29.1%
12e. How often, if at all, do you feel worn out at the end of your working day/shift?	46.7%	Not Significant	45.4%	Significantly Worse	43.1%
12f. How often, if at all, do you feel that every working hour is tiring for you?	20.5%	Not Significant	19.2%	Significantly Better	20.9%
12g. How often, if at all, do you not have enough energy for family and friends during leisure time?	30.4%	Not Significant	29.1%	Not Significant	30.3%

We are safe and healthy (continued)



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 4, Sub-score 3 - Negative experiences	7.91	Not Significant	7.92	Not Significant	7.90
11c. During the last 12 months have you felt unwell as a result of work related stress?	42.8%	Not Significant	42.7%	Not Significant	42.9%
11d. In the last three months have you ever come to work despite not feeling well enough to perform your duties?	56.8%	Not Significant	56.3%	Not Significant	56.1%
13a. In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?	13.2%	Not Significant	12.1%	Significantly Better	14.0%
13b. In the last 12 months how many times have you personally experienced physical violence at work from managers?	0.5%	Not Significant	0.6%	Not Significant	0.8%
13c. In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	1.3%	Not Significant	1.4%	Significantly Better	2.0%
14a. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	23.4%	Not Significant	23.8%	Not Significant	24.9%
14b. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	10.7%	Not Significant	10.6%	Significantly Worse	9.2%
14c. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	18.8%	Not Significant	18.3%	Not Significant	17.8%

Appendix 1 TSD NSS 2025 Results and Analysis



Additional – Health, well-being and safety at work

Torbay and South Devon
NHS Foundation Trust

Question		2024 Score	Significance	2025 Score	Significance	Sector Score
10b.	On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	30.8%	Significantly Improved	26.4%	Significantly Better	33.4%
10c.	On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	50.0%	Not Significant	50.1%	Not Significant	48.7%
11e.	Have you felt pressure from your manager to come to work?	21.1%	Not Significant	20.3%	Not Significant	20.6%
11b.	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Examples may include back pain, neck or arm strains, and joint pain.	-	N/A	39.0%	Significantly Better	41.4%

We are always learning



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 5 - We are always learning	5.32	Not Significant	5.38	Significantly Worse	5.64
People Promise 5, Sub-score 1 - Development	6.32	Not Significant	6.30	Not Significant	6.31
24a. This organisation offers me challenging work.	71.0%	Not Significant	71.5%	Significantly Better	66.8%
24b. There are opportunities for me to develop my career in this organisation.	52.0%	Not Significant	50.3%	Not Significant	51.9%
24c. I have opportunities to improve my knowledge and skills.	69.0%	Not Significant	69.1%	Not Significant	67.6%
24d. I feel supported to develop my potential.	53.1%	Not Significant	53.4%	Not Significant	54.4%
24e. I am able to access the right learning and development opportunities when I need to.	55.6%	Not Significant	56.1%	Not Significant	57.4%

We are always learning (continued)



Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question		2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 5, Sub-score 2 - Appraisals		4.32	Not Significant	4.43	Significantly Worse	4.95
23a.	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	81.6%	Not Significant	83.6%	Significantly Worse	86.3%
23b.	It helped me to improve how I do my job.	21.2%	Not Significant	20.4%	Significantly Worse	27.3%
23c.	It helped me agree clear objectives for my work.	31.8%	Not Significant	30.8%	Significantly Worse	36.3%
23d.	It left me feeling that my work is valued by my organisation.	30.2%	Not Significant	29.8%	Significantly Worse	33.2%

We work flexibly

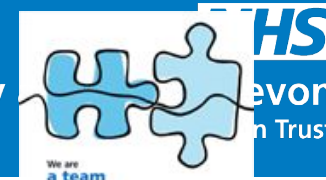


Torbay and South Devon
NHS Foundation Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 6 - We work flexibly	6.23	Not Significant	6.33	Significantly Better	6.23
People Promise 6, Sub-score 1 - Support for work-life balance	6.26	Not Significant	6.35	Not Significant	6.30
6b. My organisation is committed to helping me balance my work and home life.	47.0%	Not Significant	49.3%	Not Significant	48.7%
6c. I achieve a good balance between my work life and my home life.	56.1%	Significantly Improved	58.8%	Significantly Better	55.9%
6d. I can approach my immediate manager to talk openly about flexible working.	69.4%	Not Significant	69.9%	Not Significant	70.3%
People Promise 6, Sub-score 2 - Flexible working	6.20	Not Significant	6.31	Significantly Better	6.17
4d. The opportunities for flexible working patterns.	57.6%	Not Significant	58.8%	Significantly Better	56.4%

We are a team

Torbay

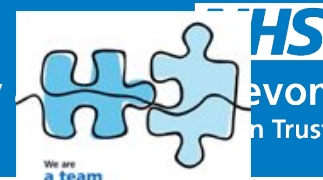


People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 7 - We are a team	6.70	Not Significant	6.73	Not Significant	6.75
People Promise 7, Sub-score 1 - Team working	6.61	Not Significant	6.63	Not Significant	6.66
7a. The team I work in has a set of shared objectives.	73.7%	Not Significant	74.0%	Not Significant	73.6%
7b. The team I work in often meets to discuss the team's effectiveness.	60.1%	Not Significant	60.0%	Not Significant	61.8%
7c. I receive the respect I deserve from my colleagues at work.	71.3%	Not Significant	72.5%	Not Significant	70.9%
7d. Team members understand each other's roles.	71.5%	Not Significant	73.0%	Not Significant	71.3%
7e. I enjoy working with the colleagues in my team.	81.8%	Not Significant	83.2%	Significantly Better	79.7%
7f. My team has enough freedom in how to do its work.	56.3%	Not Significant	58.7%	Not Significant	59.2%
7g. In my team disagreements are dealt with constructively.	55.3%	Not Significant	56.3%	Not Significant	56.3%
8a. Teams within this organisation work well together to achieve their objectives.	49.6%	Not Significant	49.9%	Significantly Worse	54.4%

Appendix 1 TSD NSS 29025 Results and Analysis

We are a team (continued)

Torbay


THS
 Devon
 Health Trust

People Promise/Theme/Question	2024 Score	Significance	2025 Score	Significance	Sector Score
People Promise 7, Sub-score 2 - Line management	6.79	Not Significant	6.82	Not Significant	6.84
9a. My immediate manager encourages me at work.	71.0%	Not Significant	72.0%	Not Significant	71.7%
9b. My immediate manager gives me clear feedback on my work.	64.1%	Not Significant	62.9%	Significantly Worse	65.0%
9c. My immediate manager asks for my opinion before making decisions that affect my work.	58.7%	Not Significant	60.5%	Not Significant	59.2%
9d. My immediate manager takes a positive interest in my health and well-being.	70.9%	Not Significant	71.1%	Not Significant	70.1%

Recommendations



Torbay and South Devon
NHS Foundation Trust

- Identify **staff groups experiencing age discrimination and reinforce zero tolerance**. Use clear visual prompts in all patient-facing areas to empower staff to challenge unacceptable behaviour.
- Identify **staff groups experiencing disability discrimination and reinforce zero tolerance**. Ensure visible policy prompts so staff feel confident addressing inappropriate behaviour from the public.
- **Review appraisal resources and systems**, supporting appraisers to identify development needs. Promote mentorship, learning opportunities, and ensure managers allocate time to listen and act on feedback.
- Investigate reports of **conflicting demands and clarify roles, responsibilities, and workloads**. Review work planning and staffing levels, showing staff feedback is valued and acted upon.
- Provide **feedback on actions taken following reported incidents**, recognising staff who speak up. Analyse themes from errors and near misses and communicate a clear action plan to prevent recurrence.

Next Steps



Torbay and South Devon
NHS Foundation Trust

- Full release of reports and data
- Local result sheets tool available
- Action Plan templates available
- Trust level actions
- Care Group reviews and actions
- Reporting upwards cascade
- Free text released/ analysis

Appendix 2 Narrative to Appendix 1: NSS 2025 Results and Analysis

SLIDE	
1	Background: self-explanatory
2	Methodology: self-explanatory
3	Key Insights: self-explanatory
4	Headlines: covered in (main) paper
5	TSD's response rate has fallen to 35%, a 4-percentage point drop and now significantly below all comparators. This suggests reduced engagement during a period of operational pressure and raises a representativeness risk. We are still struggling to mobilise staff participation at the same level seen across similar acute and community Trusts. The key concern is that lower response levels may limit the visibility of issues raised by staff. Improving visibility, communication and responses to the NSS remain clear priorities.
6	Response rates have declined across most Care Groups, particularly in frontline services, with SCS as a notable positive outlier. Internal variation across Care Groups is significant, with some areas achieving much higher participation than others. These internal disparities highlight where local leadership, communication and workload pressures may be affecting staff willingness or ability to respond. The key concern is consistency: pockets of high engagement show what is possible, but the overall picture indicates that support and targeted action may be needed in Care Groups with persistently lower levels.
7	We are seeing a clear shift in who is responding — engagement has increased in corporate and specialist groups, but reduced in our core frontline workforce, particularly nursing and support roles. This raises a representativeness risk and may suggest operational pressure is impacting our ability to hear from those delivering care day-to-day. An issue to explore! Response rates differ considerably by professional group, reflecting varying levels of engagement and competing operational pressures. Clinical groups facing higher demand appear less likely to participate, while professions with more predictable working patterns tend to show stronger response rates. The high-engagement groups demonstrate a continued appetite to contribute to organisational learning. The low-engagement groups highlight a concern: some staff may feel they have limited time, limited voice, or limited belief that their feedback leads to change. These variations identify where targeted communication and support could strengthen participation.
8	Survey responses show a continued over-representation of White British staff (86.9%) compared to the workforce comparator (61.3%), alongside lower and in some cases declining participation from minority ethnic groups, particularly Asian and Black African colleagues. This creates a representativeness risk, limiting confidence that the survey fully reflects the experience of our diverse workforce, with some groups represented by very small numbers. While there are small increases in a few groups (e.g. Filipino), overall the pattern indicates that the colleague voice captured is disproportionately weighted towards majority groups, which should be considered when interpreting results and themes. The concern here is ensuring that the voices of minority ethnic colleagues—who may already experience

Appendix 2 Narrative to Appendix 1: NSS 2025 Results and Analysis

	disparities in areas such as discrimination and safety—are fully captured and reflected in actions. Strengthening targeted engagement and safe-space conversations will help ensure inclusivity in the survey process.
9	Title Slide
10	There are consistent but modest improvements across all themes from 2024 to 2025, although none are statistically significant internally, indicating incremental rather than transformational progress. Compared to the sector, the Trust performs significantly better in areas such as recognition and reward and flexible working but remains significantly worse in “We are safe and healthy” and “We are always learning,” highlighting ongoing challenges that persist from previous surveys. The data also highlight notable dips in a small number of People Promise and engagement-related areas, particularly those associated with compassionate culture, workload pressures, and aspects of wellbeing. These reductions, although not dramatic, signal wider cultural pressures and the ongoing strain experienced by staff, especially within clinical environments.
11	Staff engagement has seen a small improvement from 6.66 to 6.68, but remains below the sector comparator (6.75), indicating that while there is some positive movement, it is not yet closing the gap. Morale has also improved marginally (5.79 to 5.80) but remains below the comparator (5.88). The sub-scores present a mixed picture: thinking about leaving has slightly increased but remains better than comparator, which is a relative positive; however, work pressure has worsened (4.93 to 4.91) and remains below comparator, reinforcing ongoing pressure within the workforce. Stressors have improved slightly and are now in line with comparator. Motivation has improved and is now above comparator, and involvement has also increased, although it remains slightly below. However, advocacy has declined (6.50 to 6.42) and is now below comparator, suggesting a weakening in how positively staff speak about the organisation. Overall, this suggests a picture of fragile improvement—with some gains in motivation and stability in retention, but continued pressure on staff and a decline in advocacy. The Trust appears to be maintaining engagement rather than strengthening it, with workforce pressure remaining a key limiting factor in improving overall experience.
12 and 13	Staff engagement has improved slightly from 6.68 to 6.72 but remains below the sector comparator (6.75), indicating steady but limited progress. The improvement is not statistically significant, suggesting engagement is being maintained rather than meaningfully strengthened.

Appendix 2 Narrative to Appendix 1: NSS 2025 Results and Analysis

	Within this, motivation has increased (6.86 to 6.93) and is now above comparator, representing a strength. All underpinning questions have improved, with two showing statistically significant gains (staff feeling enthusiastic about their job and that time passes quickly at work) indicating a positive day-to-day experience. Involvement has also improved (6.68 to 6.79) and is now marginally above comparator, with staff reporting greater opportunity to show initiative and contribute ideas. However, the ability to make improvements happen remains below comparator despite improvement, suggesting that while staff feel heard, translating this into tangible change is less consistent. In contrast, advocacy has declined (6.51 to 6.46) and is now significantly worse than comparator (6.61), indicating a weakening in how positively staff perceive and promote the organisation. While perception that patient care is the organisation's top priority has improved slightly, it remains significantly below comparator, and fewer staff would recommend the organisation as a place to work. Confidence in the standard of care has increased slightly but also remains below comparator. Overall, this presents a picture contained progress alongside a weakening organisational narrative—staff are motivated and increasingly able to contribute, but this is not yet translating into stronger advocacy or confidence in the organisation. This may suggest a disconnect between staff experience and organisational reputation.
14 and 15	Morale has improved slightly from 5.79 to 5.82 but remains below the sector comparator (5.88), indicating limited progress and a continued gap in staff experience. While the overall direction is marginally positive, the underlying drivers present a mixed and at times conflicting picture. Thinking about leaving has improved (6.15 to 6.19) and is now significantly better than comparator, suggesting increased short-term retention and reduced immediate intent to leave. However, this is nuanced: while fewer staff report actively planning to leave, a slightly higher proportion still report thinking about leaving, indicating underlying dissatisfaction has not fully shifted. In contrast, work pressure remains a significant concern, with no improvement overall (4.90) and performance significantly worse than comparator. Staff report reduced ability to meet conflicting demands and a further decline in perceptions of staffing levels, both of which are significantly below comparator. While access to materials and equipment has improved slightly, it remains below comparator and does not offset the broader pressure experienced. Stressors have improved slightly (6.32 to 6.37) and are now broadly in line with comparator, indicating some positive movement in aspects of day-to-day experience. Staff report increased involvement in change and greater autonomy in how they work, both showing significant improvement and, in the case of autonomy, performing above comparator. Relationships, respect and line manager support remain stable and broadly positive. However, clarity of role has declined and is now below comparator, suggesting some erosion in role certainty.

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	Overall, this presents a picture of stability under pressure—while retention indicators and elements of autonomy are improving, sustained workforce pressure and capacity constraints continue to limit improvements in morale. The data suggests that staff are coping and, in some areas, feeling more empowered, but structural pressures remain the dominant factor shaping overall experience.
16	Advocacy scores present a mixed but slightly weakening picture. Perception that patient care is the organisation's top priority remains broadly stable, with only a negligible change, but continues to sit below comparator. Confidence in the standard of care has improved marginally, although again remains below comparator, indicating some reassurance in care quality but not at sector levels. In contrast, recommendation of the Trust as a place to work has declined by 2 percentage points, representing the most notable negative shift within this area. This is reinforced by a small increase in negative responses, suggesting a deterioration in how staff perceive the organisation as an employer. Overall, this suggests that while confidence in care remains relatively stable, there is a weakening in organisational advocacy, particularly in terms of staff willingness to recommend the Trust as a place to work. This aligns with wider findings and indicates a gap between staff experience of care delivery and their perception of the organisation as an employer.
17	Work pressure scores remain unchanged overall (4.93 to 4.91) and continue to be significantly below the sector comparator (5.25), indicating sustained and systemic pressure across the workforce. All three underpinning measures are below comparator. Staff report a reduced ability to meet conflicting demands on their time, with both positive responses declining and negative responses increasing, reinforcing the impact of competing priorities. Perceptions of having adequate materials and equipment have improved slightly but remain below comparator, suggesting some operational gains but not enough to shift overall experience. Most notably, perceptions of having enough staff have declined further, with a high and increasing proportion of staff reporting insufficient staffing, representing the most significant pressure point. Overall, this indicates that workforce capacity and demand remain the dominant challenge, with little evidence of improvement. Despite stability in some areas, the continued gap to comparator and deterioration in staffing perceptions suggest that work pressure is a key limiting factor affecting staff experience, morale and engagement across the Trust.
18	The top 10 scores are dominated by low incidence measures (where lower scores are better, as indicated by the pink shading), primarily relating to physical violence and discrimination. This indicates that these experiences are reported by a relatively small proportion of staff, with very low levels of physical violence from managers (0.6%) and

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	colleagues (1.4%), and low reported discrimination across several protected characteristics. There are notable areas of concern within this group. Reports of unwanted sexual behaviour (3.7%) and discrimination relating to pregnancy/maternity (3.9%) and sexual orientation (4.0%) are higher, suggesting specific risks for some staff groups. Most significantly, discrimination from patients/public (5.8%) and from colleagues or managers (8.2%) are the highest reported areas, indicating that experiences of discrimination—particularly from within the organisation—remain a key issue. Overall, while these results are positive in that harmful experiences are relatively uncommon, the pattern highlights that bullying, harassment and discrimination remain the most prominent negative experiences reported by staff, and therefore represent a continued priority for improvement.
19	The bottom scores are dominated by themes relating to appraisal, workload and workforce capacity, indicating persistent structural challenges in how staff experience support and delivery of their roles. Appraisal is a clear area of weakness, with all three related questions featuring in the bottom scores. Staff report that appraisal is not consistently helping improve performance, set clear objectives or make them feel valued, suggesting that the process is not delivering meaningful impact. This aligns with wider themes around recognition and development. Work pressure also features prominently. Staff report high levels of unrealistic time pressures and difficulty meeting conflicting demands, alongside low confidence that there are enough staff to do the job properly. These findings reinforce the wider narrative of sustained operational pressure and capacity constraints. In addition, pay and feeling valued by the organisation appear in the bottom scores, indicating that recognition—both financial and non-financial—remains a challenge. Confidence that concerns raised will be addressed is also relatively low, pointing to potential gaps in organisational responsiveness and psychological safety. Finally, the presence of presenteeism (56.3%) highlights a significant risk, suggesting that a substantial proportion of staff continue to work despite not feeling well enough, likely linked to workforce pressures and staffing levels. Overall, this reflects a picture of pressure and under-recognition—staff are experiencing high workload and capacity challenges, alongside appraisal and reward processes that are not fully supporting or valuing them. These factors are likely key contributors to the wider themes of morale, engagement and advocacy.
20	The most improved scores indicate positive movement in staff experience, particularly around autonomy, involvement and work-life balance. Staff report increased choice in how

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	they do their work and greater involvement in decisions affecting their teams, reinforcing earlier findings that staff feel more able to contribute and influence change. Improvements in work-life balance also suggest some benefit from flexible working and local support arrangements. There is a notable improvement in reporting of physical violence incidents, which likely reflects increased confidence in reporting processes rather than an increase in incidents themselves, indicating progress in safety culture and openness. Overall, these improvements point to strengthening in local experience and empowerment, with staff feeling more involved and supported in how they work. However, these gains are relatively modest and sit alongside ongoing structural pressures, suggesting that while progress is being made, it is not yet sufficient to shift overall experience at scale.
21	The most declined scores highlight deterioration in development, wellbeing and workforce capacity, reinforcing key structural challenges within the organisation. The largest decline is in career development opportunities (-1.7pp), suggesting that staff feel less able to progress or grow within the organisation. This is closely followed by a reduction in perceptions that the organisation takes positive action on health and wellbeing (-1.6pp). Workforce capacity remains a consistent pressure point, with further decline in perceptions of having enough staff to do the job properly (-1.6pp). This aligns with wider findings on work pressure and reinforces staffing as a key constraint. There is a decline in the proportion of staff who do not think about leaving (-1.5pp), indicating a slight worsening in retention sentiment, alongside reduced confidence in manager feedback (-1.2pp), suggesting some weakening in local management experience.
22	There are several statistically significant improvements, particularly in staff involvement, autonomy and work-life balance, reinforcing a positive shift in local experience and empowerment. The most notable improvement is in reporting of physical violence (+8.4pp), suggesting increased confidence in speaking up and reporting incidents. A reduction in additional paid hours (-4.4pp) may indicate a slight easing of workload, although this contrasts with wider work pressure findings. Importantly, there are no significantly worse scores, indicating that while overall improvement is modest, it is consistently in a positive direction.
23	The Trust performs significantly better than the sector across a range of areas, particularly motivation, autonomy, involvement and work-life balance, indicating a strong local experience for many staff. Staff are more positive than the sector about enthusiasm for their job, having a choice in how they work, and being able to contribute ideas. There are also strengths in recognition, pay and flexible working, suggesting improvements in how staff feel supported and rewarded.

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24 and 25	Compared to the sector, the Trust shows a consistent pattern of underperformance across workload, safety culture, management and organisational processes, reinforcing systemic challenges rather than isolated issues. The most significant gaps relate to work pressure and staffing, with staff less able to meet conflicting demands and significantly less likely to feel there are enough staff to do their job properly. There are also notable gaps in teamworking, line management and wellbeing, including lower scores for manager feedback, team functioning and organisational action on health and wellbeing. Alongside this, staff report higher levels of emotional exhaustion, frustration and feeling worn out, indicating a more pressured day-to-day experience than the sector. A further theme is weaker organisational responsiveness and learning culture, with lower confidence that concerns are addressed, that action is taken following incidents, and that feedback is provided on changes. This is compounded by poorer scores on appraisal effectiveness and development, suggesting that organisational systems are not consistently supporting staff. Finally, there are concerning signals in experience of discrimination and harassment, with higher reported rates in several areas compared to the sector, alongside lower reporting of incidents. Overall, this presents a picture of sustained operational pressure combined with gaps in organisational processes and culture, which together are limiting improvements in staff experience.
26	Title Slide
27	People Promise scores show largely stable performance with slight improvement across most areas, with 6 of 7 themes increasing, although generally only marginally. The strongest areas remain compassionate and inclusive culture, particularly diversity and equality, which is the highest scoring sub-theme and performs above comparator. However, there are persistent areas of underperformance, with several themes below comparator including voice, safety and learning, indicating ongoing structural challenges. Appraisal remains the lowest scoring area, reinforcing consistent feedback that performance and development processes are not yet effective.
28	Compassionate and inclusive” remains a high scoring theme and broadly in line with comparator, indicating a strong underlying cultural foundation. However, the compassionate culture sub-score has declined and is now significantly below comparator, suggesting a softening in how this is experienced in practice. There is a clear gap in organisational responsiveness, with staff less positive that patient care is prioritised and that action is taken on concerns. Advocacy also remains weak, with fewer staff recommending the organisation as a place to work.
29	Compassionate leadership remains strong and has improved slightly, now performing broadly in line with comparator, indicating a positive experience of line management and support.

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	Experiences of discrimination from patients/public are significantly lower than comparator, and there is a slight reduction in discrimination from colleagues, alongside improved perceptions of respect for individual differences.
30	Inclusion (locally and within own team) is a strength, with the sub-score improving and now significantly above comparator, indicating a positive and improving team experience.
31	Discrimination data continues to raise concern (where lower scores are better, as indicated by the pink shading), particularly among clinical staff and underrepresented groups. This slide presents a mixed position in relation to reported experiences of discrimination. Positively, reported discrimination on the grounds of race and religion or belief is significantly lower than the sector comparators. However, reported discrimination is significantly higher than comparator for age, disability, and “other” categories. All categories on this answer need further investigation and action. Reports of bullying, harassment and discrimination signal persistent cultural issues that undermine psychological safety. Stronger zero-tolerance reinforcement, visible leadership action, and improved support structures are needed to address these experiences.
32	The overall score for “We are recognised and rewarded” has increased slightly from 5.93 to 5.96 and is now significantly above the sector comparator (5.88). This is reflected across most component questions, with recognition for good work, level of pay, peer appreciation, and manager recognition all scoring significantly better than comparator, indicating relative strengths in day-to-day recognition and local team environments. However, the measure relating to feeling valued by the organisation (40.7%) has not improved significantly and remains below comparator (42.2%), highlighting a gap between local experiences and organisational-level recognition.
33 and 34	The overall score for “We each have a voice that counts” has improved slightly (6.52 to 6.57) but remains below the sector comparator (6.62), indicating limited progress. Within this, autonomy and control has strengthened, with improvements in opportunities to show initiative, involvement in decision-making, and choice in how work is carried out, with several measures significantly improved or better than comparator; however, clarity of role has declined slightly and is now below comparator. In contrast, raising concerns has deteriorated, with the sub-score falling (6.23 to 6.21) and now significantly below comparator, driven by lower confidence that concerns will be addressed. Overall, this suggests that while staff feel increasingly empowered in their roles, confidence in organisational responsiveness, particularly in acting on concerns, remains weaker and below sector expectations.
35	The data suggests that while reporting culture remains strong, confidence in organisational learning and feedback following incidents is weaker and below sector expectations.

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	Question 18 (seeing errors/near misses/incidents): Reported rates have increased (36.8% to 37.8%) and are significantly higher than the sector comparator (35.3%), indicating that more staff are observing incidents that could cause harm. Question 19c (action taken following incidents): While there is a slight improvement (62.6% to 63.1%), this remains significantly below comparator (67.3%), suggesting that staff are less confident that effective action is consistently taken to prevent recurrence. Question 19d (feedback following incidents): Scores remain broadly unchanged (55.2% to 55.1%) but are significantly below comparator (61.0%), indicating a clear gap in providing feedback to staff on changes made following incidents.
36, 37, 38	Across “We are safe and healthy,” results show a mixed but overall concerning picture, with health and safety climate, staffing, and workload pressures all below sector benchmarks, indicating structural pressure on teams. Burnout indicators are also generally worse than comparators, with higher levels of emotional exhaustion and fatigue, although there is a small improvement in perceptions of constant tiredness. In terms of negative experiences, violence from patients/service users has reduced, but harassment and abuse, particularly from managers, has worsened, highlighting a need to focus on internal culture as well as external pressures. Overall, the data suggests that workforce capacity, wellbeing, and psychological safety remain key areas of risk despite some improvements.
39	This slide shows a positive reduction in additional paid hours, indicating some easing of workload pressure relative to last year and compared to sector. However, unpaid additional hours remain high and unchanged, suggesting underlying workload demand persists. The pressure perceived from managers to attend work has slightly reduced, which is encouraging but not a significant shift. Musculoskeletal issues are lower than sector, though still affecting a substantial proportion of staff, reinforcing the need to continue focus on workforce health.
40, 41	Across “We are always learning,” there is a mixed picture with overall performance below sector, despite some small improvements. While staff report slightly better access to learning and more challenging work, perceptions of career development and support remain broadly static and below comparator. The most significant concern is appraisals, where all measures have declined and are significantly worse than sector, particularly in terms of impact, clarity of objectives, and feeling valued. This suggests that while learning opportunities exist, the quality and effectiveness of development conversations and appraisal processes remain a key issue.
42	‘We work flexibly’: shows an area of strength, with flexible working improving and now significantly better than sector overall.

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	Work–life balance has improved, suggesting some positive impact from workforce initiatives or local practices. Access to flexible working opportunities is also stronger than comparator, reinforcing this as a consistent positive theme. However, organisational commitment to work–life balance and ability to discuss flexibility with managers remain more static.
43 and 44	Across “We are a team,” results are broadly stable with strong local team relationships, particularly enjoyment of working with colleagues, which is now above sector. However, cross-team working is a clear weakness, significantly below sector, indicating challenges in collaboration beyond immediate teams. Within line management, most measures are stable or slightly improved, but clear feedback from managers has declined and is significantly worse than sector, highlighting a specific development need.
45	Recommendations focus on tackling discrimination, improving appraisal quality, clarifying roles and workloads, and strengthening incident-feedback loops. These actions directly address key cultural, safety and relational challenges highlighted in the survey and support improved staff experience and organisational culture.
46	Actions already underway include preparing reports, providing resources, coordinating improvement frameworks, and aligning Care Group planning. Planned actions aim to strengthen leadership responses, standardise improvement tools, and embed survey findings into operational and strategic practice.

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Appendix 3

Staff Survey Question by Question Analysis Table

Full question-by-question table compiled from the simplified data sheet using exact row references.

Note: Q10 was intentionally omitted. Scores shown are the exact 2024 (col O), 2025 (col Q), and comparator (col S) values used in the discussion.

	2025 score	2024 score	Change from 2024	Comparator relationship	Insight
2A – I look forward to going to work.	51.37%	50.21%	+1.16pp	Below comparator (51.72%)	Just over half of staff report positively that they look forward to work. The improvement is encouraging, but the score remains only just below comparator, suggesting motivation is stable rather than strongly positive.
2B – I am enthusiastic about my job.	66.64%	65.14%	+1.50pp	Above comparator (65.45%)	Around two-thirds of staff report enthusiasm for their job. The improvement and above-comparator position suggest positive momentum in day-to-day engagement.
2C – Time passes quickly when I am working.	71.46%	70.53%	+0.93pp	Above comparator (69.15%)	This is the strongest of the three motivation indicators. Improvement and performance above comparator suggest many staff remain absorbed and engaged in their day-to-day work.
3A – I always know what my work responsibilities are.	83.22%	84.89%	-1.68pp	Below comparator (86.52%)	This remains a high score, showing most staff feel clear about their responsibilities. The decline and below-comparator position suggest some weakening in role clarity or consistency.
3B – I am trusted to do my job.	89.21%	88.50%	+0.71pp	Below comparator (89.80%)	A very strong result indicating staff largely feel trusted to do their job. The small improvement is positive, although the score remains just below comparator.
3C – There are frequent opportunities for me to show initiative in my role.	72.38%	70.88%	+1.49pp	Above comparator (72.21%)	A solid positive score with improvement and performance slightly above comparator. Staff generally feel able to show initiative in their role.
3D – I am able to make suggestions to improve the work of my team / department.	71.15%	69.94%	+1.20pp	Above comparator (69.83%)	A positive result showing staff generally feel able to contribute ideas for improvement. Improvement and an above-comparator position suggest a reasonably healthy local voice culture.
3E – I am involved in deciding on changes introduced that affect my work area / team / department.	49.05%	46.80%	+2.26pp	Below comparator (49.18%)	Fewer than half of staff positively report involvement in change. The improvement is welcome, but involvement in change is still not experienced consistently.
3F – I am able to make improvements happen in my area of work.	52.86%	51.22%	+1.63pp	Below comparator (54.70%)	Just over half of staff feel able to make improvements happen. Better than last year, but still below comparator, suggesting staff do not always feel able to turn ideas into change.
3G – I am able to meet all the conflicting demands on my time at work.	41.12%	41.96%	-0.83pp	Below comparator (46.56%)	A weaker result, with fewer than half of staff feeling able to manage conflicting demands. The decline and below-comparator position suggest workload pressure remains a significant issue.
3H – I have adequate materials, supplies and equipment to do my work.	52.36%	51.13%	+1.23pp	Below comparator (54.07%)	This is moderate rather than strong. The slight improvement is positive, but only around half of staff report adequate materials, supplies and equipment.
3I – There are enough staff at this organisation for me to do my job properly.	26.20%	28.16%	-1.95pp	Below comparator (31.85%)	This is the weakest result in Q3 and a clear pressure point. Only around a quarter of staff feel there are enough staff to do the job properly, and the position has worsened.
4A – The recognition I get for good work.	21.89%	23.08%	-1.19pp	Below comparator (22.85%)	A low score indicates that recognition for good work is not widely experienced. The decline and below-comparator position suggest a worsening perception of recognition.
4B – The extent to which my organisation values my work.	30.88%	30.23%	+0.65pp	Above comparator (28.15%)	Around one-third of staff feel valued by the organisation. Although slightly improved and above comparator, the overall score remains low.
4C – My level of pay.	40.66%	42.99%	-2.33pp	Below comparator (43.73%)	Fewer than half of staff report satisfaction with pay. The notable decline and below-comparator position indicate pay is a significant and increasing concern.
4D – The opportunities for flexible working patterns.	18.42%	19.58%	-1.16pp	Below comparator (19.27%)	A very low score indicates that flexible working opportunities are not widely experienced. The decline suggests this remains a persistent and slightly worsening issue.
5A – I have unrealistic time pressures.	29.23%	30.95%	-1.72pp	Below comparator (29.75%)	Fewer than one-third of staff report positively on time pressure. The decline and below-comparator position reinforce workload as a significant and increasing concern.
5B – I have a choice in deciding how to do my work.	15.11%	16.02%	-0.91pp	Below comparator (17.53%)	A very low score indicates limited perceived autonomy in how work is carried out. The decline and comparator gap suggest staff feel increasingly constrained in their roles.
5C – Relationships at work are strained.	18.28%	18.49%	-0.21pp	Above comparator (18.23%)	A low score indicates strained relationships remain present for a proportion of staff. The position is broadly stable and in line with comparator.

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	2025 score	2024 score	Change from 2024	Comparator relationship	Insight
6A – I feel that my role makes a difference to patients / service users.	2.65%	3.09%	-0.44pp	Above comparator (2.62%)	A very low positive score indicates very few staff strongly endorse this item at the highest response level. The decline suggests a slight weakening, although performance remains marginally above comparator.
6B – My organisation is committed to helping me balance my work and home life.	19.98%	21.47%	-1.50pp	Below comparator (20.74%)	Around one-fifth of staff report positively, indicating limited perceived organisational support for work-life balance. The decline and below-comparator position suggest a worsening experience.
6C – I achieve a good balance between my work life and my home life.	18.80%	19.56%	-0.76pp	Below comparator (20.07%)	Fewer than one in five staff report achieving a good work-life balance. The decline and comparator gap indicate this remains a consistent pressure point.
6D – I can approach my immediate manager to talk openly about flexible working.	13.13%	14.73%	-1.60pp	Above comparator (12.89%)	A very low score indicates only a small proportion feel able to openly discuss flexible working with their manager. Despite being slightly above comparator, confidence is worsening.
7A – The team I work in has a set of shared objectives.	10.98%	10.30%	+0.69pp	Above comparator (9.13%)	A low score indicates relatively few staff strongly endorse clear shared objectives. However, the improvement and above-comparator position suggest a small strengthening in clarity of team purpose.
7B – The team I work in often meets to discuss the team's effectiveness.	22.69%	21.59%	+1.10pp	Above comparator (19.71%)	Just over one-fifth of staff report positively, indicating structured team reflection is not widespread. The improvement and above-comparator position suggest progress from a low base.
7C – I receive the respect I deserve from my colleagues at work.	11.33%	11.08%	+0.25pp	Above comparator (10.83%)	A low score at the highest response level suggests limited strong endorsement of respect from colleagues. The score is stable to slightly improving and above comparator.
7D – Team members understand each other's roles.	13.05%	13.46%	-0.41pp	Above comparator (12.31%)	A low score suggests limited strong agreement that roles are well understood. The slight decline indicates a small deterioration, though the score remains above comparator.
7E – I enjoy working with the colleagues in my team.	5.10%	4.69%	+0.41pp	Above comparator (4.89%)	A very low score at this response level indicates strong positive endorsement is limited. However, the improvement and above-comparator position suggest a small strengthening in team cohesion.
8A – Teams within this organisation work well together to achieve their objectives.	21.86%	21.34%	+0.52pp	Above comparator (17.73%)	Just over one-fifth of staff strongly endorse effective team working across the organisation. Improvement and a strong position above comparator suggest this is a relative strength.
8B – The people I work with are understanding and kind to one another.	10.59%	10.28%	+0.31pp	Below comparator (10.73%)	A low top-box score indicates limited strong endorsement of kindness at the highest level. While slightly improved, the score sits just below comparator.
8C – The people I work with are polite and treat each other with respect.	10.63%	10.29%	+0.34pp	Above comparator (10.25%)	A low top-box score reflects limited strong endorsement, but the improvement and above-comparator position suggest respectful behaviours are relatively well embedded compared with peers.
8D – The people I work with show appreciation to one another.	11.37%	10.99%	+0.38pp	Below comparator (11.43%)	A low score indicates that strong endorsement of appreciation is limited. While improving, the score remains marginally below comparator.
9A – My immediate manager encourages me at work.	11.86%	12.55%	-0.69pp	Above comparator (10.73%)	A low top-box score indicates limited strong endorsement of manager encouragement. The decline suggests a slight weakening, although performance remains above comparator.
9B – My immediate manager gives me clear feedback on my work.	16.74%	17.89%	-1.15pp	Above comparator (14.75%)	A moderate top-box score compared with others in this set, but declining. While still above comparator, the drop suggests reduced strength in how feedback is experienced.
9C – My immediate manager asks for my opinion before making decisions that affect my work.	20.27%	22.62%	-2.35pp	Above comparator (19.73%)	One of the higher scores in this group, but with the largest decline. This suggests a noticeable reduction in staff feeling involved in decisions, despite remaining above comparator.
9D – My immediate manager takes a positive interest in my health and well-being.	12.82%	13.43%	-0.61pp	Above comparator (12.55%)	A low score indicating limited strong endorsement. Slight decline suggests a marginal weakening in perceived wellbeing support, though still above comparator.

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	2025 score	2024 score	Change from 2024	Comparator relationship	Insight
9E – My immediate manager values my work.	10.99%	11.26%	-0.27pp	Above comparator (10.42%)	A low score indicates limited strong endorsement of feeling valued by the manager. Largely stable but slightly declining, with performance remaining above comparator.
9F – My immediate manager works together with me to come to an understanding of problems.	13.27%	13.67%	-0.40pp	Above comparator (12.45%)	A low-to-moderate score showing limited strong endorsement. Slight decline suggests a small weakening in collaborative problem-solving.
9G – My immediate manager is interested in listening to me when I describe challenges I face.	13.43%	14.39%	-0.95pp	Above comparator (12.31%)	Declining score indicates reduced strong endorsement of listening behaviours. However, performance remains above comparator, suggesting relative strength.
9H – My immediate manager cares about my concerns.	12.55%	14.03%	-1.47pp	Above comparator (12.36%)	A notable decline suggests reduced strong endorsement of managerial care. Despite this, the score remains slightly above comparator, indicating relative but weakening performance.
9I – My immediate manager takes effective action to help me with any problems I face.	14.43%	14.86%	-0.43pp	Above comparator (13.49%)	A low-to-moderate score with slight decline. While still above comparator, strong endorsement of action-taking is limited and not improving.
11A – My organisation takes positive action on health and well-being.	18.96%	18.31%	+0.65pp	Above comparator (16.37%)	A low score indicates limited strong endorsement of organisational action on wellbeing. However, the improvement and above-comparator position suggest some progress from a low base.
11B – In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	38.22%	27.66%	+10.56pp	Below comparator (41.36%)	A substantial increase indicates a marked rise in reported musculoskeletal issues linked to work. Despite being below comparator, the scale of deterioration is significant.
11C – During the last 12 months have you felt unwell as a result of work related stress?	42.03%	42.35%	-0.32pp	Below comparator (42.91%)	A moderate score indicates that a significant proportion of staff report stress-related ill health. The small reduction suggests little real improvement.
11D – In the last three months have you ever come to work despite not feeling well enough to perform your duties?	56.24%	56.87%	-0.64pp	Above comparator (56.08%)	A high score indicates many staff report attending work while unwell. The slight reduction is marginal, suggesting presenteeism remains widespread.
11E – Have you felt pressure from your manager to come to work?	20.49%	21.73%	-1.24pp	Below comparator (20.55%)	Around one-fifth of staff report feeling pressure from their manager to attend work. The decline suggests slight improvement, but this remains a notable issue.
12A – How often, if at all, do you find your work emotionally exhausting?	35.77%	36.66%	-0.89pp	Above comparator (34.53%)	Over one-third of staff report high emotional exhaustion. The slight improvement is positive, but levels remain high and above comparator.
12B – How often, if at all, do you feel burnt out because of your work?	29.74%	30.70%	-0.96pp	Below comparator (31.97%)	Around three in ten staff report burnout. The reduction is positive, but burnout continues to affect a substantial proportion of staff.
12C – How often, if at all, does your work frustrate you?	40.54%	40.19%	+0.35pp	Above comparator (36.81%)	A high score indicates that frustration is widely experienced. The slight increase and above-comparator position suggest worsening experience and a clear area of concern.
12D – How often, if at all, are you exhausted at the thought of another day/shift at work?	27.75%	28.73%	-0.98pp	Below comparator (29.10%)	Just over a quarter of staff report exhaustion at the thought of work. The slight improvement is positive, though fatigue remains notable.
12E – How often, if at all, do you feel worn out at the end of your working day/shift?	44.21%	45.46%	-1.25pp	Above comparator (43.10%)	A high score indicates that nearly half of staff feel worn out at the end of their shift. Although slightly improved, this remains a widespread experience.
12F – How often, if at all, do you feel that every working hour is tiring for you?	18.91%	20.35%	-1.44pp	Below comparator (20.94%)	Around one in five staff report continuous fatigue. The reduction is positive, though fatigue remains a persistent issue.
12G – How often, if at all, do you not have enough energy for family and friends during leisure time?	28.73%	30.24%	-1.51pp	Below comparator (30.27%)	Nearly one-third of staff report insufficient energy outside work. While improving, this indicates ongoing impact of work on personal life and recovery.
13A – In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their	10.17%	11.62%	-1.44pp	Below comparator (13.97%)	A declining 'never' score indicates fewer staff can say they never experienced violence from patients/public, meaning exposure is increasing. The below-comparator position suggests this is more prevalent locally.

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	2025 score	2024 score	Change from 2024	Comparator relationship	Insight
relatives or other members of the public?					
13B – In the last 12 months how many times have you personally experienced physical violence at work from managers?	0.51%	0.54%	-0.03pp	Below comparator (0.79%)	Very low scores reflect that 'never experienced' is measured at the strongest level only. The small decline suggests a marginal worsening, though absolute levels remain very low.
13C – In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	1.29%	1.34%	-0.05pp	Below comparator (2.01%)	A very low score indicates limited strong endorsement of 'never experienced'. The slight decline and comparator gap suggest marginally higher exposure compared with peers.
13D – The last time you experienced physical violence at work, did you or a colleague report it?	29.11%	37.46%	-8.34pp	Below comparator (29.32%)	A substantial decline indicates that fewer incidents are being reported. Despite being in line with comparator, the scale of reduction suggests a significant weakening in reporting behaviour.
14A – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	21.94%	22.15%	-0.21pp	Below comparator (24.94%)	A lower 'never' score indicates slightly increased exposure to bullying, harassment or abuse from patients/public. The comparator gap suggests this issue is more prevalent locally.
14B – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?	10.69%	11.07%	-0.38pp	Above comparator (9.23%)	A declining 'never' score indicates a slight increase in exposure to negative behaviours from managers. Despite this, performance remains above comparator.
14C – In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	17.57%	18.58%	-1.01pp	Below comparator (17.77%)	A notable decline indicates increased exposure to bullying, harassment or abuse from colleagues. The movement below comparator suggests a worsening position relative to peers.
14D – The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	50.67%	51.02%	-0.35pp	Above comparator (47.44%)	Around half of incidents are reported, indicating moderate reporting levels. The slight decline suggests a marginal weakening, although performance remains above comparator.
15 – Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation?	11.83%	12.46%	-0.63pp	Below comparator (12.63%)	A low top-box score indicates limited strong endorsement of fairness in career progression. The decline and below-comparator position suggest a worsening perception of equity and opportunity.
16A – In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	4.93%	5.22%	-0.29pp	Below comparator (9.40%)	A low score indicates relatively low reported discrimination from patients/public. The reduction is positive, and the substantially lower rate compared with comparator suggests a relative strength.
16B – In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	8.12%	8.81%	-0.69pp	Below comparator (9.05%)	A moderate score indicates that a proportion of staff continue to experience discrimination from colleagues or managers. The reduction is positive, and performance is better than comparator.
17A – In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public?	7.67%	8.32%	-0.65pp	Below comparator (8.03%)	A declining 'never' score indicates increased exposure to unwanted sexual behaviour from patients/public. The below-comparator position suggests this is more prevalent locally.
17B – In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in	3.66%	3.86%	-0.20pp	Above comparator (3.50%)	A slight decline indicates a marginal increase in exposure. However, performance remains slightly above comparator, suggesting relatively lower prevalence than peers despite the deterioration.

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	2025 score	2024 score	Change from 2024	Comparator relationship	Insight
the workplace from staff / colleagues?					
18 – In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	34.98%	34.35%	+0.63pp	Below comparator (35.34%)	Around one-third of staff report seeing errors or near misses. The increase suggests slightly greater visibility or occurrence, while remaining just below comparator indicates broadly similar levels to peers.
19A – My organisation treats staff who are involved in an error, near miss or incident fairly.	9.60%	9.12%	+0.48pp	Below comparator (9.65%)	A low score indicates limited overall confidence in fair treatment following incidents. While improving slightly, perception of fairness remains weak.
19B – My organisation encourages us to report errors, near misses or incidents.	5.17%	4.71%	+0.46pp	Above comparator (4.22%)	A low score indicates that strong agreement on encouragement to report is limited. However, improvement and position above comparator suggest relative strength.
19C – When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	12.34%	11.08%	+1.26pp	Above comparator (9.70%)	A moderate score within this set indicates some confidence that action is taken. Improvement and the above-comparator position suggest strengthening perception of organisational response.
19D – We are given feedback about changes made in response to reported errors, near misses and incidents.	19.98%	20.11%	-0.12pp	Above comparator (15.20%)	Around one-fifth of staff agree that feedback is provided. While slightly declining, the strong position above comparator suggests this is a relative strength compared with peers.
20A – I would feel secure raising concerns about unsafe clinical practice.	9.88%	8.84%	+1.04pp	Above comparator (9.12%)	A low score indicates limited strong confidence in feeling secure to raise concerns. However, the improvement and position above comparator suggest strengthening confidence in speaking up.
20B – I am confident that my organisation would address my concern.	16.07%	14.14%	+1.94pp	Above comparator (13.77%)	A higher score relative to Q20a indicates greater confidence in organisational response than in speaking up itself. The strong improvement and above-comparator position suggest growing trust that concerns will be acted upon.
21 – I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).	8.28%	8.49%	-0.21pp	Above comparator (8.25%)	A low score indicates limited strong endorsement that the organisation respects individual differences. The slight decline suggests a marginal weakening, although performance remains broadly in line with comparator.
22 – I can eat nutritious and affordable food while I am working.	13.06%	14.79%	-1.73pp	Below comparator (19.27%)	A low and declining score indicates that access to nutritious and affordable food is not widely experienced. The significant gap below comparator highlights this as a clear area of relative weakness.
23A – In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	14.58%	15.97%	-1.39pp	Above comparator (10.22%)	A low and declining score indicates limited strong positive anticipation of work. The comparator gap suggests weaker engagement compared with peers.
23B – It helped me to improve how I do my job.	31.41%	32.23%	-0.82pp	Above comparator (26.26%)	A low score with a clear decline indicates weakening enthusiasm for work. Falling below comparator reinforces this as a deteriorating area of engagement.
23C – It helped me agree clear objectives for my work.	18.70%	17.93%	+0.77pp	Above comparator (15.91%)	A moderate top-box score but declining trend suggests reduced engagement or absorption in work. The comparator gap indicates weaker experience relative to peers.
23D – It left me feeling that my work is valued by my organisation.	23.96%	25.45%	-1.49pp	Above comparator (22.41%)	A higher score relative to others in this set, but declining. While still above comparator, fewer staff strongly feel able to contribute ideas, indicating weakening voice.
24A – This organisation offers me challenging work.	7.93%	8.07%	-0.14pp	Below comparator (7.99%)	A low score indicates limited strong endorsement that work is challenging. The slight decline suggests a marginal weakening, with performance broadly in line with comparator.
24B – There are opportunities for me to develop my career in this organisation.	25.94%	24.27%	+1.67pp	Above comparator (22.18%)	A relatively strong score and clear improvement indicate increasing confidence in career development

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	2025 score	2024 score	Change from 2024	Comparator relationship	Insight
					opportunities, with performance notably above comparator.
24C – I have opportunities to improve my knowledge and skills.	14.07%	14.10%	-0.03pp	Above comparator (12.88%)	A moderate score with minimal change suggests stability in perceived opportunities to develop skills, with performance above comparator indicating relative strength.
24D – I feel supported to develop my potential.	21.12%	21.24%	-0.11pp	Above comparator (18.90%)	A moderate score indicates some confidence in support for development. The slight decline suggests stagnation rather than improvement, though performance remains above comparator.
24E – I am able to access the right learning and development opportunities when I need to.	18.53%	18.37%	+0.16pp	Above comparator (15.82%)	A moderate and slightly improving score suggests reasonable access to learning opportunities, with a clear advantage over comparator organisations.
24F – I am able to access clinical supervision opportunities when I need to.	13.76%	14.34%	-0.58pp	Above comparator (13.58%)	A moderate-to-low score with a small decline suggests slightly reduced access to clinical supervision, though still marginally above comparator.
25A – Care of patients / service users is my organisation's top priority.	13.51%	13.16%	+0.35pp	Above comparator (11.22%)	A moderate score indicates some strong endorsement that patient care is prioritised. The improvement and above-comparator position suggest this is a relative strength.
25B – My organisation acts on concerns raised by patients / service users.	8.45%	7.07%	+1.38pp	Above comparator (7.15%)	A low but improving score indicates growing confidence that patient concerns are acted upon, with performance above comparator suggesting relative strength.
25C – I would recommend my organisation as a place to work.	18.56%	17.30%	+1.26pp	Above comparator (16.76%)	A moderate and improving score indicates strengthening advocacy as a place to work, with performance above comparator suggesting a relatively positive position.
25D – If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	14.68%	13.79%	+0.90pp	Above comparator (13.31%)	A moderate and improving score indicates increasing confidence in care quality, with performance above comparator reinforcing this as a relative strength.
25E – I feel safe to speak up about anything that concerns me in this organisation.	17.46%	17.80%	-0.34pp	Above comparator (15.67%)	A moderate score indicates some confidence in speaking up. The slight decline suggests a small weakening, though performance remains above comparator.
25F – If I spoke up about something that concerned me I am confident my organisation would address my concern.	23.91%	22.25%	+1.66pp	Above comparator (19.72%)	One of the stronger scores in this set, with clear improvement. This indicates growing confidence that concerns will be addressed, and a strong position relative to comparator.
26A – I often think about leaving this organisation.	31.54%	31.41%	+0.13pp	Above comparator (29.05%)	Around one-third of staff report thinking about leaving. The slight increase and above-comparator position indicate a consistently higher level of turnover intention than peers.
26B – I will probably look for a job at a new organisation in the next 12 months.	19.87%	21.36%	-1.49pp	Below comparator (20.88%)	A reduction indicates fewer staff intending to actively seek a new role. The score now sits below comparator, suggesting a relative improvement in short-term retention risk.
26C – As soon as I can find another job, I will leave this organisation.	15.14%	14.54%	+0.59pp	Below comparator (16.74%)	A moderate score indicates a proportion of staff with strong intent to leave. The increase suggests worsening sentiment, although remaining below comparator indicates relatively lower levels than peers.
Question 27 onwards provides EDI and other metrics data					