



Torbay and South Devon
NHS Foundation Trust

Public Board of Directors

Date: Thursday 3 September 2026

Time: 12.30 pm - 2.30 pm

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

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TSDFT Public Board of Directors

The Board Room - Hengrave House



Torbay and South Devon
NHS Foundation Trust

03/09/2026 12:30 - 14:30

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Torbay and South Devon
NHS Foundation Trust

**MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
PUBLIC BOARD OF DIRECTORS MEETING
HELD IN THE BOARDROOM AND MS TEAMS
AT 12.30 PM ON THURSDAY 2ND JULY 2026**

Present:	Dr M Beaman	Chairman
	Mr J Teape	Chief Executive
	Mr J Corrigan	Chief Finance Officer
	Mr A Ghadiali	Non-Executive Director
	Mr M Greaves	Non-Executive Director
	Mr A Griffiths	Non-Executive Director
	Mrs N McMinn	Chief Nursing Officer
	Ms J Piper	Chief People Officer
	Mr P Richards	Non-Executive Director
	Mrs D Stark	Associate Non-Executive Director
	Mr C Saxby	Non-Executive Director
	Mr S Tapley	Chief Strategy and Planning Officer
	Mr S Wadham-Sharpe	Chief Operating Officer
	Ms J Webber	Non-Executive Director
In Attendance:	Ms J Bassett	Director of Midwifery and Gynaecology (for item 73/07/26)
	Mrs L Densham	Lead Governor
	Mrs S Fox	Corporate Governance Manager
	Ms L Grigg	Devon Senior Lead for Maternity and Neonatal Voices Partnership (for item 73/07/26)
	Ms J Harris	Associate Director of Communications and Partnership
	Mr M Joyce	Governor
	Dr R Honney	Deputy Medical Director
	Ms C Parnell	Chief of Staff
	Ms A Thorne	Patient (for item 73/07/26)
	Members of the Public	

WELCOME AND INTRODUCTIONS

70/07/26 The Chairman welcomed all those in attendance, in particular three new Non-Executive Directors who had joined the Board on 1st July and were attending their first meeting: Arwel Griffiths, Debbie Stark and Joanna Webber.

Ten questions had been received from members of the public, all of which had been shared with the Board. The questions broadly related to the provision of services at Torbay Hospital including pathology, recruitment and workforce stability, deficit support funding and safeguarding assurance. All the questions and the Trust's responses would be published on its website within the next 24 hours.

PRELIMINARY MATTERS

71/07/26 **Apologies for Absence, Quoracy and Declarations of Interest**

Apologies for absence were received from Liz Edwards-Smith, Non-Executive Director and Kate Lissett, Chief Medical Officer.

The meeting was confirmed as quorate and no declarations of interest were received.

72/07/26 **Unconfirmed Minutes of the Meeting held on 7th May 2026**

The Board received the minutes of the meeting held on 7th May 2026, circulated with the agenda pack. The action log was reviewed, and updates were received on outstanding actions.

The Board APPROVED the Unconfirmed Minutes from the Public Board meeting held on 7th May 2026 as a true and correct record, noting the amendment agreed detailed above.

73/07/26 **Patient Story**

Anais Thorne had joined the meeting to provide detail of her experiences of an early pregnancy loss.

Following a private early pregnancy scan Anais was referred to the Trust's Early Pregnancy Unit because the scan could not confirm a heartbeat. A scan at the Trust sadly confirmed pregnancy loss – this took place about five days after the private scan. Anais then later attended the Emergency Department due to pain related to her miscarriage.

Anais said that her partner (Dan) received little acknowledgement as the baby's father by staff in both the Early Pregnancy Unit and in the Emergency Department and was not engaged in discussions, addressed by name or offered emotional support. Anais did state that the midwife involved in her care was excellent and did involve Dan in discussions.

This impacted on the family unit with Dan having feelings of anger, exclusion and resentment which added to an already stressful time with Anais having to also support Dan.

Counselling support was provided to Anais but not to Dan.

The care environment was not always appropriate to provide privacy, compassion and support during early pregnancy loss, with Anais and Dan being asked to wait in a waiting room with pregnant ladies who were also waiting for scans.

Anais informed the Board that this had happened in December 2024 but she only now felt able to talk about it. She added that she worked in perinatal mental health herself. In addition, Anais said that if this happened again she was not sure if she would feel safe and secure returning to the Trust for treatment.

The Board thanked Anais for sharing her story, noting how difficult it was, and that it was very timely given the recent publication of both the Ockenden and Amos reports on maternity services.

JT apologised to Anais on behalf of the Trust for the level of care both she and Dan had experienced and asked her what the Trust could do to make improvements.

JB stated that a lot of work had taken place since 2024 to hear the voice of patients and make improvements, this included making sure partners and wider family members were better supported throughout the pregnancy journey.

It was noted that midwives received bereavement training, but that this needed to be expanded, for example the sonographer that Anais had seen did not work in the Maternity Unit. The same would apply to staff in the Emergency Department and other departments.

It was suggested work could take place at system level in particular to strengthen relationships between Trusts and private scan providers as it could help reduce the gap between private scans and waiting for one at the hospital.

It was noted that improvements had recently been made to the Trust's Bereavement Room and Anais was asked if she felt there were any other improvements that could be made. Anais said she recognised that space was an issue however, for example, when she left the sonographer's room, a lady was leaving the other sonographer's room beside her excited at the results of her scan. She suggested, if possible, clinical rooms were separated so families receiving bad news were separate from those that were not.

The Board thanked Anais for presenting her patient story, recognising how difficult it must have been for her to do this.

74/07/26

Report from the Chairman

MB briefed the Board on the following issues and events he had attended since the last meeting:

- The annual People Awards at the Riviera Centre. The event was well attended and an opportunity for Board members to celebrate staff successes, in addition it was the first time a volunteers award was presented.
- A cream tea to celebrate volunteers' week
- A League of Friends photoshoot to celebrate raising of c£1.5m for the benefit of patients.
- A quarterly League of Friends meeting.
- Medical Staff Committee which helped the MB to gain feedback from the Trust's consultant body
- Hosted a visit by the new independent Chair of the NHSE South West Region (Dame Gill Morgan), which included visits to the Maternity Unit, Emergency Department and Day Surgery Unit.
- Visits to the Information Technology and Estates and Facilities teams, opening of the Harbour Unit and Maternity Triage. As part of the Estates and Facilities visit, the Chair met the Portering Team many of whom had worked for the Trust for many years and told MB they had stayed so long because of the people they worked with and supported.
- An event in the Rose Garden to celebrate 100 years since the laying of the hospital's foundation stone.
- Monthly Maternity Safety Champion walkaround. It was noted that MB would hand over this role to JW in September.

The Board received and noted the Chairman's report.

75/07/26 **Chief Executive's Report**

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

- The paper contained a proposal to begin to rotate Public Board meetings across the Trust's neighbourhood with a 12-month pilot commencing later in the year. The Board supported this approach.
- The amount of capital development taking place was highlighted including Emergency Department, theatres, oral and maxillo facial surgery and maternity. Thanks were placed on record to staff involved who have had to keep services running whilst improvement works took place.
- The Board was reminded that it had one of the oldest estates in the country and although the Trust worked hard to maintain its estate, it was not possible to keep it up to date with modern building standards and that hospital redevelopment had been impacted by the delay in the New Hospitals Programme. One specific issue related to the Tower Block. It was reported that the scaffolding that had been put up around it was now in the process of being removed as those issues had been rectified, however the Trust was managing a fire risk within the Tower Block. JT provided assurance that significant additional controls had been put in place to manage both the risk of fire and to ensure staff were fully trained if evacuation was necessary but that building solutions would still be required to fully manage the risk. Further work was due to take place which included compartmentation, improved detection systems and possibly fire suppression but that funding from NHSE would be required. The work completed to date had been undertaken with the advice of the Fire Brigade, fire specialists and NHS England and this ongoing dialogue to resolve remaining issues was critical.
- The Trust continued to provide safe care for its patients whilst managing those risks and whilst strongly advocating for a permanent solution through receipt of additional funding. In terms of funding, there were two potential routes to obtain capital: through the New Hospitals Programme or the Estates Safety fund. The Trust was actively lobbying for this funding and encouraged members of the public to support the Trust in this regard.
- A meeting with stakeholders was taking place later in the month and following that meeting a fuller report would be provided to the Public Board.
- A briefing was provided on the development of Gadeon House for the long term provision of cellular pathology services. There had been a lot of public interest in this decision. The Board was informed that the current location of the service, which was a portacabin, would come to the end of its life in around 18 months' time. The Trust had therefore taken advantage of emergency capital funding through the Estates Safety Fund to relocate the service to a joint location with the Royal Devon University Hospital Trust. Clarity was provided that this did not change where patients would receive care, or the need to provide quick turnaround of tests, which would still be provided on site. The new service would manage less urgent tests.
- Over the last week both the Ockendon and Amos reports into maternity services had been published. A full report on those reports would be presented to the Quality and People Committee, alongside an action plan to take account of the recommendations in each report. The letter received from NHSE in relation to these reports outlined potential funding to support the

recruitment of newly qualified midwives and potential funding to support the improvement of the maternity and neonatal estate.

- It was noted that the Trust had also exited Maternity Safety Improvement Programme and would be subject to routine oversight by the regulators.
- Unfortunately the Trust had moved from National Oversight Framework level 3 to 4 and JT was invited to provide some background on this issue:
 - The Board was reminded that the Trust was assessed on the following indicators: access to services; effectiveness and experience; patient safety; people and workforce; and finance and productivity.
 - The Trust was above average for effectiveness and experience and patient safety, below average for people and workforce and low performing for access to services and finance and productivity.
 - The workforce data took account of areas such as sickness rates and it was recognised that this was an area where improvements needed to be made. In respect of performance, improvements needed to be made in respect of referral to treatment times, cancer and urgent and emergency care, noting some of this was due to the Epic implementation. Although the Trust had delivered its financial plan, deficit support funding had been withdrawn as other parts of Devon had not delivered their financial plan.
- Noting a recent summit had been held around actions that could be taken to remove the need for corridor care, a query was raised around when the Board could expect to see improvements. It was explained that actions had been split into three areas: personal, team and wider Trust. Around 45 personal pledges were made on the day and 26 teams agreed actions. Plans for those actions were expected by 8th July with a follow up event to be held to discuss how to take them forward. It was noted that, as yet, no costs had been identified for the agreed actions.
- In terms of wider Trust actions, these were aligned to the five key areas related to delivering Urgency and Emergency Care over the next year. These actions would be shared with wider teams, again to work out how they could be delivered. Some of the actions would aim to make unscheduled health care as scheduled as possible through the implementation of best practice such as same day emergency care and also making better use of the Frailty Hub.
- In terms of delivery of the actions, it was noted that the action plan would be the focus of a deep dive at the next Finance and Operations Committee meeting and as part of that timelines and expected impact of actions would be provided.

The Board noted the report of the Chief Executive and approved the proposal to pilot holding Public Board meetings at different locations across the Trust's footprint.

76/07/26 **Board Assurance Framework**

The Board received the Board Assurance Framework (BAF), circulated with the agenda pack noting that the BAF was now aligned to the Trust's strategic signature moves. Committee Chairs were working closely with CP to ensure that, over the next few months, agendas were aligned to the BAF to ensure Committee time was focussed on the right issues.

Included in the meeting pack was a draft Corporate Risk Register and that work to transfer risks to the new risk platform DCIQ was not yet complete. This meant that some of the data in the CRR was not yet accurate as not all risks had yet been added to DCIQ.

The management of long-standing risks was queried. It was noted that management of long-standing risks had been an ongoing challenge and as part of the move to the new risk management system all risks had been reviewed to ascertain if they could be closed down or needed updating before transfer. In addition, a review of the Trust's risk appetite had been undertaken, and that at present some risks exceeded the risk appetite.

The Board received and noted the Board Assurance Framework and Draft Corporate Risk Register, and agreed the recommended assurance recommendations.

TO APPROVE

77/07/26 **CoG and Board Policy of Engagement for Serious Concerns**

The Board received the CoG and Board Policy of Engagement for Serious Concerns, circulated with the agenda pack, noting that it had been previously reviewed and approved by the Council of Governors. It was suggested, before publication, paragraph 1.1 of the Appendix be reviewed to ensure it was written in plain English. (*post meeting note – actioned*)

The Board approved the CoG and Board of Directors' Policy of Engagement for Serious Concerns.

FOR REVIEW

78/07/26 **Our Plan for Better Care**

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

- The Board was reminded that the Our Plan for Better Care was built on the five signature moves in the Trust's strategy. These were neighbourhoods; reimagining acute care; joined up care; digital; and workforce. Workstreams were in place for each of the signature moves. Each workstream reported to the Our Plan for Better Care Oversight Group and the output of their work was reported to the Board.
- Since the last report to the Board assurance had slightly weakened. It was hoped that the expansion of the Frailty Hub to seven days a week would have a significant impact on performance. Work was also continuing on workforce, cultural transformation and One Devon finance.
- In respect of delivery, seven of the 13 deliverables due at the end of May had been delivered.
- Progress had been made in respect of the transfer of Adult Social Care to Torbay Council.

- Successful delivery of this programme would result in a £23.5m contribution of the Trust's £54.4m CIP.
- Noting that some indicators had moved to a red rating, ST was asked if he required any support from the Board to support delivery of the actions. ST explained that, as the Board was aware, a number of reorganisations and consultations with teams were currently taking place, including the Transformation Team. Through this work the Trust would be able to align skilled members of staff to support teams to deliver their actions as part of the Our Plan for Better Care.

The Board:

- **Noted the Transformation delivery report and progress made during the reporting period;**
- **Acknowledged the risks to delivery and ongoing work required to improve the Trust's position; and**
- **Took assurance that the transformation programme was executive owned and work was being undertaken to evidence impact to the organisation's key priorities.**

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

79/07/26

Audit and Risk Committee

The Board received the Audit and Risk Committee Chair's report, circulated with the agenda pack. The Board noted that the Committee had met to review and recommend approval of the Annual Report and Accounts and Quality Account by the Board of Directors and had approved the Letter of Representation. The Board was informed that the Trust had been issued with a satisfactory Head of Internal Audit rating for 2025/26, an improvement on the limited assurance rating issued for 2024/25. The Trust would need to make sure it continued to deliver actions issued as part of Internal Audit reviews throughout the current year to ensure it retained that rating.

80/07/26

Charity Committee

The Board received the Charity Committee Chair's report, circulated with the agenda pack. The following was discussed:

- The Committee noted the level of fundraising that the Trust's Charity team delivered. Alongside this there has been an increase in requests for charitable funding support some of which was for areas that were considered part of delivering core NHS services. The Charity would be reviewing its remit to ascertain if it was able to support these types of bids.
- The Committee received an impact story related to the Health and Arts Group and how, through this, the Charity was able to bring together a wide range of stakeholders.
- The Committee also discussed its role in supporting the Trust's Neighbourhood Strategy; risk management and innovations across the charity sector.
- The governance framework that supported the Charity was also discussed and whether an independent structure would provide a better framework into the future.

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

81/07/26

Finance and Operations Committee

The Board received the Finance and Operations Committee Chair's report, circulated with the agenda pack. It was reported the Committee received the following reports:

- Month 2 Finance Report, which was broadly on plan, however the split between recurrent and non-recurrent CIP delivery needed to be improved.
- EPR progress report and action plan, noting that implementation had gone well and the team had been congratulated on the work undertaken to deliver the implementation.
- Report on the fire risk in the Tower Block. The fire risk was currently above the Trust's risk appetite, notwithstanding the work that had been undertaken to strengthen governance; improved operational control and improvement works to the building, including an improved alarm system; evacuation lifts; and installation of fire dampers. An action plan had been put in place and shared with key stakeholders including the Fire Brigade. Alongside this, work was being undertaken to identify further interim tactical interventions that could be put in place to further reduce the risk of fire. The Board would need to discuss and agree its 'red lines' to support it in making a decision around the level of risk it could continue to hold in respect of the Tower Block. Based on the work undertaken to date, the Board was invited to accept the current residual risk whilst the further work articulated above took place.
- In respect of operational performance the Committee noted that Urgent and Emergency Care performance standards had not been met; an elective recovery plan was in place; and cancer performance was slightly behind plan. There had been an improvement in diagnostic performance.
- A query was raised around the actions being taken to improve the Trust's performance so that it could move from the National Framework Oversight rating 4 back to 3. SWS reported that improvement focussed on Urgent and Emergency Care; Referral to Treatment times; Cancer; and diagnostics. The Board was reminded that the Trust had been very clear that a reduction in performance during the Epic implementation period had been planned and agreed with regional and national teams. SWS provided assurance that recovery plans were in place and improvements in performance starting to be delivered.
- Unfortunately there was an issue with the Trust's MRI scanners which was impacting on performance meaning in the last week diagnostic trajectories have had to be rewritten. To mitigate this issue, an options appraisal paper was in the process of being prepared.
- Areas that required additional detail included the work to reduce corridor care and elective care activity, to bring it back to pre-Epic levels. In this respect work was taking place at individual consultant and speciality level to identify areas of underperformance.
- Finally, it was noted that some targeted interventions in ENT, Ophthalmology and Orthopaedics were taking place to understand what work needed to take place to close the gap between current and pre-Epic implementation activity.
- The area of most concern was Urgent and Emergency Care. The Trust had experienced its busiest month ever in June as well as managing the impact to

two heatwaves. Before this the Trust was predicting a 4.5% improvement in the handover position, however despite demand had delivered a 1% improvement.

- In respect of learning following the two heatwaves, a deep dive had taken place and it had been identified a lot of the issues experienced were as a result of the Trust's ageing estate and lack of air conditioning units. Nationally, there had been a lot of discussion around heatwave planning in the same way as Trusts developed winter plans.
- The Trust was reminded the New Hospitals Programme had been delayed due to the need to prioritise investment in hospitals with reinforced aerated autoclave concrete, however this had impacted on the Trust's estate. The support from the Trust's stakeholders in respect of replacing the Tower Block was welcomed however there might be wider community support the Trust could seek in terms of further funding to improve the Trust's estate.
- JT reported that, with MB, he regularly met with the Trust's local MPs who were strong advocates for the Hospital, and he agreed that it was important to build on relationships in the community to gain support for additional funding.

The Board received and noted the report of the Committee Chair.

82/07/26 Operational Performance Report

The Board received the Operational Performance report, circulated with the agenda pack and agreed the recommended assurance ratings.

83/07/26 Monthly Finance Report

The Board received the Monthly Finance report, circulated with the agenda pack.

The Trust's financial position at the end of May was a £4.7m deficit, as planned and the risks associated with delivery of the plan were outlined.

The Board was informed that a further cut of service line reporting was due to be undertaken, noting that this was overseen by the Finance and Operations Committee with regular deep dives on areas that were not performing as expected, eg Trauma and Orthopaedics.

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

84/07/26 Electronic Patient Record (EPR) Status Report

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

The Board:

- **agreed the recommended assurance rating and took SATISFACTORY assurance as to those matters reviewed; and**
- **took significant assurance that Epic Go-Live had been navigated successfully and adoption of Epic workflows was progressing well.**

85/07/26 Quality and People Committee

The Board received the Quality and People Chair's report, circulated with the agenda pack.

The Committee received, in particular, the Quality Report for Healthcare; Learning Academy report which focussed on investment in people; and Mortuary Activity

Report which focussed on the work that had taken place to implement the actions following the national enquiry into the crimes committed by David Fuller; and the Fire Risk Comprehensive Review and action plan, reviewed through the lens of quality, patients and staff. Discussions took place around evacuation plans and the work to identify those patients that could be moved to alternative locations to enable improvement works to take place and reduce the number of patients on wards overnight. The gaps in capacity and expertise in the Estates Team were also noted.

Also noted was the deteriorating position in respect of stroke performance and the difficulty of ring-fencing stroke beds whilst managing demand. A stroke deep dive would be taking place at a future Quality and People Committee.

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

86/07/26

Perinatal Governance Report

The Board received the Perinatal Governance report, circulated with the agenda pack. The following was discussed:

- No mortalities had been experienced since the last report. The Board was reminded that the Trust had experienced four neonatal deaths over a nine month period and this had resulted in a national alert. A thematic review of the deaths had been undertaken. The review had identified some actions that would be taken, and these were being addressed.
- Full compliance with all 10 of the Maternity Incentive Scheme safety actions for Year 7 had been achieved.
- Workforce pressures remained with the service having a 3.81 WTE deficit compared to the Birthrate Plus midwifery establishment and neonatal Qualified in Speciality (QIS) levels below recommended standards. An action plan was in place to manage QIS levels with support from the South West Neonatal network. The Board was informed that staffing levels below benchmark would affect the Trust's Clinical Negligence Scheme for Trusts (CNST) compliance.
- The Board recognised the quick action taken by NM and her team as a result of the neonatal deaths, and also the letter from Sir James Macky outlining a 10 point plan following publication of the Amos independent investigation.
- It was suggested it might be helpful to hold a Board Seminar given the national reviews and local areas for improvement that had been identified for example maternity staffing; training compliance of doctors; cultural issues for learning in practice.
- Reference to cultural and psychological safety concerns was made. NM explained that historically nationally there had been tension between midwives and obstetricians and the Trust was focusing on this relationship with the support of the Cultural Insights Group with for example, listening events.

The Board:

- **Noted and agree the assurance recommendations confirmed that the executive oversight report was sufficient to enable assurance of key issues that are described in full in the supplementary report;**
- **Confirm 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;
- continued to support the ongoing culture and wellbeing initiatives; and
- noted the impact of non-compliance with Birth Rate Plus establishment recommendations.

87/07/26 **Mortality Scorecard**

The Board received the Mortality Scorecard, circulated with the agenda pack.

Due to staffing issues there had been a delay in coding data which could negatively affect the accuracy and quality of mortality data. The coding position had, however, improved and all 2025/26 coding was complete and was expected to positively impact on mortality data in future reports. Epic would also contribute to improved data capture.

The Board was reminded that the Medical Examiner service scrutinised all deaths in hospitals and the community that did not go to the Coroner, and since October 2025 had been using the new DCIQ incident reporting system for reporting deaths. This enabled improved safety insight and triangulation of data and the capture of Medical Examiner requests for Structured Judgement Reviews (SJR) . Since that time, to the end of the financial year, 31 deaths had been examined and referred for further review via the SJR process due to possible care factors impacting on the outcome or due to concerns raised by bereaved families.

The Board accepted the report and noted mortality data trends.

CLOSING MATTERS

88/07/26 **Any Other Business and Review of Meeting**

The Board welcomed the Patient Story that was presented at the start of the meeting, which provided an important message around listening to patients, staff and families.

The agenda also reflected the amount of work that was currently being undertaken across the Trust.

89/07/26 **Board Assurance Framework (matters for review or escalation)**

No issues were discussed.

90/07/26 **Board Workplan**

The Board received and noted the Board Workplan.

91/07/26 **Date and Time of Next Meeting:**

The next Board meeting in public is scheduled to take place at 12.30 pm, Thursday 3rd September 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
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. July Update: this work was still ongoing.	Open
53/05/26	Planning Update – present paper on EQIA review process to QPC.	NM	July Update: this had been completed.	Closed

Presented to:	Board of Directors					
Title of Report	Chief Executive Officer's report					
Date of Meeting	03.09.2026	Author	Laura Patrick, Head of Communications and Engagement; Jane Harris, Director of Communications			
Executive Lead	Joe Teape, Chief Executive	Executive Sign Off	27.08.2026			
Governance Route						
Purpose of paper	For Approval	For Assurance	To Update	For Information		
			X	X		
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. 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					
Recommendation	The Board is asked to receive and note the Chief Executive's report.					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
How this paper supports delivery of the Strategy						
Board Assurance						
BAF Ref	Principal Risk	Current Score	Impact of this paper			
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led	
Compliance / Regulatory Requirements						

Ethical or EDI implications?				
Assurance rating	Significant	Moderate	Limited	Inadequate
Assurance rationale				
Appendices				

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 Dawlish Hospital, Paignton Health and Wellbeing Centre and Torbay Hospital. I also held an online Meet Joe for colleagues who are unable to join a Meet Joe in person and participated in and/or hosted our corporate induction and Trust Talk.
4. During the past two months I have hosted our latest quarterly our people awards breakfast. I had great pleasure in joining the thank you afternoon tea for supporters, donors and fundraisers to celebrate the 30th anniversary of our Torbay and South Devon NHS Charity. It was also a delight to be present for the ribbon cutting for our new volunteer wall of fame on Level 2 at Torbay Hospital and for our refurbished birthing pool, The Cove. I also enjoyed spending time with colleagues in our community dietetics services, porters and waste team and mortuary team and a number of other services and teams.
5. We welcomed our latest cohort of doctors in training who joined us at the beginning of August. We have successfully recruited to all of our Foundation Programme placements for the coming year with every Foundation Year 1 and Foundation Year 2 post filled. This is a positive endorsement of Torbay and South Devon as a place where doctors can learn, develop and build their careers.
6. I have continued to meet regularly with pathology colleagues, along with fellow executives and senior leaders, as well as fortnightly meetings with histopathology (cellular pathology) colleagues as we progress a long-term solution for our routine histopathology service.
7. My routine meetings with the Integrated Care Board, NHS England, Torbay Council and our Council of Governors continue and provide valuable opportunities for discussion and to listen to diverse voices.
8. I appreciated joining the Council of Governors for their quarterly meeting last month. As ever, my many conversations with governors have been especially valuable, providing honest feedback, constructive challenge, and a direct link to

the concerns and aspirations of our wider membership.

These ongoing discussions with governors, alongside broader community engagement, have helped to shape our planning and decision-making, ensuring that the voices of our colleagues, patients, partners and governors are at the heart of everything we do.

Leadership update

9. Following the appointment of Arwel Griffiths and Jo Webber earlier this summer, Debbie Stark joined us as an Associate Non-Executive Director in July. Debbie brings significant experience from senior roles across public health, the NHS and local government and has already begun contributing to Board discussions and development.
10. This month we are pleased to welcome Karen Cox as a Non-Executive Director. Karen joined the Board on 01 September to support an effective handover ahead of Paul Richards' departure after many years dedicated service later this autumn.
11. Karen brings extensive experience from across healthcare, education and public service. Having started her career as a nurse, she has gone on to hold senior leadership roles in both healthcare and higher education, alongside a range of trustee and non-executive positions.
12. Her appointment further strengthens the breadth of experience and perspective available to the Board and comes at an important time as we continue our work to improve services, support our people and deliver our long-term ambitions for health and care in Torbay and South Devon.
13. Together with our recently appointed Non-Executive Directors and substantive Executive team, Karen's arrival provides an opportunity to continue refreshing our Board development programme and ensuring we have the capabilities, insight and challenge needed for the years ahead.

Planning 2026/27

14. As the Board will be aware we have a significant set of challenges if we are to deliver our annual plan for 2026/27.
15. Delivery of our financial plan is dependent upon managing risks of more than £10m and our performance particularly across Referral to Treatment pathways (partly expected due to Epic implementation) and urgent and emergency care is materially below the commitments we made at the start of the year.
16. Given the challenges outlined we are reviewing our delivery approach this year and are refocussing our plan for better care priorities into these key areas. Updates can be provided by the relevant Executive as part of the Board meeting and are included in the monthly performance report and these areas will be subject to detailed recovery plans and oversight.
17. We have also commenced our planning arrangements for 2027/28.

NHS England Oversight

18. Since the last Board meeting we attended Torbay and South Devon NHS Foundation Trust Provider Oversight Meeting which was held on 07 July 2026 and was chaired by Mark Cooke, Managing Director for NHS England South West.

19. We provided an updated to NHS England on:

- our governance changes and Board Assurance
- Adult social care transition
- performance, finance and workforce
- urgent and emergency care, corridor care and support requirements
- estates, fire safety and other risks
- Epic implementation, reporting and National Oversight Framework

Segmentation and League Table publication

20. The Quarter 1 2026 NHS Oversight Framework (NOF) segmentation data is expected to be published online in early September. These will relate to performance across April to June 2026.

Governor elections

21. I am pleased that our 2026 governor elections are progressing well, with nominations received in three of the four constituencies where vacancies exist. Members in South Hams and Torquay will be invited to vote in contested elections from mid-August, while nominations received in Teignbridge mean that constituency will return an uncontested governor. New governors will take up their roles on 01 October 2026.

22. Our governors play an important role in ensuring community voices are heard and reflected in our work. They bring local insight, challenge and support, helping us stay connected to the people and communities we serve. I am grateful to everyone who has put themselves forward and look forward to working with our new governors when they take up post later this year.

Annual report and accounts 2025/26

23. The annual report and accounts for 2025/26 were formally laid before Parliament on 13 July 2026 and have been uploaded to our website.

24. The fully designed annual report summary for 2025/26 is also now on our website and is being shared with colleagues, governors and our wider communities: [Our year, your trust - Annual Report Summary 2025-26](#).

Annual Members Meeting 2026

25. As agreed by the Membership Committee of our Council of Governors, this year's Annual Members' Meeting is being arranged as a community health event, rather than a stand-alone annual meeting. The formal statutory meeting will remain an important part of the event, but it will sit within a wider programme of community engagement, health promotion and involvement activity designed to support our vision of supporting every person, family and community we serve to live well.

26. Planning is progressing well. The event will take place on 30 September at Paignton Library. We are working closely with Healthwatch throughout the planning process and are keen to ensure the event feels welcoming, inclusive and community-focused. Governors will host a drop-in session for members and the public to meet them.
27. Alongside the formal Annual Members' Meeting, we are running a series of small-group neighbourhood conversations. Each conversation will last around 45 - 60 minutes and will use a fictional case study to prompt discussion. These are early listening conversations, not a consultation on a set of proposals or a fixed plan.
28. People will be asked to share thoughts, ideas and experiences about what works already, what could be improved and what support people need to live well in their communities to help shape a future neighbourhood model. There will be separate discussions on six themes: frailty and falls, cardiovascular health, diabetes, end of life care, respiratory health and children and young people with long-term health conditions.
29. A key feature of the day will be a community health marketplace. Interest has been strong and the event is increasingly becoming a partnership opportunity rather than simply a showcase for our services. Alongside teams from Torbay and South Devon NHS Foundation Trust, we are working with partners including Devon Partnership NHS Trust, Children and Family Health Devon and public health as well as VCSE partners.
30. The marketplace offer will include NHS Health Checks, community services, a range of cancer screening, The Harbour frailty service, our sensory team, TALKWORKS and Your Health Torbay among many others. The emphasis is on interaction rather than information alone, with opportunities for attendees to take part in health checks, healthy ageing and living well activities and have conversations with frontline teams about the support available within their communities.
31. We recognise that attendance is likely to include people with a wide range of interests and views, including campaign groups, elected representatives, members of the public and partner organisations. Our approach is to create an event that is accessible and engaging. Success will be measured by whether attendees feel welcomed, listened to and able to engage constructively with services, governors and Board members.

Board meetings in public

32. At our Board meeting in public on 02 July, the Board approved a 12-month pilot rotating our Board meetings in public across our five localities. The pilot will begin with the November 2026 Board meeting in public and we will share details of where this meeting will take place in due course.
33. All our Board meetings in public are now accessible online and we are proactively seeking questions from the public in advance of each meeting through our social media channels and a local media release.

Listening to our communities

34. In August, we launched our [Listening to our communities webpage](#), bringing together answers to some of the questions we hear most frequently from patients, local people, governors and stakeholders about healthcare services across Torbay and South Devon. The resource has been developed to provide easier access to information about local services, investment, future planning and how decisions are made, drawing together information that was previously spread across a range of Board papers, reports and other publications.
35. The webpage reflects our commitment to openness, transparency and meaningful dialogue with the communities we serve. It is not intended to be a static resource and will continue to be updated as new questions emerge, decisions are made and further information becomes available. We have also used the launch to encourage people to engage directly with us through our Board meetings in public, our governors and other engagement opportunities.
36. The launch forms part of a wider programme of community engagement, including the focus groups at our forthcoming Annual Members Meeting and our ongoing work to ensure community voices help shape the future development of health and care services across Torbay and South Devon.

Priority areas

Estate resilience, fire safety and emergency preparedness

37. Members of the Board will see a separate paper on this agenda setting out the Board's consideration of fire safety risks associated with the Tower Block at Torbay Hospital and the work underway through our Fire Safety Improvement Programme. That paper provides a detailed overview of the current position, the mitigations in place and the actions being taken to reduce and manage risk.
38. Alongside that programme of work, recent incidents and exercises have reinforced the importance of strong emergency preparedness arrangements, effective risk management and the professionalism of colleagues who respond when unexpected events occur.
39. On 28 July, we declared a Level 2 Business Continuity incident following the failure of an ageing electrical component within a distribution board at Torbay Hospital. The fault triggered a fire alarm and resulted in a temporary loss of power affecting a number of clinical and operational areas. Established emergency and business continuity arrangements were implemented immediately, patients and colleagues were safely evacuated, and services were progressively restored throughout the afternoon.
40. A multidisciplinary debrief concluded that colleagues responded professionally and effectively throughout the incident. More than 100 people were evacuated safely within minutes and participants reflected positively on the contribution made by regular training, exercises and clear command structures. As with all incidents, opportunities for further improvement were identified and are being incorporated into ongoing emergency preparedness and fire safety work.

41. More recently, colleagues responded to an incident on Allerton Ward which required the implementation of established emergency response procedures. While the circumstances were different, the incident again demonstrated the professionalism of colleagues and the importance of clear escalation arrangements, effective communication and strong multi-disciplinary working when responding to unexpected events. A formal debrief will be undertaken and any learning identified will be incorporated into our ongoing emergency preparedness and patient safety work.
42. These events have taken place against a backdrop of wider work to strengthen preparedness across the organisation. Earlier this summer we undertook a major multi-agency evacuation exercise involving clinical teams, operational colleagues and partner organisations. The exercise tested our ability to respond to a significant incident affecting inpatient services and provided valuable assurance regarding command arrangements, communication processes and evacuation procedures. It also identified areas where arrangements could be strengthened further, allowing improvements to be made before they are needed in a real incident.
43. Across our estate, we are also continuing to take proactive action to identify and address potential risks before they result in incidents. Recent fire safety reviews at the Hetherington Centre led to improvements in corridor clearance, storage arrangements, evacuation planning and local training arrangements. While no incident had occurred, the review provided a timely reminder that maintaining safe environments depends on the consistent management of day-to-day risks as well as responding to major challenges.
44. On 03 August, a fire occurred at the former nurses' home building on the Teignmouth Hospital site. Emergency services attended promptly and the fire was contained without injury to patients, colleagues or members of the public. Services based at the hospital itself continued to operate as normal and we have continued to work closely with Devon and Somerset Fire and Rescue Service and Devon and Cornwall Police as investigations continue. The incident also provided an opportunity to reinforce fire safety messages and review arrangements across our wider estate.
45. Taken together, these incidents, exercises and reviews reinforce a common theme. While major estate challenges such as those described in the separate Tower Block paper rightly attract significant attention, maintaining safe environments depends on a combination of investment, effective risk management, regular training, robust emergency preparedness arrangements and a culture of continuous learning. I would like to thank all colleagues involved in responding to incidents, participating in exercises and supporting improvement work across our sites. Their professionalism and commitment play a vital role in keeping patients, visitors and one another safe.

Urgent and emergency care and eliminating corridor care

46. Improving urgent and emergency care remains one of our highest operational priorities as we prepare for winter. While our teams continue to work hard in exceptionally challenging circumstances, we know that overcrowding and corridor

care are not acceptable for patients or staff, and we remain focused on delivering sustainable improvements to patient flow across the system.

47. In August, we hosted a national Getting It Right First Time (GIRFT) review of urgent and emergency care. The review team recognised the openness and commitment of colleagues across the organisation and identified a number of priorities to support further improvement. These include establishing a GP-led Urgent Treatment Centre within the Emergency Department, strengthening front-door streaming arrangements, making better use of frailty services, embedding national clinical operational standards and improving length of stay to support patient flow across the hospital. The review also highlighted the importance of strong medical, nursing and operational leadership at every level of the organisation.
48. The GIRFT team will return in October to review progress and assess our readiness for winter. Their feedback was clear that success will be judged not simply by the completion of actions, but by demonstrable improvements in patient flow, reduced emergency department congestion and progress towards eliminating corridor care.
49. Alongside our partners across Devon, we continue to implement a comprehensive programme of work to improve urgent and emergency care, reduce avoidable hospital admissions where appropriate, speed up discharge pathways and ensure patients are cared for in the right place, first time. While there is no single solution to the pressures facing urgent and emergency services, the GIRFT visit provided valuable external challenge and assurance that we are focusing on the areas most likely to make a meaningful difference for patients ahead of winter.

Torbay Adult Social Care transition programme

50. As Board are aware, in March 2026, we gave notice on the current Section 75 agreement under which adult social care services in Torbay are provided on behalf of Torbay Council. Since then, we have been working closely with Torbay Council, NHS Devon and colleagues across adult social care to support a safe and orderly transition to new arrangements from 01 April 2027.
51. The transition programme continues to make steady progress across governance, workforce, finance, operational planning and enabling workstreams. Governance arrangements have been strengthened and assurance processes continue to mature, helping provide oversight of what is a significant and complex programme affecting services, staff and local communities.
52. A particular focus remains supporting colleagues through the transition process. Work is progressing on staff, location and activity mapping, alongside the detailed preparations required for TUPE and workforce transfer arrangements. Dedicated communication channels, staff engagement activity and joint working with Torbay Council continue to support colleagues as plans develop.

53. Throughout this period our priority remains unchanged: maintaining safe, high-quality services for the people who rely on adult social care and preserving the strong partnership working between health and social care that has characterised Torbay's integrated model for many years. We remain committed to working collaboratively with Torbay Council to ensure continuity of care and a smooth transfer of responsibilities when the current agreement ends in April 2027.
54. As the programme moves into its next phase, both ourselves and Torbay Council will continue to engage with colleagues, trade unions, people using services, carers and wider stakeholders as detailed planning progresses.

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

55. Work continues to progress the proposed relocation of Cellular Pathology services to Gadeon House, alongside development of the associated business case and supporting documentation.
56. The programme is being progressed in response to the significant estates and infrastructure challenges associated with our current laboratory accommodation and is focused on securing a safe, sustainable and resilient future for cellular pathology services.
57. As part of our ongoing engagement programme, a dedicated questions and answers resource has been published on our website addressing issues and concerns raised by colleagues, stakeholders and members of the public. As outlined earlier in this report, I meet regularly with cellular pathology colleagues along with other executives and senior leaders to provide updates and listen to any concerns.
58. The Pathology service is also undertaking its annual GP user survey, with additional questions included to understand awareness of the proposed changes, gather feedback from primary care colleagues and identify issues that should inform future engagement and communications activity.
59. Alongside development of the cellular pathology business case, colleagues from Torbay and South Devon and Royal Devon University Healthcare NHS Foundation Trust continue to work together to explore whether the co-location of pathology services at Gadeon House could create opportunities for future collaboration across cellular pathology, blood sciences and microbiology. This is being overseen by our joint Programme Board. The work is testing whether there is a robust clinical, operational and financial case for any future joint working and will help inform future decisions. No decisions have been taken at this stage.

Capital investment programme

60. 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.

61. In 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.
62. 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.
63. The new day theatre came into operation on 20 July and the refurbishment of existing day theatres are now underway.
64. 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.
65. 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.
66. 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.
67. 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.
68. 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.
69. I was pleased to join colleagues last month for the opening of The Cove, our newly refurbished birthing suite at Torbay Hospital. The project has delivered a new birthing pool, a fully refurbished birth environment and, importantly, a dedicated accessible wet room, helping to ensure that more women can benefit from water-based pain relief and birthing options regardless of their mobility needs or disability.
70. The name was chosen in partnership with women and families through our Maternity and Neonatal Voices Partnership, reflecting the importance of involving people in shaping the services they use.

71. The Cove forms part of a wider programme of investment in our maternity services. Alongside the refurbishment, we have recently completed enhancements to maternity triage, creating additional assessment space and improving the environment in which women are received, assessed and supported when they arrive at hospital. These improvements are helping us provide care in a more timely, responsive and dignified way.
72. At a time when many families across Torbay and South Devon continue to experience significant health inequalities and financial pressures, it is important that we continue to invest in services that improve access, experience and outcomes for all women and babies. I am particularly pleased that The Cove has already welcomed its first babies, providing families with a high-quality environment at one of the most important moments in their lives.

Radiotherapy services retain ISO 9001 accreditation

73. Our Radiotherapy Department has successfully retained its ISO 9001:2015 accreditation following an external assessment by the British Standards Institution (BSI). The assessment concluded that the department's quality management system remains effective, continues to achieve its intended outcomes and should retain certification.
74. The assessor highlighted the department's ongoing commitment to quality improvement and noted that quality is embedded throughout the service's processes. The report confirmed there were no outstanding findings from previous assessments and no new non-conformities were identified during the review.
75. The assessment reviewed a wide range of areas, including leadership and governance arrangements, risk management, patient pathways, clinical physics, regulatory compliance, patient experience and continuous improvement processes. It also recognised the continued development of the service, including preparations following the introduction of Epic earlier this year.
76. I would like to thank colleagues across radiotherapy, physics and cancer services for their continued commitment to delivering high-quality, safe and effective care for patients. Retaining ISO 9001 accreditation provides independent assurance of the quality of the service and the professionalism of the teams who deliver it.

National cancer patient experience survey

77. The results of the National Cancer Patient Experience Survey have once again highlighted the high quality of care provided by our cancer services. For the fourth consecutive year, we have been recognised among the best performing trusts nationally for cancer patient experience.
78. The survey gathered feedback from people who received cancer-related treatment between April and June 2025. A total of 493 patients from Torbay and South Devon responded, representing a response rate of 60%, significantly higher than the national average of 48%.

79. Patients gave particularly positive feedback about the compassion of our colleagues, the accessibility of clinical teams, the quality of information they received and the personalised nature of their care. We achieved above-expected results in more than 20 areas of the survey, particularly relating to communication, information, care planning and emotional support. No areas of our performance were below the expected national range.
80. Overall, patients rated their cancer care experience at 9.1 out of 10. They also reported high levels of confidence in the way their care was coordinated, with 91% saying their care team worked well together and 91% rating the administration of their care as good or very good.
81. The survey also identified opportunities to further improve support for people following diagnosis and after treatment has ended. In particular, some patients felt that support from primary care following diagnosis could be strengthened, while others highlighted the challenges of accessing emotional support and navigating life beyond cancer treatment. These findings will help inform our ongoing improvement work with partners across health and care services.
82. Patient feedback is one of the most important ways we understand what is working well and where we need to improve, and I would like to thank everyone who took the time to share their experiences.

Adult inpatient experience survey findings

83. The 2025 Adult Inpatient Survey gathers feedback from people aged 16 and over who spent at least one night in hospital, providing an important insight into people's experiences of inpatient care.
84. Overall, respondents rated their experience of care more highly than in the previous survey, with the overall score increasing from 8.2 to 8.4 out of 10. Across all 51 questions, results were rated as "about the same as most trusts", with no areas performing below the national benchmark.
85. People gave particularly positive feedback about the dignity and respect with which they were treated, the compassion of our colleagues, the cleanliness of our wards and their confidence in clinical staff. These results are particularly encouraging given the significant pressures many of our services continue to face and reflect the commitment and compassion of my colleagues to ensure patients are cared for and supported during their stay.
86. The survey also identified opportunities to further improve aspects of discharge planning and communication with patients and carers, which will help inform our ongoing improvement work. Patient feedback is one of the most important ways we understand what is working well and where we need to focus our efforts, and I would like to thank everyone who took the time to complete the survey.

Lord Mann review

87. Following publication of the Lord Mann Review earlier this summer and the letter to NHS leaders, I can confirm that we have submitted our response through the national reporting portal ahead of the deadline, confirming "yes" to both questions

relating to adoption of the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility.

88. This aligns with our ongoing commitment to creating a great place to work where everyone feels they belong, is valued and respected, and is able to do their best work.
89. As I have shared with Board previously, we know there are significant cultural and morale challenges that we need to address across our organisation. While adopting these definitions is an important step, it is only one element of the wider work required to strengthen our culture, improve colleagues' experience and ensure Torbay and South Devon is an inclusive, compassionate and supportive place to work for everyone.
90. We have also begun discussions with system partners about adopting a more consistent public-facing approach to tackling abuse, aggression, discrimination and harassment.
91. This includes support for a *That's Not Okay* digital and print campaign which has been developed by Royal Devon using insight and data from real feedback and is being adopted across NHS organisations in Devon.
92. Over time, colleagues, patients and visitors can expect to see a more consistent approach across acute, community and mental health services, with aspirations to extend this further into primary care, community pharmacy and optician services as discussions progress.

Investing in the future of health and care research

93. We have secured £400,000 of funding from the Torbay Medical Research Fund to support the development of the next generation of clinical researchers across Torbay and South Devon.
94. The funding will provide three pre-doctoral and three doctoral fellowships over the next three years for colleagues working in nursing, midwifery, allied health professions, pharmacy and psychology, with the first cohort due to begin in April 2027.
95. This investment will strengthen research capacity across our organisation, supporting colleagues to develop advanced research skills while generating evidence that can improve care and outcomes for local people. It also supports our wider ambitions to attract, develop and retain talented staff by creating new opportunities for professional and academic career development.
96. Established by local medical practitioners in 1970, the Torbay Medical Research Fund has a long history of supporting research that benefits local communities and we are deeply grateful for their support.
97. We are proud to be the only organisation in the South West offering this level of research opportunity across such a broad range of professional groups, helping

to ensure that research remains embedded in everyday clinical practice and continues to drive innovation and improvement in patient care.

National funding supports expansion of clinical research capacity

98. We have secured £88,000 of National Institute for Health and Care Research (NIHR) funding to strengthen its pharmacy aseptic services and support the delivery of clinical trials.
99. The funding has enabled the installation of a new negative pressure isolator, specialist equipment used in the preparation of high-risk medicines, including chemotherapy and novel treatments used in research studies. The additional capacity will benefit both research participants and patients receiving routine care by improving access to timely medication preparation.
100. Research and Development colleagues have also funded two additional pharmacy posts, providing extra capacity to support the safe delivery of clinical trials while strengthening day-to-day services.
101. The investment reflects the benefits of being a research-active organisation. In addition to giving local people access to new and innovative treatments through clinical trials, research activity attracts external funding that can be used to improve infrastructure, develop services and build workforce capability. It also supports our strategic ambition to embed research more fully within clinical practice and improve outcomes for patients across Torbay and South Devon.

Strengthening Board oversight of research

102. NHS England has published a new [framework for NHS boards on monitoring research activity](#), reflecting the growing expectation that research should be embedded as a core part of NHS delivery rather than a standalone activity. The framework sets out how boards should oversee research performance, participation and impact, helping ensure that patients benefit from innovation and access to new treatments and technologies. We will review the framework and consider any implications for local reporting and assurance arrangements.

NHS Veteran Aware reaccreditation

103. We have successfully achieved reaccreditation as an NHS Veteran Aware organisation, recognising our continued commitment to meeting the needs of serving personnel, veterans and their families.
104. The accreditation, awarded through the Veterans Covenant Healthcare Alliance (VCHA), recognises healthcare organisations that demonstrate good practice in identifying, understanding and responding to the needs of the Armed Forces community.
105. Reaccreditation provides external assurance that the arrangements we have in place continue to support equitable access to healthcare for veterans and their families, while helping ensure that they are not disadvantaged when accessing our services.

Our commitment to a Greener NHS

106. We are strengthening our approach to sustainability through the launch of the Greener Torbay Action Group, bringing together colleagues from across the organisation to develop and deliver a coordinated programme of environmental improvement initiatives.
107. We are also benefiting from support and shared learning from colleagues at University Hospitals Plymouth NHS Trust, whose Net Zero and decarbonisation programme has delivered both environmental and financial benefits.
108. To support this work, we have recently appointed a new Energy and Decarbonisation Manager and will shortly be joined by an NHS Graduate Management Trainee. Initial activity will focus on opportunities within Estates and Facilities Management, creating a foundation for wider engagement across the organisation. The programme will support our ambition to reduce our environmental impact, improve efficiency and contribute to a more sustainable future for the communities we serve.

Our people

Our latest our people award winners

109. In August we celebrated the latest winners of our quarterly Our People Awards, which recognise colleagues and teams who exemplify our values and go above and beyond for patients, families and one another.
110. This quarter's winners were:
- We are safe and healthy – Security and Enhanced Care Team, recognised for developing a proactive, patient-centred approach that improves safety and support for vulnerable patients with complex needs.
 - We are compassionate and inclusive – Laura, Estates Business Support, recognised for the care, kindness and support she provides to colleagues across her department.
 - We are always learning – Kate, Practice Education Facilitator, recognised for her leadership, compassion and commitment to learning and improvement while acting as Lead Midwife for Education during a particularly challenging period.
 - We are a team – Emergency Department team, recognised for their resilience, adaptability and teamwork during a period of significant operational challenge and change.
 - We work flexibly (joint winners) – Marie, Senior Specialist Dental Nurse and Hüseyin, Web Services Lead, recognised respectively for their commitment to patients and their support for carers and carers' services.
 - We each have a voice that counts – Amanda, Advisor, recognised for her compassionate support for bereaved families and colleagues through complex statutory processes.
111. I would like to congratulate all the winners and nominees. Their commitment, professionalism and compassion demonstrate the values that underpin the care and support we provide every day across Torbay and South Devon.

Colleague response to incident on Torquay seafront

112. Following the serious seafront incident in Torbay during July, I would like to recognise the actions of two of our doctors, Dr Aslam and Dr Win Aung. Both doctors were off duty at the time and at the seafront separately. They became aware of the incident and provided urgent clinical care until the emergency services arrived.
113. Dr Aslam and Dr Aung delivered care under significant pressure, including managing the situation while interventions were being challenged by members of the public. Their actions reflected the professionalism, compassion and clinical expertise demonstrated by our colleagues every day, often in circumstances that attract little public attention.
114. On 29 July, I met with both doctors to thank them personally for their response and to recognise the impact the incident had on them and their colleagues.
115. We have also supported arrangements for Steve Darling MP to visit the team and meet the doctors.
116. This incident serves as a powerful reminder of the contribution our colleagues make not only within our hospitals, community and adult social care services, but also when responding to emergencies in our communities.

Environmental Health rating back to 5*s at Torbay Hospital

117. In May Environmental Health (EH) completed their annual inspection of food hygiene standards across Torbay Hospital and awarded a 4-star rating (previously 5).
118. The feedback mainly related to the fabric and condition of parts of the kitchen environment, along with some minor weekend processes around allergen information.
119. I am pleased to confirm that the feedback has been addressed, we have been reassessed and we have returned to a 5-star rating.

Mortuary Board Assurance Statement

120. In response to the NHS England letter dated 26 June 2026 concerning post-death care and mortuary oversight, the Board delegated authority to the Quality and People Committee to consider and approve the Trust's Board Assurance Statement, enabling submission by the national deadline of 31 July 2026.
121. At its meeting on 28 July 2026, the Committee reviewed the supporting gap analysis, action plan and mitigations, and approved the assurance statement.
122. The completed statement was submitted to NHS England on 29 July 2026. The assurance confirmed that appropriate governance and oversight arrangements are in place, with time-limited actions identified to address the remaining areas requiring further improvement.

National, regional and local issues and topics of interest

Our Torbay and South Devon NHS Charity

123. Our Charity continues to make a visible difference for patients, colleagues and communities across Torbay and South Devon, thanks to the generosity of local supporters, volunteers, fundraisers and staff. From funding equipment and environmental improvements to supporting wellbeing and patient experience initiatives, charitable donations continue to help us go beyond what can be funded through NHS budgets alone.
124. One of the most visible recent examples is the new volunteer wall of fame on Level 2 at Torbay Hospital. Supported by our Charity and local corporate sponsor MW Benney, the installation celebrates our volunteers award winner and finalists while also recognising the important role volunteers play in supporting patients, visitors and colleagues every day.
125. Our Charity has also continued to work in partnership with local organisations to improve patient outcomes and quality of care. Selected as the President's Charity of the Year by Torquay Rotary, this is funding equipment including Blazepods and other resources designed to help tackle hospital-acquired deconditioning by encouraging mobility, activity and rehabilitation for patients during their hospital stay. Torquay Rotary have also continued to support the baby loss (Heartease) garden at Torbay Hospital, planting an alpine flower bed, installing additional seating and creating a calm, reflective and supportive space for families.
126. Through our "Helping to Make Things Better" grants programme, our Charity continues to support ideas generated by colleagues working closest to patients. Current projects include the creation of a dedicated seating area within the main entrance of Torbay Hospital, incorporating more accessible high-backed seating with armrests to better support patients and visitors with mobility needs while they wait for transport home. The programme is also funding artwork within the Community Dental Service waiting area at Castle Circus, helping create a calmer environment and reduce anxiety for people attending appointments.
127. In July, the Chair and I were delighted to celebrate our Charity's 30th anniversary with a special cream tea event attended by more than 60 supporters. The event provided an opportunity to thank the individuals, families, volunteers, community groups and organisations whose generosity has helped improve care and experience for patients over the past three decades.
128. Support from our communities remains strong. Recent fundraising activity has included events organised by Stover Golf Club, a sponsored skydive undertaken by colleague Lynn Wilson and a cycle challenge completed by NHS colleague Simon Clark, who cycled between three Devon hospitals to raise funds for local NHS charities.

129. Looking ahead, we have secured three places in next year's London Marathon, providing another exciting opportunity for colleagues and members of the public to support local NHS services.

130. Every donation, fundraising challenge and act of support helps our Charity make a difference. Whether improving clinical environments, supporting rehabilitation, creating more inclusive facilities or helping colleagues bring forward ideas that enhance patient care, our Charity continues to demonstrate the remarkable impact that local communities can have on local healthcare.

Our Leagues of Friends

131. We continue to work closely with our eight Leagues of Friends (Ashburton, Brixham, Dawlish, Newton Abbot, Paignton, Teignmouth, Torbay and Totnes) and are deeply grateful for their support and donations.

132. The Chair and I met with representatives from Torbay, Totnes, Paignton, Dawlish and Newton Abbot Leagues of Friends as well as our Torbay Hospital Nurses League in June where we had a constructive conversation about the opportunities and challenges we all face and how we can work better together to maximise the benefits for local people and our communities.

Equality and Human Rights Commission (EHRC) Code of Practice: single-sex spaces and facilities

133. We are continuing to review the implications of the updated Equality and Human Rights Commission (EHRC) Code of Practice and the emerging national guidance for healthcare settings relating to single-sex spaces and facilities.

134. A multidisciplinary task and finish group has been established to assess what this means for our services, patients and colleagues. The issues involved raise important considerations around privacy, dignity, safety, inclusion and legal compliance, and it is important that any future changes are carefully considered and implemented consistently.

135. We are working closely with NHS partners as national guidance continues to develop and are not making any immediate changes to our local arrangements while this work is underway. Any future decisions will be informed by national guidance, legal advice, equality impact assessment and engagement with relevant groups. We will continue to keep colleagues, patients and stakeholders informed as the position becomes clearer.

MY CARE and NHS App now linked

136. Patients can now use their NHS App login to access MY CARE with a new secure link between the two online services.

137. MY CARE is the online service that allows patients to see detailed information about their hospital and specialist community care using a mobile device or computer. The NHS App gives you information about your GP care, repeat prescriptions, vaccinations and NHS 111 online.

138. The new developments are linking these two systems, so that it's easier for patients to keep track of their care. There are two ways that patients can do this:
139. Patients can log in to MY CARE by using their NHS App login details. They can go to the MY CARE log in page and then select 'Continue to NHS login'.
140. Patients can click on their hospital and specialist community care appointments* in the NHS App to transfer to MY CARE and get more detailed information.
141. Patients will be asked to give consent for their NHS login details to be shared with the MY CARE team to log in to or set up a MY CARE account.
142. Thanks to the Devon-wide electronic patient record that has been introduced this year, these new developments will apply to patients attending appointments at Royal Devon University Healthcare NHS Foundation Trust and University Hospitals Plymouth NHS Trust.
143. A common request from patients has been to integrate MY CARE with the NHS app. The MY CARE team has worked with software provider Epic and NHS England to find a secure way to join up the two systems, making it simpler for patients.

One Devon EPR go live

144. On 23 July 2026 University Hospitals Plymouth successfully went live with the Epic electronic patient record (EPR), bringing our organisation, UHP and the Royal Devon onto the same system. This represents a major step forward for the One Devon EPR programme and creates new opportunities to improve how care is delivered, strengthen collaboration and support more integrated care across the county.
145. Benefits for patients and colleagues include:
- improved information sharing between organisations, supporting safer and more joined up clinical decision-making.
 - better continuity of care for patients receiving treatment from more than one provider.
 - reduced duplication of assessments and tests.
 - more consistent clinical processes and ways of working across Devon.
 - a stronger digital foundation to support any future service transformation.
146. As part of the go-live learning, we have strengthened our protocols for site team / on-call team coordination to ensure any technical issues with the potential to affect patient care across the three trusts are identified and resolved as quickly as possible.
147. The UHP go-live has also demonstrated the strength of the One Devon EPR partnership. A number of our Epic Super Users volunteered to support colleagues during the go-live period, sharing the expertise, insight and practical experience gained through our own Epic implementation at Easter. Their contribution reflects

the collaborative culture that underpins this programme and we'd like to extend sincere thanks to everyone who gave their time and expertise to support UHP and help ensure a successful transition for colleagues and patients.

Maternity services in North Devon

148. Royal Devon University Healthcare NHS Foundation Trust has advised partners about the temporary suspension of obstetric-led births at North Devon District Hospital due to significant medical staffing shortages. We understand this is a challenging situation for colleagues, expectant families and local communities in North Devon.

149. The temporary changes are intended to maintain safe maternity services while recruitment and workforce stabilisation efforts continue. We are working closely with system partners to understand and manage any wider implications for maternity services across Devon. Our Director of Midwifery remains actively involved in discussions and both the Chair and I have offered our support to colleagues at Royal Devon during this period.

150. This situation highlights the workforce challenges being experienced by NHS organisations across the country. As partners within the Devon health and care system, we will continue to work collaboratively to support safe, sustainable maternity services for women and families across the county.

South Local Care Partnership

151. Board will be aware of ongoing work across Torbay and South Devon to develop Integrated Neighbourhood Teams, bringing health, social care, voluntary sector and community partners together to provide more joined-up support for local people.

152. At its July meeting, the South Local Care Partnership approved a new Action Learning Set approach designed to help partners turn shared ambitions into practical action. The approach will provide a structured way for organisations to come together around common challenges, learn from each other's experience and accelerate delivery of agreed neighbourhood priorities.

153. The proposal was presented by our Chief Strategy and Planning Officer, Simon Tapley, who emphasised that while we have helped develop the approach, its success depends on collective ownership across all partner organisations rather than leadership by any one organisation.

154. The framework is intended to support delivery of locally agreed priorities, strengthen relationships between organisations and provide a practical mechanism for sharing learning and spreading successful approaches more quickly across neighbourhood teams.

155. This is a positive example of the role we are increasingly playing within the wider health and care system: helping to bring partners together, supporting collaboration and contributing expertise, while ensuring that solutions are developed and owned collectively. It also reflects growing momentum behind

neighbourhood working across Torbay and South Devon and a shared commitment to improving outcomes through closer partnership working.

156. The next phase of work will focus on agreeing the initial areas of focus and putting the arrangements into practice with partners across the South locality.

Local government reorganisation

157. The Government has confirmed the future direction of local government reorganisation in Devon, with existing council structures expected to be replaced by four new unitary authorities.
158. Detailed implementation arrangements are still being developed and, as with any major programme of change, some aspects of the process continue to be subject to ongoing discussion and challenge.
159. While there are no immediate changes to services, detailed transition planning is expected to continue over the coming months, with elections to the new authorities anticipated in 2027 and implementation of the new arrangements in 2028.
160. Local authorities are key partners for the NHS, particularly in relation to adult social care, public health, housing and wider determinants of health. As plans develop, we will continue to work closely with local government colleagues and Devon ICB to ensure that strong partnership working remains at the heart of arrangements and that the interests of patients, communities and colleagues are fully considered.

Let's Talk Neighbourhood Health

161. Devon ICB has recently launched its Let's Talk Neighbourhood Health engagement programme, creating opportunities for local people, colleagues and communities to help shape future neighbourhood-based health and care services across Devon. The programme reflects a shared ambition to support people to stay well for longer, improve access to care closer to home and strengthen the role of neighbourhoods in delivering more joined-up care.
162. As an NHS Provider, we welcome the focus on neighbourhood health and the opportunity for local communities to contribute to the conversation. We have been working with Devon ICB and system partners on the development of the engagement approach and are supporting the programme locally by promoting opportunities for involvement and facilitating conversations with our own colleagues and communities.
163. Alongside the Devon-wide engagement, we are continuing our own neighbourhood work across Torbay and South Devon, including a programme of community conversations at our Annual Members' Meeting. Together, these activities will help ensure that future neighbourhood models are informed by the experiences, priorities and ideas of the people who use and deliver services.

Smokefree South West campaign launches this September

164. A major new stop smoking campaign, Smokefree South West, will launch across the region in September 2026, marking the first large-scale regional stop smoking campaign in more than a decade.
165. Running until the end of October, the campaign will be promoted on TV, radio and social media and across all 15 South West local authority areas.
166. Developed in partnership with local authorities and the NHS in the South West, the campaign aims to encourage people who smoke to make a quit attempt and access the free local support available to help them stop smoking for good.
167. The campaign is based on Greater Manchester's successful What Will You Miss? initiative and uses powerful, emotionally driven storytelling to highlight the impact smoking can have on the moments that matter most.
168. We're working with our maternity colleagues to share stories of local women and families who we have supported to stop smoking as part of the campaign.

WorkWell Devon

169. A new Devon-wide WorkWell programme has recently launched to help people whose health is affecting their ability to stay in work, return to work or find employment. The programme provides personalised support and practical coaching to help people overcome health-related barriers to work and connect with services that may improve their health and wellbeing. It also works with employers and partner organisations to promote healthier and more supportive workplaces.
170. We welcome the programme's focus on the important relationship between health and work. For many people, good work contributes positively to physical health, mental wellbeing, independence and social connection. By supporting people to remain in or return to employment where appropriate, WorkWell has the potential to improve outcomes for individuals while contributing to healthier and more resilient communities across Devon.

Strengthening partnership working

171. We have been advised of plans by NHS Devon and NHS Cornwall and Isles of Scilly ICBs to strengthen place-based partnership working across the integrated care system. The proposals are intended to provide greater clarity, consistency and responsiveness at Place level through strengthened leadership arrangements, closer alignment between NHS organisations and local authorities, stronger representation within local governance structures and an increased focus on neighbourhood-based models of care.
172. In practical terms, this will include the introduction of Executive Place Leads, who will provide continuity of leadership at Place level, represent local priorities within ICB decision-making, support alignment between NHS and local authority plans, promote opportunities for joint working and co-commissioning, and provide

senior leadership across place-based partnerships involving NHS providers, local government, primary care and the voluntary sector.

173. For Torbay Place, Simon Gittoes-Davies, Chief Finance Officer for NHS Devon, will assume the Executive Lead role. Recruitment is underway to appoint a dedicated Torbay Place Director, with the appointment expected to be completed during summer 2026. The wider arrangements will see Peter Collins, Chief Population Health Officer, supported by John Groom as Place Director, leading the Devon Place arrangements, Libby Ryan-Davies, Chief Strategic Commissioning and Planning Officer, working alongside Chris Morley as Place Director for Plymouth and Susan Bracefield, Chief Clinical Officer, acting as Executive Lead for Cornwall and the Isles of Scilly, with recruitment also underway to appoint a Place Director.

174. The proposals reflect the growing emphasis on place-based leadership within the NHS and are closely aligned to the neighbourhood health agenda and the development of integrated neighbourhood teams. We will continue to engage with partners as the arrangements are implemented and consider how they can support our ambitions for neighbourhood working, prevention and stronger collaboration across health, care, local authority and voluntary sector organisations.

NHS Cornwall and Isles of Scilly and NHS Devon – Chief Executive recruitment

175. Recruitment for the permanent cluster Chief Executive for NHS Cornwall and Isles of Scilly and NHS Devon began last week.

176. Applications will be open until Friday 18 September, with interviews and panels to start from the following week.

177. Further information about the role is available on the [dedicated recruitment website](#).

178. Susan Bracefield is currently acting into the role in interim Chief Executive role.

NHS England Quality Strategy

179. NHS England published its new [Quality Strategy for NHS-funded care in England](#) on 14 July. The strategy is published on behalf of the National Quality Board and provides a structured approach to making quality the organising principle of NHS-funded care in England during the next decade by setting out a shared approach across three interdependent domains: safety, effectiveness and experience.

180. Nicola McMinn, our Chief Nurse, is benchmarking the strategy and will present her findings and recommendations to the Quality and People Committee.

Casey Commission launches national conversation on adult social care

181. The Government's Independent Commission on Adult Social Care, chaired by Baroness Louise Casey, has launched the 'Big Conversation on Care', a national engagement exercise seeking views on the future of adult social care in England.

182. The Commission will gather feedback from people who draw on care and support, unpaid carers, staff working in health and social care, and the wider public. The findings will inform recommendations to Government on the long-term reform of adult social care.

183. Given our role as an integrated care organisation and the close relationship between adult social care and NHS services, the Commission's work will be relevant to the future development of health and care services locally and nationally.

184. The engagement will run over the coming months, with further recommendations expected from the Commission in due course. [Take part online | The Casey Commission](#)

Local media and social media update

185. Supporting our communities to access timely, accurate information about our services remains a key priority. Through our website, social media channels, local media partnerships and direct engagement activity, we continue to share information about service developments, celebrate the contribution of our people and provide practical health advice and guidance.

186. Alongside providing information, our digital channels increasingly support our wider commitment to listening to our communities. They help us understand what matters to local people, identify emerging concerns and questions, and ensure that we can respond openly and transparently. This approach aligns with our wider commitment to strengthen dialogue with communities through initiatives such as our neighbourhood conversations and Listening to Our Communities information.

187. Since the July Board report, media activity has included coverage of several significant developments across our organisation, including the opening of a new birthing suite at Torbay Hospital, the reopening of Teignmouth Hospital following the fire in a clinic building, a legacy gift that transformed the pacemaker room at Torbay Hospital, and national recognition for bereavement midwife Fay Martin.

- [Our NHS needs you! Become a governor and make your voice count](#)
- [Welcoming new members of our Board of Directors](#)
- [MY CARE and the NHS App are now linked](#)
- [Torbay and South Devon NHS Charity thanks supporters at special anniversary event](#)
- [Patients rate Torbay and South Devon's cancer services as among the best in the country](#)
- [Legacy gift transforms pacemaker room at Torbay Hospital](#)

- [New birthing suite opens at Torbay Hospital to enhance birth experience for women and families](#)
- [Teignmouth Hospital open following fire in clinic building](#)
- [Explore your future with free NHS virtual work experience](#)
- [Taking the plunge: John's incredible leap for our charity](#)
- [Patients continue to report positive experiences of inpatient care in Torbay and South Devon](#)
- [Big-hearted bereavement midwife shortlisted for prestigious national award](#)
- [Communities invited to free health and wellbeing event at Paignton Library](#)

188. We remain grateful to local and regional media partners for helping us communicate important information about our services and the work of our people.

Social media

189. Our corporate Facebook, Instagram and LinkedIn accounts continue to provide important channels for communicating with patients, families, colleagues, partners and local communities.

190. In the past two months, engagement has increased significantly across our social media platforms. On Facebook, content was viewed more than 761,000 times and engagement increased by 142% compared with the previous reporting period. Our audience grew to 18,468 followers, with strong interest in content highlighting exceptional care, service developments and public health advice.

191. Instagram continues to grow steadily, with followers increasing from around 600 at the start of the year to more than 1,000. Engagement increased by 150% during July and August, reflecting growing interest in visual storytelling when sharing information about our services and people.

192. LinkedIn remains our primary professional channel, supporting recruitment, employer brand activity and engagement with health and care partners. We are working with our recruitment team to strengthen our strategic use of the platform to attract future colleagues and showcase innovation and achievement across our organisation.

193. Across all channels, content relating to colleague and team achievements, new service developments, patient care stories and health information generated the highest levels of engagement.

Website

194. Our website remains an important source of information for patients, families and communities. During July, our website received 189,271 page views. While this represented a small decrease compared with June, we believe seasonal factors, including the summer holiday period, may have contributed to this change.

195. The most visited pages related to urgent and minor injury services, physiotherapy appointments and other commonly accessed patient information,

demonstrating the importance of ensuring timely, accessible information is available online.

National recognition for website accessibility

196. As a public sector organisation, we have an important responsibility to ensure that information about our services is accessible to everyone.
197. Over the past 18 months, a significant programme of work has been undertaken to improve accessibility across our website. This has included reviewing existing content, addressing accessibility issues and embedding good practice to ensure compliance with recognised accessibility standards.
198. In August 2026, independent assessments by Silktime gave our website an accessibility score of 97%, placing us 13th nationally among NHS organisations assessed. This represents a significant improvement in both our accessibility performance and national ranking and reflects the commitment of teams across the organisation to making information easier to access and use.
199. We will continue to work with service leads to improve content quality, accessibility and user experience across our website.

Presented to:	Trust Public Board			
Title of Report	August Board Assurance Framework and Corporate Risk Register			
Date of Meeting	3 rd September 2026	Author	Cath Parnell, Chief of Staff	
Executive Lead	JoeTeape - CEO	Executive Sign Off	Yes	
Governance Route	Trust Executive Group 20 August 2026 Quality and People Committee 25 August 2026 Finance and Operations Committee 26 August 2026			
Recommended Action	For Approval	For Assurance	To Update	For Information
		X	X	
Executive Summary	The Board Assurance Framework (BAF) and supporting Corporate Risk Register (CRR) are the key mechanisms through which the Board receives evidence on delivery of the Trust's strategic objectives and the risks, controls and assurances affecting each objective. For 2026/27, the Trust completed a full redesign of the BAF, implemented in April 2026. Monthly development cycles with the Executive Team are continuing to embed improved strategic risk reporting, strengthen assurance on delivery of the Trust's strategy and support clearer committee oversight.			
	The full BAF and CRR are provided as appendices, with a summary overview included in this paper. Reporting will continue to be refined through future cycles, taking account of Board feedback and further opportunities to improve clarity, escalation and assurance.			
	<u>August BAF</u>			
	Overall, the August 2026 BAF does not indicate a material change to the Trust's strategic risk profile compared with June 2026. Most domains remain above target and are receiving continued executive and committee oversight. The key points for the Board are:			
	• <u>Stable overall strategic risk profile</u>: No material overall movement has been identified since June 2026. Current scores remain above target across most domains, with significant exposure continuing in operational performance, finance, workforce, digital and data, estates and infrastructure, strategy and organisational transition. • <u>Clearer risk articulation and scoring framework</u>: The August BAF consolidates the 10-domain structure and applies the Board-approved appetite and tolerance			

	framework. Principal risk wording, controls, assurance ratings and required actions have been further refined. • <u>Persistent high-risk areas</u>: Financial sustainability, operational performance and patient flow, workforce capacity and wellbeing, digital and cyber resilience, estates constraints, Tower fire safety and organisational transition remain key areas of Board focus. Data quality issues have emerged following the Epic implementation which affect performance assurance and are being actively explored and addressed by the Finance and Operations Committee. • <u>Embedding and assurance remain incomplete</u>: The migration of the risk registers to the new DCIQ IT platform and implementation of the revised BAF structure have been completed. Work is now underway to ensure consistent application across services, sustained control effectiveness, mature assurance mapping, timely closure of actions and robust committee escalation. <u>August CRR</u> The August 2026 CRR reflects completion of the transfer of organisational risks to DCIQ and the transition from implementation to embed a business-as-usual risk management approach across care groups and corporate functions. Reporting is now clearer and continues to mature. Further improvement work is underway to refine DCIQ access, permissions and risk-age reporting limitations which currently constrain some aspects of oversight and management. Mitigating actions in progress include nomination and training of risk champions, targeted support, and focused reviews of high-rated domains and longstanding risks. Trend reporting and deep dives will be developed as sufficient data become available.					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
						X
How this paper supports delivery of the Strategy	While the paper is most directly aligned to the Foundation element of the Trust Strategy, it also supports delivery of the wider strategic signature moves by identifying and escalating the principal risks that may affect quality and safety, workforce sustainability, operational performance, digital enablement, estates resilience, financial sustainability and organisational transition. In doing so, it provides the Board with a structured					

	view of the risks and assurances that may impact successful delivery of the strategy.				
Board Assurance					
BAF Ref	Principal Risk	Current Score	Impact of this paper		
BAF-LG	Leadership and Governance	2x4=8	Positive – This paper strengthens the BAF by improving Board visibility of principal risks, controls, assurance gaps and required actions. It supports clearer escalation through Committees and improved alignment between the BAF and CRR. No material change to the overall strategic risk profile is identified, so continued oversight remains required.		
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led
					X
Compliance / Regulatory Requirements	This paper supports compliance with NHS provider governance and regulatory requirements, including CQC Well-Led expectations, the NHS Foundation Trust Code of Governance and NHS provider licence requirements, by providing executive oversight of material risks, controls, assurance, escalation and mitigation through the Corporate Risk Register, BAF and committee reporting framework.				
Ethical or EDI implications?	Yes – the paper includes risks with potential EDI and ethical implications, including health inequalities, equitable access, patient safety, workforce wellbeing, digital inclusion and organisational transition. These will be monitored through Board and Committee oversight.				
Assurance rating	Significant	Moderate	Limited	Inadequate	
			X		
Assurance rationale	The paper demonstrates continued improvement in the management and reporting of the BAF and CRR. The revised BAF structure and DCIQ migration are complete, reporting is clearer, and risk management has moved into business-as-usual arrangements. A limited assurance rating remains appropriate because consistent application across the Trust is not yet fully evidenced and DCIQ access, permissions and risk-age reporting limitations continue to constrain oversight. Further work is underway to allow demonstration of sustained control effectiveness, mature assurance mapping, timely closure of actions and robust escalation.				
Appendices	Appendix One – Summary of Material BAF Changes from June 2026 Appendix Two – Board Assurance Framework August 2026 Appendix Three – Corporate Risk Register August 2026				

Appendix One – Summary of Material BAF Changes from June 2026

Area	August 2026 position	Change from June 2026
Overall strategic risk profile	No material change identified overall. Most risks remain above target and require continued oversight.	No material movement in overall risk exposure; reporting has been strengthened.
Quality, Safety, Clinical Outcomes and Patient Experience	Risk wording strengthened to reflect sustained demand, patient flow, workforce capacity, estates and equipment constraints.	Strengthened narrative rather than a material score change. Continued focus on safe staffing, patient flow, estates and equipment risks.
People and Culture	Continued focus on workforce sustainability, safe staffing, wellbeing, sickness absence, retention, culture and capacity to deliver recovery and transformation.	Further emphasis on workforce sustainability and triangulation of workforce indicators with quality and productivity impacts.
Health Inequalities and Population Health	Assurance is developing through Joint Strategic Needs Assessment, population health intelligence and partnership working.	Wording strengthened to reflect the need to use data to identify inequalities and demonstrate improvement in access, experience and outcomes.
Finance	Financial sustainability remains a key strategic risk, with ongoing focus on recurrent savings delivery, run-rate reduction, productivity and grip and control.	Since June, controls and assurance have been expanded around recurrent savings, run-rate reduction, expenditure controls, procurement and capital constraints; sustained delivery against the recovery trajectory remains to be demonstrated.
Performance and Patient Flow	Operational performance remains below target, with continued focus on urgent and emergency care, elective recovery, diagnostics, cancer performance and operational resilience.	No material improvement is evidenced since June. Epic-related data quality issues continue to affect performance assurance, while RTT performance and waiting-list reporting have been added to the CRR.

Estates, Infrastructure and Digital Enablement	Risk remains above target with continued focus on estates risk, capital prioritisation, infrastructure resilience, digital delivery controls and benefits realisation.	Assurance wording has been strengthened, but long-term estates planning, backlog maintenance and digital resilience remain areas of concern.
Leadership and Governance	The redesigned BAF and strengthened committee reporting provide improved visibility of strategic risks, controls and assurance sources.	Since June, the revised BAF structure and DCIQ migration have been completed and risk management has moved to business as usual. Limited assurance remains that the framework is consistently understood, applied and embedded; a post-implementation review and sample testing are planned.
Strategy and Business	Risk remains significant, including the expanded Tower estate fire safety and infrastructure risk.	The material expansion made in June remains a key Board focus. August strengthens the Tower estate control framework through clearer executive accountability, comprehensive fire safety arrangements, recovery programme governance, external agency engagement and action to increase fire management capacity.
Organisational Transition	Current score remains significant, reflecting the risks associated with Section 75 transition, service continuity, workforce implications and financial disaggregation.	The risk remains significant and above target. Since June, the focus has shifted from defining the transition risk to evidencing programme governance, service-continuity planning, workforce engagement, financial disaggregation and assessment of effects on service users and carers.



Torbay and South Devon
NHS Foundation Trust

Board Assurance Framework

2026/2027

August 2026 v1

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 (National Protective Security Authority) 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.

Assurance rating – TSDFT four-level scale

The Trusts assurance option descriptors and categories have been updated to align with the refined framework now in use by Audit South-West. This aims to improve consistency and clarity by providing standardised assessments aligned to recognised audit standards, a clearer articulation of control effectiveness and residual risk as well as comparability across any audits undertaken.

Significant	Controls are well designed and are applied constantly. Any weakness are minor and considered unlikely to impair the effectiveness of controls to eliminate to mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence
Moderate	Controls are generally sound and operating effectively. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives
Limited	There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness or mitigate risks to the achievement of key objectives
Inadequate	There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives

Board Assurance Framework – 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. That high operational pressures, burnout, and inadequate support lead to a decline in staff wellbeing, resulting in increased sickness absence, reduced retention, and a compromised quality of patient care	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 2026/27				
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: 4 x 4 = 16	Current Score: 3 x 4 = 12	Target Score: 2 x 4 = 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 quality and safety governance framework providing structured oversight, ward-to-board reporting, escalation and assurance through Quality and People Committee.	Quality and People Committee (QPC) and Board reporting provide oversight of quality, safety and patient experience, supported by ward-to-board triangulation, audit, mortality review, quality reporting and escalation of emerging risks.	Moderate	
C2	Patient Safety Incident Response Framework (PSIRF) and incident reporting systems supporting identification, investigation and learning.	PSIRF oversight includes incident reporting, thematic analysis, learning responses, duty of candour and safety improvement actions, triangulated with harm, complaints, claims, mortality and patient experience.	Moderate	
C3	Clinical effectiveness and outcomes monitoring programme using Getting It Right First Time (GIRFT), National Confidential Enquiry into Patient Outcome and Death (NCEPOD), specialty outcome indicators, peer review and accreditation to benchmark performance and drive improvement.	GIRFT, NCEPOD, outcome indicators, peer review and accreditation provide clinical effectiveness assurance. Assurance is limited by inconsistent specialty-level triangulation.	Limited	
C4	Safe staffing including establishment reviews and escalation processes to manage workforce pressures	Monthly safe staffing reports to Board; National Quality Board red flag reporting	Significant	
C5	Infection prevention and control programme incl. Healthcare Acquired Infection (HCAI) surveillance to minimize avoidable harm	IPC assurance comes through annual reporting, HCAI surveillance, outbreak reporting, audits and committee oversight. Assurance is limited by estate, isolation capacity and sustained improvement requirements.	Limited	
C6	Care Quality Commission (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	Moderate	
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Specialty-level outcomes, harm, complaints, mortality and workforce data are not yet routinely triangulated at committee level.	Develop specialty outcomes dashboard and agree QPC reporting cycle, linking mortality, harm, complaints, experience and staffing, with actions tracked through care group governance.	Chief Medical Officer	Q2 26/27
GC	Vacancies and temporary staffing continue to create safety risk in key services	Identify highest-risk staffing gaps, agree recovery plans, strengthen daily escalation triggers and monitor impact through safe staffing, quality and workforce governance.	Chief People Officer	Q2 26/27
GC	Ageing estate, equipment constraints and insufficient isolation capacity continue to limit safe care delivery and infection prevention control.	Prioritise highest-risk estate, equipment and isolation issues, agree funded mitigation plans and monitor delivery through estates, IPC and capital governance routes.	Director of Estates and Facilities	Q3 26/27

Tab 2.6 Board Assurance Framework and Corporate Risk Register

GC	PSIRF learning is not yet consistently translated into measurable safety improvement across all care groups.	Agree care group safety improvement priorities, track PSIRF actions to completion, test impact through thematic reviews and report progress through patient safety governance and QPC.	Chief Nursing Officer / Chief Medical Officer	Q3 26/27
GA	Patient experience, complaints, PALS and CQC insight are not yet consistently triangulated with quality and safety data.	Implement routine patient experience report triangulating complaints, PALS, surveys, FFT, CQC insight and incidents, with themes, actions and impact reported to QPC.	Chief Nursing Officer	Q3 26/27
GA	Limited independent assurance over the impact of operational pressures on quality, safety, and patient experience	Define a quality impact framework for operational pressures, including agreed triggers, manual interim dashboard, thematic deep dives and independent QPC review of harm, experience, staffing and flow impacts. July 2026 – Plan in place but progress delayed by Business Intelligence resource constraints and Epic recovery priorities. Manual data collation continues pending automated reporting.	Chief Nursing Officer	~~Q1 26/27~~ Q2 26/27 - <i>Deadline extended due to Resourcing constraints</i>

BOARD ASSURANCE FRAMEWORK 2026/27					
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: 4 x 4= 16	Current Score: 4 x 4 = 16	Target Score: 3 x 4 = 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.					
Risk: That high operational pressures, burnout, and inadequate support lead to a decline in staff wellbeing, resulting in increased sickness absence, reduced retention, and a compromised quality of patient care					
Ref	Key Controls	Assurance Summary		Rating	
C1	Workforce strategy and annual workforce plan aligned to operating plan, including workforce CIP delivery	Workforce key performance indicators dashboard to Quality and People Committee (QPC) and Board (vacancies, turnover, sickness, agency), staff survey, Culture Insights Review Group (CIRG) dashboard, workforce controls, temp staffing usage, WTE reductions against plan		Moderate	
C2	Recruitment and supply routes including apprenticeship pipeline	Monthly recruitment tracker; time-to-hire metrics; , apprenticeship levy, NHSE contract delivery, placement numbers, National Education and Training (NET) survey, Quality panels		Limited	
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		Limited	
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, training needs analysis, skills gap analysis		Moderate	
C5	Restorative, Just and Learning Culture plan, and strategies to address equality, diversity and inclusion, sexual safety, violence and aggression	CIRG dashboard, Workforce Race Equality and Workforce Disability Standards data; staff survey results and action plans, EDI Committee reports, incident data, staff network engagement and feedback, ER data, establishment of Restorative Just Learning Policy Review and Implementation Groups		Limited	
C6	Staff engagement and staff voice	CIRG, staff survey, Freedom to Speak Up (FTSU), trade union feedback, staff networks, listening and feedback mechanisms		Moderate	
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. Strategy developed and presented to Executive Committee and Board as part of development session.		Chief People Officer	Q2 26/27 On Track
GC	Ineffective People and Education Directorate staffing model to deliver strategy.	Restructure consultation and revised structure implemented		Chief People Officer	Q4 26/27
GC	Persistent vacancies in nursing, medical and allied health professionals workforce groups	Expand recruitment pipeline; grow-your-own; advanced practice expansion		Chief People Officer	Ongoing
GC	Wellbeing offer and routes to speak up and access support do not meet workforce needs	Strengthened independent FTSU function; wellbeing business case addressing musculoskeletal, mental health and staff health checks; wellbeing website and resources including clearer pathways & signposting; guidance on standards of behaviour and organisational response; occupational health service review & recommendation; strengthened wellbeing and staff engagement support resource		Chief People Officer	Q2 26/27 On Track

Tab 2.6 Board Assurance Framework and Corporate Risk Register

		delivered through people directorate org change; CARES-Well project. Independent FTSU function commissioned and business case approved.		
GC	Wellbeing offer and routes to speak up and access support do not meet workforce needs	Embed independent FTSU resource and wellbeing business case.	Chief People Officer	Q3 26/27
GA	Limited real-time workforce data to support operational decision-making	Implement integrated workforce dashboard linked to electronic staff record, SafeCare and rostering	Chief People Officer	Q3 26/27

BOARD ASSURANCE FRAMEWORK 2026/27				
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: 4 x 4 = 16	Current Score: 3 x 4 = 12	Target Score: 3 x 3 = 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	Population health management data packs per neighbourhood; Core20PLUS5 performance monitoring	Limited
C2	Joint Strategic Needs Assessment (JSNA) informing commissioning and service design	Annual JSNA refresh; Health and Wellbeing Board reports	Significant
C3	Neighbourhood health and care team development programme	Neighbourhood model milestones; community engagement feedback, action learning set model agreed by the Local Care Partnership and implementation to be through the reference group	Limited
C4	Prevention and early intervention service programmes	Screening uptake; immunisation coverage; smoking cessation referrals	Limited

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 Integrated Care System 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, draft outcomes framework produced now with ICB for review and comment	Chief Strategy and Planning Officer	Q4 26/27

BOARD ASSURANCE FRAMEWORK 2026/27				
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: 4 x 4 = 16	Current Score: 3 x 4 = 12	Target Score: 2 x 4 = 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 Integrated Care System (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 Isles of Scilly ICS governance structures	Board reporting on ICS decisions and impact; Chief Executive Officer’s report to Board		Significant
C2	Joint working with Torbay Council through Section 75 agreement	Section 75 partnership board minutes; integrated performance reporting		Significant
C3	Provider collaborative participation and mutual aid arrangements	Provider collaborative board reports; peer review outcomes		Limited
C4	Place-based partnership governance with Local Authority and Voluntary, Community, Social Enterprise sector	Place partnership board reports; community engagement outputs		Limited
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	ICS governance structures still evolving post-cluster – Trust influence uncertain	Proactive engagement in ICS design; secure representation in key forums. Trust Board sign off of new governance structures. – June 2026 Approved in principle – awaiting ICB to update and deliver refined approach	Chief Executive	Q1 26/27 Q2 26/27 – Deadline extended due to external factors
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 2026/27				
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: 5 x 4 = 20	Current Score: 4 x 4 = 16	Target Score: 3 x 4 = 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 Data Security and Protection Toolkit (DSPT) non-compliance.				
Ref	Key Controls	Assurance Summary		Rating
C1	Cyber security strategy with monitoring, patching and incident response plan	Cyber key performance indicators dashboard; penetration testing; CareCERT (Care Computer Emergency Response Team) compliance, Internal audit follow up undertaken and moved to significant assurance		Moderate
C2	DSPT compliance programme	Annual DSPT submission; internal audit of DSPT assertions		Significant
C3	Digital strategy and investment prioritisation aligned to Trust strategy	Digital programme board reports; benefits realisation tracking		Limited
C4	Information governance framework incl. DPO, SIRO and Caldicott Guardian	Information Governance Committee reports; Data Subject Access Request compliance; data breach data		Moderate
C5	Business continuity plans for critical digital systems incl. disaster recovery	Business Continuity Plan testing outcomes; disaster recovery (DR) testing schedule and results		Inadequate
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
C7	Established a control framework for the safe, lawful and ethical implementation of innovation within the Trust.	Approved Trust Policy, Defined governance and documentation, Committee papers, Established steering group overseen by the Our Plan for Better Care		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, Internal Audit follow up planned for September	Chief Strategy and Planning Officer	Q2 26/27
GC / GA	Lack of clarity across Devon regarding the Target Operating Model	Establish active engagement with the System Chief Executives', Integrated Care Board with independent review	Chief Strategy and Planning Officer	Q3 26/27
GC	Lack of clarity regarding governance arrangement post Epic implementation	Local arrangements mapped for implementation after University Hospital Plymouth Epic Go Live, oversight of recruitment processes. Links to development of the Target Operating Model for OneDevon	Chief Strategy and Planning Officer	Q3 26/27
GA	Board-level digital literacy and cyber risk awareness needs strengthening	Annual Board cyber awareness session booked for Feb 2027; Non-Executive Director digital champion identified; Ongoing oversight by Finance and Operations Committee.	Chief Strategy and Planning Officer	Q4 26/27

BOARD ASSURANCE FRAMEWORK 2026/27				
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: 4 x 4 = 16	Current Score: 3 x 4 = 12	Target Score: 2 x 4 = 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 Finance and Operations Committee (FOC) and Board; NHSE financial returns		Significant
C2	Cost Improvement Programme (CIP)/efficiency programme with Programme Management Office oversight and Quality Impact and Assurance (QIA) process	CIP tracker with scheme-level RAG (Red, Amber, Green); QIA sign-off log		Limited
C3	Capital programme governance and prioritisation framework	Capital planning group reports; Capital Departmental Expenditure Limit compliance monitoring		Moderate
C4	Financial controls framework incl. Standing Financial Instructions, Scheme of Delegation and budget holder accountability	Internal audit of key financial controls; counter-fraud reports		Significant
C5	System-level financial oversight group and Integrated Care System financial framework	ICS financial reporting; system recovery group minutes		Limited
C6	Clear approach to managing and recovering the Adult Social Care (ASC) bad debt	Quarterly reports to FOC; Monitored monthly through ASC Programme Board		Moderate
C7	Clear visibility on procurement implementation and maximising benefits realisation of the OneDevon approach	Procurement Improvement Plan monitored through One Devon Procurement Board, updates reported to FOC quarterly		Limited
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 ensuring sufficient level of recurrent delivery.	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
GC	ASC Bad Debt	Clear understanding of existing debt structure i.e. Secured, semi secured (probate), ongoing current client debt, residual debt risk. Agree approach with Torbay Council on transfer of debt from 1 April 2027.	Chief Finance Officer	Q2 26/27
GC	Income risk of not delivering Pre Epic activity	Joint process between Operations and Epic to ensure data quality issues resolved; Targeted focus with MIOs to return all clinics back to 100% activity by end of July; Weekly scrutiny of activity v plan including additional activity	Chief Operating Officer	Q2 26/27

Tab 2.6 Board Assurance Framework and Corporate Risk Register

GC	Spending more than funding available to recover	Continued monitoring of contractual income against contract through monthly financial reporting and align with deployment of reserves to deliver required demand/performance	Chief Finance Officer	Q2 26/27
GA	Medium-term financial plan continued development	Update 3–5 year financial recovery and sustainability plan	Chief Finance Officer	Q3 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 2026/27				
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: 4 x 5 = 20	Current Score: 4 x 4 = 16	Target Score: 3 x 4 = 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 Integrated Performance Report to Finance and Operations Committee (FOC) and Board with exception reporting and trend analysis. Elective recovery deep dive to be presented to June FOC. Work ongoing to recover activity levels to pre Epic activity in all outpatient clinics. Weekly scrutiny of backlog clearance plan in place. Ongoing issues understanding true position of elective activity and Referral to Treatment (RTT) waiting lists. Joint piece of work between Trust, ICB, Epic and Region due to conclude by 14 th August.	Limited
C2	Elective care recovery programme with waiting list management and validation	RTT and Patient Tracking List (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.	Inadequate
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	Inadequate
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.	Inadequate
C5	Estates and facilities management incl. statutory compliance programme and productivity impact assessments	Statutory compliance dashboard; condition survey data; PAM score	Limited

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	Urgent and Emergency Care (UEC) performance below trajectory and national standard, and increased use of corridor care	UEC improvement plan, corridor care working group in place, Getting It Right First Time review undertaken w/c 10 th August, 5-point plan being created with expectations of enacting by end of September at latest.	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 July 2026- Targeted focus with MIOs to return all clinics back to 100% activity by end of July, target has been missed. Targeted piece of work through Thrive training ongoing. Outpatient activity has met plan for month of August, however Quarter 1 recovery remains work in progress.	Chief Operating Officer	~~Q1 26/27~~ Q2 26/27

Tab 2.6 Board Assurance Framework and Corporate Risk Register

GC	Integrated Care Board contractual changes for elective activity risk altering elective plan and risk to meeting trajectories.	Elective plan being re-worked with proposal planned for Trust Executive Group and FOC.	Chief Operating Officer	June 2026 Completed
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 key performance indicators.	Chief Operating Officer	Q2 26/27
GA	July 2026 - Ongoing Data Quality issues following Epic implementation and impact on performance	Daily oversight of data quality improvements in place with resource in place to resolve across key areas. Expectation of completion 14 th August.	Chief Operating Officer	Q2 26/27

BOARD ASSURANCE FRAMEWORK 2026/27				
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: 3 x 4 = 12	Current Score: 2 x 4 = 8	Target Score: 2 x 3 = 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 terms of reference and accountability	Annual governance review; Board effectiveness review; well-led self-assessment		Significant
C2	Risk management framework incl. strategy, policy, BAF and corporate risk register	ARC oversight; internal audit of risk management; Risk Group reports		Limited
C3	Internal audit programme and counter-fraud plan	Head of Internal Audit Opinion; audit tracker; counter-fraud annual report		Significant
C4	Regulatory compliance monitoring (Care Quality Commission, NHSE and statutory requirements)	Provider information returns; NHSE oversight framework; annual report		Significant
C5	Freedom to Speak Up, complaints and whistleblowing arrangements	Freedom to Speak Up (FTSU) guardian reports to Board; complaints trends and learning		Limited
Type	Gaps in Control (GC) / Gaps in Assurance (GA)	Actions Required	Owner	Target
GC	Risk management framework undergoing major refresh — Datix Web to DatixCloudIQ (DCIQ) migration	Complete DCIQ configuration; implement new risk management operating manual	Chief of Staff	Q1 26/27 – Completed
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 Completed
GC	Freedom to Speak Up and whistleblowing arrangements are currently insufficient to meet the needs of the workforce or	Strengthened independent FTSU function to be implemented	Chief People Officer	Q3 26/27
GA	Policies overdue for review — compliance rate requires improvement	Policy review acceleration programme with clear prioritisation	Chief of Staff	Q2 26/27
GA	Limited assurance that the new BAF and Risk Management Framework are consistently understood, applied and embedded across directorates, committees and executive risk review processes.	Increased senior oversight of process with controlled handover to business as usual; Undertake a post-implementation review of the new framework, including sample testing of risks, scoring, controls, assurance sources, escalation routes and committee reporting; report findings and improvement actions to ARC.	Chief of Staff	Q3 26/27

BOARD ASSURANCE FRAMEWORK 2026/27				
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: 4 x 5 = 20	Current Score: 4 x 4 = 16	Target Score: 3 x 4 = 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	Moderate
C2	Transformation programme governance with senior responsible officers (SRO), programme boards and Programme Management Office (PMO)	Transformation dashboard; benefits tracking; milestone reporting	Moderate
C3	Business continuity planning arrangements for critical services	Business continuity plan testing programme; Emergency Preparedness, Resilience and Response (EPRR) assurance; annual EPRR self-assessment; decant and mutual aid planning; reporting to Trust Executive Group, Finance and Operations (FOC) and Quality and People Committees (QPC) and Board	Limited
C4	Green Plan and environmental sustainability programme	Carbon footprint monitoring; Greener NHS dashboard; Green Plan tracking	Moderate
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 Integrated Care Board 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.	Inadequate

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 Trust Executive Group, FOC/QPC and Board. 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 Executive Officer Chief Strategy and Planning Officer	Q2 26/27 Q2 26/27

Tab 2.6 Board Assurance Framework and Corporate Risk Register

GA	Lack of visibility of the Procurement approach to sustainability	Procurement Improvement Plan monitored through One Devon Procurement Board, updates reported to FOC quarterly	Chief Finance Officer	Q2 26/27

BOARD ASSURANCE FRAMEWORK 2026/27						
Signature Move: Foundation			Ref:	BAF-OT		
BAF Domain: Organisational Transition			Appetite:	Moderate		
Executive Lead: Chief Executive		Committee: Board (direct oversight)	Tolerance:	>12		
Initial Score: 4 x 5 = 20	Current Score: 4 x 4 = 20	Target Score: 3 x 3 = 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.						
Ref	Key Controls		Assurance Summary		Rating	
C1	Section 75 transition programme board with joint Trust/Council membership		Programme board reports to Board and Council; milestone tracking		Limited	
C2	Transition risk register with regular review and escalation processes		Risk register review at each programme board; escalation as needed		Moderate	
C3	Staff engagement and communication plan for affected workforce		Staff feedback; Trade Union consultation outcomes; workforce stability metrics		Limited	
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 Chief Executive/Director of Adult Social Services sessions to agree transition plan, timeline and resources - COMPLETED		Chief Executive	Q1 26/27 COMPLETED
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 Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and employment implications not yet fully scoped		Human Resource 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



Torbay and South Devon
NHS Foundation Trust

Corporate Risk Register

2026/2027

August 2026

Corporate Risk Register – Summary Heatmap

DCIQ Risk Category	BAF Domain	Appetite	Aggregate Risk Score	Total No of Risks in Category	Corporate Risks 15+	Direction	Position
Clinical Safety and Patient Experience	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	12	150	9	▲ Increasing	Above appetite
Infection Prevention and Control	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	15	15	1	► Stable	Above appetite
Health and Safety	Quality, Safety, Clinical Outcomes and Patient Experience	Very Low	20	75	4	► Stable	Above appetite
Workforce, Inclusion and Education	People and Culture	Moderate (Low for EDI)	20	52	5	► Stable	Above appetite
Legal and Regulatory	Leadership and Governance	Very Low	12	11	1	▲ Increasing	Above appetite
Communication and Reputational	Leadership and Governance	Very Low	12	7	0	► Stable	Above appetite
Performance	Performance	Low	20	37	3	▲ Increasing	Above appetite
Estates and Facilities	Performance	Low	20	38	3	► Stable	Above appetite
Financial	Finance	Low	25	16	2	► Stable	Above appetite
Strategy and Transformation	Strategy and Business	High	12	1	0	► Stable	Within appetite
Business Continuity	Strategy and Business	Low	12	41	0	► Stable	Above appetite
Environmental	Strategy and Business	Moderate	12	2	0	► Stable	Within appetite
Information Governance	Digital and Data (system-aligned)	Low	9	20	0	► Stable	Above appetite
Digital, Cyber and Data	Digital and Data (system-aligned)	Low	20	41	1	► Stable	Above appetite
Partnership and System	Partnership and System	High	-	0	0	► Stable	No risk recorded
Health Inequalities and Population Health	Health Inequalities and Population Health	Moderate	16	4	0	► Stable	Above appetite
Organisational Transition	Organisational Transition	Moderate	12	2	0	► Stable	Within appetite

TSDFT ~Corporate Risk Register – August 2026

Clinical Safety and Patient Experience

Signature Move: 'Reimagining acute and specialist care'

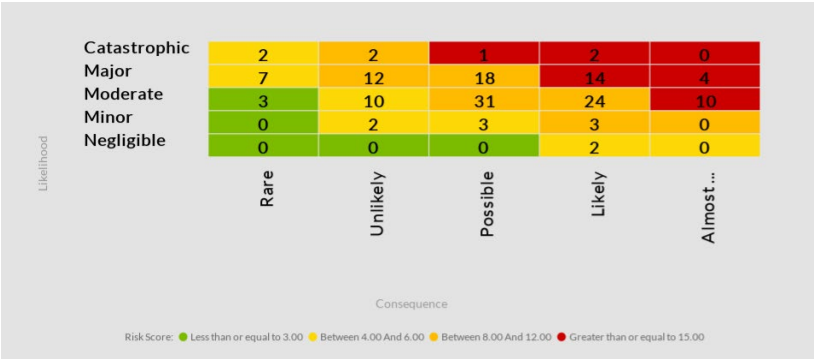
BAF Domain: Quality, Safety, Clinical Outcomes and Patient Experience | Committee: Quality and People Committee

Appetite Very Low	Tolerance > 3	Current Aggregate Risk Score 12	Corporate Risks at 15 + 9	Direction ▲ Increasing	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

Total number of risks in category = 150



Linked Corporate Risks

37	Pharmacy Aseptic (4001)	20
47	Medical Device Rolling Replacement Programme (1947)	16
233	Stroke Services (3287)	16
43	Mental Health Transfers (2948)	16
372	EPIC Risk Assessments and Key Reporting Information	16
527	NEW * Delays in treatment and monitoring of Multiple Sclerosis Patients *	16
51	Obstetric Theatre (2965)	15
55	Urgent Treatment Centre Acuity (3502)	15
58	Clinical Governance Capacity (3928)	15

Commentary

Risk remains above appetite and is increasing, with 9 corporate risks scoring 15 or above. The main change from last month is the addition of a new multiple sclerosis risk, scored at 16, relating to delays in treatment and monitoring. Other material risks remain stable under enhanced governance oversight.

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

Appetite
Very Low

Tolerance
> 3

Current Aggregate Risk Score
15

Corporate Risks at 15 +
1

Direction
▶ Stable

Position
Above appetite

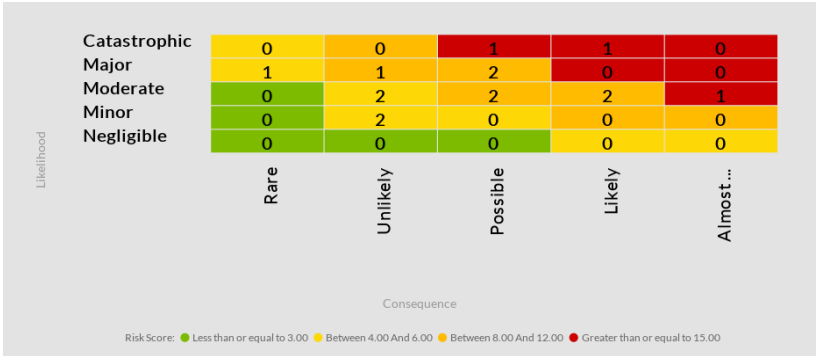
Overarching Risk Statement

CAUSE: Ageing estate infrastructure limiting single-room capacity, sustained patient flow pressures, and variability in Infection Prevention and Control 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.

Total number of risks in category = 15



Linked Corporate Risks

56 Infection Prevention and Control Overarching (3944) 15

Commentary

The infection prevention and control position remains stable but above appetite, with 15 risks and 1 corporate risk scoring 15. The key changes from last month are continued E. coli and C. difficile performance above target, increased MSSA rates, and ongoing QMLR data-quality issues limiting assurance.

Reporting processes are being strengthened to improve data quality, triangulation and infection prevention and control assurance, with targeted recovery actions under enhanced oversight.

Health and Safety

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

Appetite
Very Low

Tolerance
> 3

Current Aggregate Risk Score
20

Corporate Risks at 15 +
4

Direction
▶ Stable

Position
Above appetite

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.

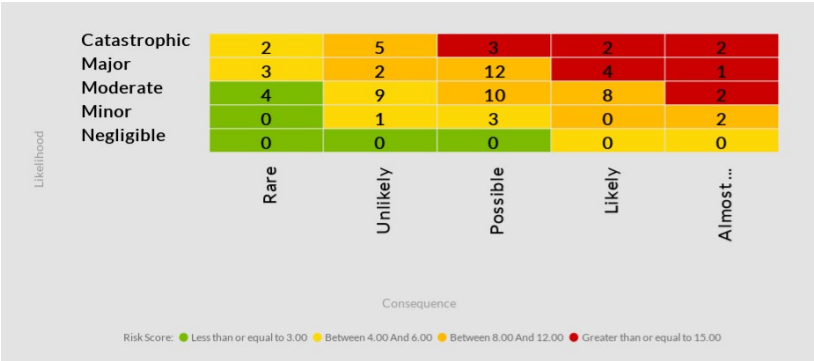
EVENT: The Trust is unable to minimise health and safety related incidents affecting staff, patients and visitors to an acceptable level

IMPACT: Serious injury or harm; HSM 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	Road Traffic Collision Buildings (4124)	15

Total number of risks in category = 75



Commentary

Risk exposure remains stable but above the Trust’s very low appetite, with an aggregate score of 20 across 75 recorded risks, including 4 corporate risks scoring 15 or above. The position is driven by significant and persistent safety risks associated with the estate and infrastructure, including fire safety, alongside wider workplace hazards. Existing governance, statutory compliance arrangements and risk review processes provide controls; however, further assurance is required that mitigating actions are delivered to plan, controls are consistently effective and material risks are escalated and monitored through the appropriate executive and committee routes.

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 Aggregate Risk Score
20

Corporate Risks at 15 +
5

Direction
▶ Stable

Position
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.

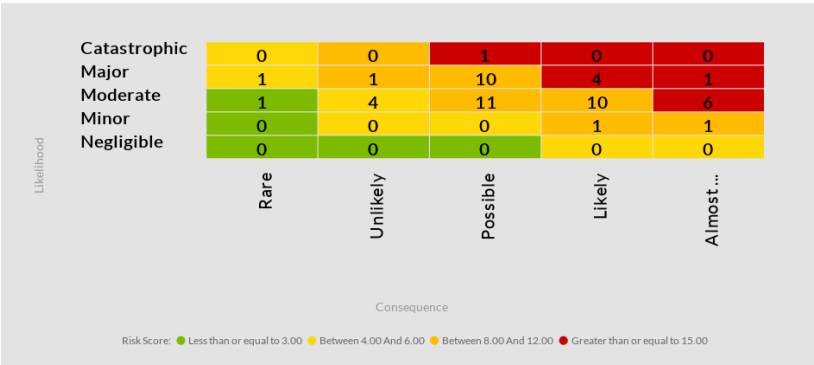
EVENT: The Trust does not have sufficient permanent workforce capacity and capability to meet patient need safely and sustainably.

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	Systemic Anti-Cancer Therapy (SCAT) Nursing (2037)	16
569	Breast Radiotherapy (3456)	16
196	Haematology (3789)	15
158	Sexual Safety	12

Total number of risks in category = 52



Commentary

Linked corporate risks for specialist vacancies in radiotherapy, haematology, SACT, breast radiotherapy being reviewed by HRBPs and Workforce Risk Group, Sexual Safety risk being reviewed and monitored by sexual safety group. Equality Diversity and Inclusion risk managed within category at low appetite and monitored through Cultural Insights and Review Group, Inclusion Steering group and Culture Plan. Workforce Programme Group. Temporary staffing has decreased between Month 01 and Month 03. Establishment review to take place from September with NHSE support.

Legal and Regulatory

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

Appetite
Very Low

Tolerance
> 3

Current Aggregate Risk Score
12

Corporate Risks at 15 +
1

Direction
▲ Increasing

Position
Above appetite

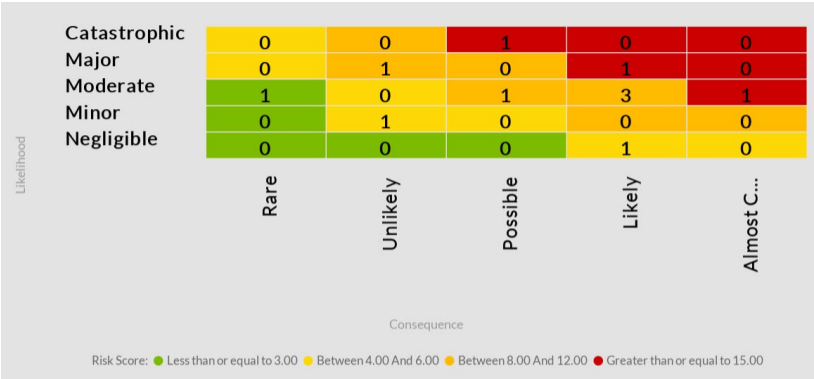
Overarching Risk Statement

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.

Total number of risks in category = 11



Linked Corporate Risks

180	Trust wide legal and regulatory compliance (3955)	10
320	Risk Management support exceeding capacity – single point of failure	16

Commentary

The category remains above the Trust’s very low risk appetite, with an aggregate score of 12, 11 risks and 2 rated 15 or above; the trend is increasing. Key exposures are non-compliant with statutory, regulatory, contractual and professional requirements. Controls include accountable leadership, legal advice, policies, training, audit and action plans. Continued oversight is required to address gaps promptly and evidence sustained compliance.

Communication and Reputation

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

Appetite
Very Low

Tolerance
> 3

Current Aggregate Risk Score
12

Corporate Risks at 15 +
0

Direction
▶ Stable

Position
Above appetite

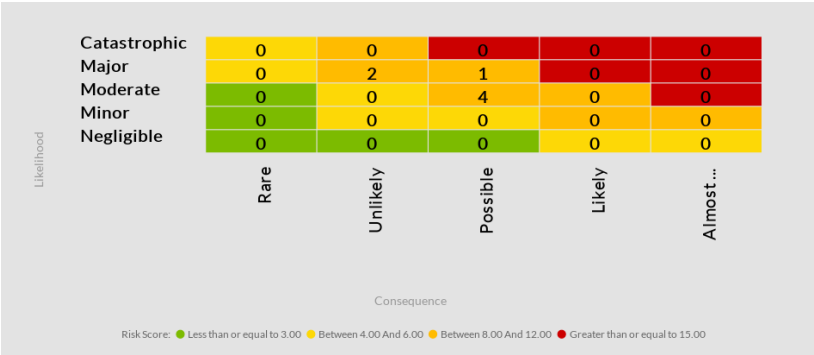
Overarching Risk Statement

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 affecting the Trust's reputation.

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

Total number of risks in category = 7



Linked Corporate Risks

316 Trustwide Learning from Deaths Process (3775) 12

Commentary

External scrutiny remains significant, with continuing public, political, stakeholder and media interest in service change, estate pressures, financial sustainability and the future shape of local care. Some issues are increasingly being linked together in public discussion, creating a broader narrative about the organisation and the future of services in Torbay and South Devon. (new corporate risk pending approval)

Mitigations have been strengthened through the Board-approved reputational risk and escalation framework and the developing strategic communications and engagement plan. Together these support early identification of emerging issues, calm and proportionate escalation, consistent leadership messages, proactive stakeholder engagement and clearer public information.

The risk remains stable but above appetite. The focus is on maintaining public confidence through accurate information, transparent engagement and timely escalation where issues may affect confidence in services, decisions or relationships.

Performance

BAF Domain: Performance | Committee: Finance and Operations Committee

Appetite
Low

Tolerance
> 6

Current Aggregate Risk Score
20

Corporate Risks at 15 +
3

Direction
▲ Increasing

Position
Above appetite

Overarching Risk Statement

CAUSE: Sustained growth in demand, system flow constraints, workforce gaps in key specialities, 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 Recovery Support Programme exit criteria, financial penalties.

Total number of risks in category = 37



Linked Corporate Risks

46	Cancer Waits (1815)	16
570	NEW *Performance Data and Waiting List Reporting *	20
45	Patient Flow	20

Commentary

The performance category remains above the Trust’s low risk appetite, with an aggregated score of 20 and 3 corporate risks rated 15 or above. Principal pressures relate to urgent and emergency care, patient flow, elective recovery, diagnostics and cancer waiting times, alongside the continuing stabilisation of operational processes and reporting following EPIC implementation. Recovery plans and executive oversight arrangements are in place; however, sustained improvement against key access standards has not yet been demonstrated. Continued focus is required on demand and capacity management, discharge and flow, workforce and deployment, data quality and delivery of credible recovery trajectories. We have added new Corporate risk re: referral to treatment in relation to data quality issues following EPIC implementation and being behind schedule in activity recovery.

Estates and Facilities

BAF Domain: Performance | Committee: Finance and Operations Committee

Appetite
Low

Tolerance
> 6

Current Aggregate Risk Score
20

Corporate Risks at 15 +
3

Direction
▶ Stable

Position
Above appetite

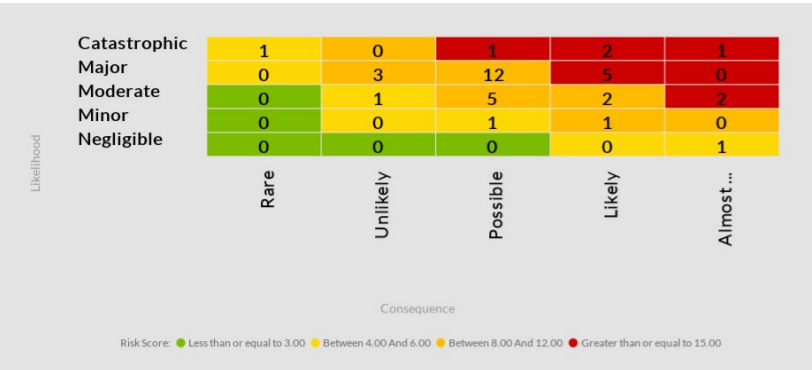
Overarching Risk Statement

CAUSE: Backlog maintenance exceeding £120m, New Hospitals Programme 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 health technical memoranda and statutory requirements

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

Total number of risks in category = 38



Linked Corporate Risks

39	Estates Overarching (1083)	25
72	Cancer Services Building Poor Condition (4201)	20

Commentary

Risk exposure remains stable but above the Trust's low appetite, with an aggregate score of 20 across 39 risks and 3 corporate risks scoring 15 or above. The position reflects the £120m+ maintenance backlog, constrained capital and deferral of the New Hospital Programme, with poor building condition and infrastructure fragility creating continuing risks to safety, statutory compliance arrangements provide controls; however, the residual estate remains a significant concern and further assurance is required on risk prioritisation, delivery of mitigations and demonstrable compliance with NHS technical standards.

Financial

BAF Domain: Finance | Committee: Finance and Operations Committee

Appetite
Low

Tolerance
> 6

Current Aggregate Risk Score
25

Corporate Risks at 15 +
2

Direction
▶ Stable

Position
Above appetite

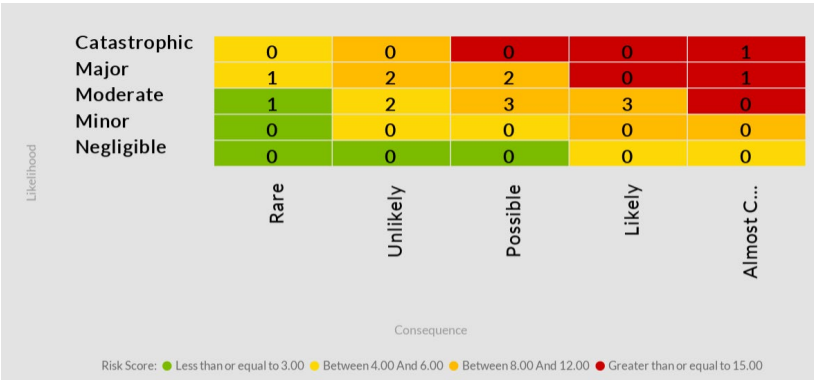
Overarching Risk Statement

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.

Total number of risks in category = 16



Linked Corporate Risks

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

Commentary

Financial risk remains stable but materially above the Trust’s low appetite, with the highest aggregate score on the register at 25 across 16 risks, including 2 corporate risks scoring 15 or above. The position reflects the structural deficit, system-wide pressures, historic underfunding, temporary staffing costs and the financial recovery, grip and control arrangements and efficiency programmes provide mitigation; however, further assurance is required on recurrent cost improvement delivery, financial systems and reporting, and achievement of a credible trajectory towards organisational financial balance.

Adult Social Care debt is a risk that is being actively managed by the Executives and monitored via the Committee governance.

Strategy and Transformation

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

Appetite
High

Tolerance
> 20

Current Aggregate Risk Score
12

Corporate Risks at 15 +
0

Direction
▶ Stable

Position
Within appetite

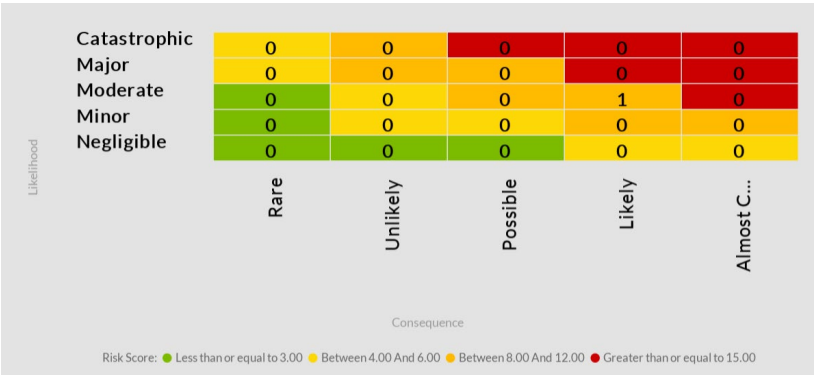
Overarching Risk Statement

CAUSE: Completing operational and financial pressures, constrained workforce and transformation capacity, complex interdependencies across the Trust and wider system, and insufficiently aligned delivery plans, resources, governance or benefits realisation arrangements

EVENT: The Trust is unable to translate its strategic objectives and five signature moves into prioritised, adequately resourced and deliverable transformation programmes or to implement and sustain the required changes at the necessary pace and scale.

IMPACT: Strategic objectives and expected benefits are not achieved, resulting in delayed improvements in quality, access, productivity and population health; failure to modernise services and deliver sustainable models of care; inefficient use of resources and reduced confidence among patients, staff, partners, regulators and the Board.

Total number of risks in category = 1



Linked Corporate Risks

No corporate risks.

Commentary

The category is within the Trust’s high risk appetite, with an aggregate score of 12,1 recorded risk and none rated 15 or above. Risks arising from individual transformation programmes are captured under the most relevant Corporate Risk Register categories, including performance, finance, workforce, digital and organisational transitional transition, to support clear ownership and avoid duplication. Work is underway to strengthen programme governance, prioritisation, capacity and dependency management, with regular scrutiny of delivery, risks, milestones and benefits. Material variance will be escalated promptly and corrective action monitored through the relevant executive and committee arrangements.

Business Continuity

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

Appetite
Low

Tolerance
> 6

Current Aggregate Risk Score
12

Corporate Risks at 15 +
0

Direction
▶ Stable

Position
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.

Total number of risks in category = 41



Linked Corporate Risks

Tower risk currently within Health & Safety risk category

Work underway to review and assess risk categorisation of existing risks

Commentary

This is a new risk category and currently remains above the Trust's low risk appetite, with an aggregate score of 12, 40 risks and none rated 15 or above. Work is underway to review the corporate alignment of business continuity risks, including their relationship with infrastructure, cyber, workforce, supply-chain and environmental categories, to support clear ownership and avoid duplication. Further work will strengthen business impact assessments, continuity and recovery plans, supplier assurance, training and exercising, with oversight to confirm plans are current, tested and effective.

Environmental

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

Appetite
Moderate

Tolerance
> 12

Current Aggregate Risk Score
12

Corporate 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.

Total number of risks in category = 2

Likelihood	Catastrophic	0	0	0	0	0
	Major	0	0	1	0	0
	Moderate	0	0	1	0	0
	Minor	0	0	0	0	0
	Negligible	0	0	0	0	0
		Rare	Unlikely	Possible	Likely	Almost C...
Consequence						
Risk Score: ● Less than or equal to 3.00 ● Between 4.00 And 6.00 ● Between 8.00 And 12.00 ● Greater than or equal to 15.00						

Linked Corporate Risks

322Trust's 2040 Green Plan (3566)12

Commentary

Environmental risk remains stable and within the Trust’s moderate appetite, with an aggregated score of 12 across 2 risks and no corporate risks scoring 15 or above. The principal exposures relate to delivery of statutory environmental and net zero commitments, resource efficiency and resilience to climate-related disruption. The Trust’s Green Plan, sustainability governance, monitoring and climate adaptation arrangements provide controls; continued assurance is required on delivery against measurable carbon, energy and waste trajectories and the integration of climate resilience into business continuity and investment decisions.

Information Governance

Signature Move: 'Smart use of technology for better care

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

Appetite
Low

Tolerance
> 6

Current Aggregate Risk Score
9

Corporate Risks at 15 +
0

Direction
▶ Stable

Position
Above appetite

Overarching Risk Statement

CAUSE: Volume and complexity of personal data processes 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: Information Commissioner’s Office enforcement, financial penalties, patient harm, loss of public trust, legal liability.

Linked Corporate Risks

Work underway to review and assess risk categorisation of existing risks

Commentary

The categories remains above the Trust's low risk appetite, with a current aggregate score of 9, 20 recorded risks and no corporate risks rated 15 or above. The principal exposures relate to compliance with data protection, confidentiality, records management and information sharing requirements; appropriate access to records; data quality and retention; staff awareness; and the additional complexity arising from EPIC data migration and integrated service arrangements. Controls include information governance policies and training, role-based access, audit and monitoring, data protection impact assessments, incident reporting and investigation, records-management arrangements, Caldicott oversight and delivery of the data security and protection toolkit. Continued oversight is required to demonstrate sustained compliance, timely management of incidents and subject rights, completion of improvement actions and that personal and confidential information is handled lawfully, securely and accurately.

Total number of risks in category = 20

Likelihood	Catastrophic	0	0	0	0	0
	Major	1	3	3	0	0
	Moderate	2	1	4	1	1
	Minor	0	0	1	2	1
	Negligible	0	0	0	0	0
		Rare	Unlikely	Possible	Likely	Almost C...
Consequence						
Risk Score: Less than or equal to 3.00 Between 4.00 And 6.00 Between 8.00 And 12.00 Greater than or equal to 15.00						

Digital, Cyber and Data

Signature Move: 'Smart use of technology for better care

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

Appetite
Low

Tolerance
> 6

Current Aggregate Risk Score
20

Corporate Risks at 15 +
1

Direction
▶ Stable

Position
Above appetite

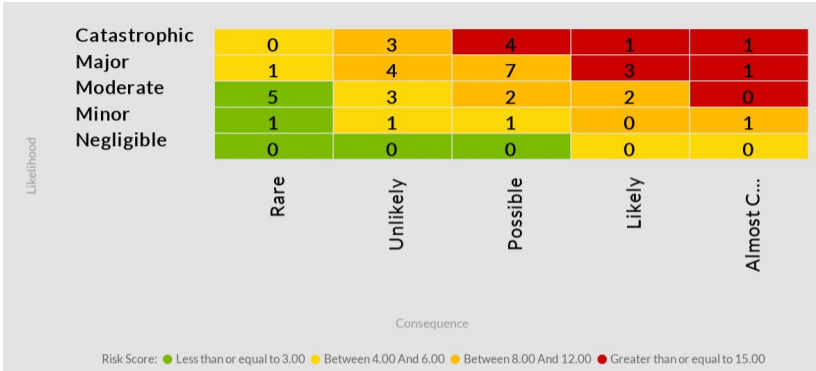
Overarching Risk Statement

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.

Total number of risks in category = 41



Linked Corporate Risks

40	IT Infrastructure (1159)	20
54	Cloud Services (3460)	12

Commentary

The category remains above the Trust’s low risk appetite, with a current aggregate score of 20, 41 risks in the category and 2 corporate risks rated 15 or above. The principal exposures relate to the resilience of core IT infrastructure and cloud services, the stabilisation and optimisation of EPIC, dependencies on legacy and third-party systems, cyber security, data availability and quality, and the capacity to maintain safe and effective digital services. Controls include cyber monitoring and incident response arrangements, infrastructure and supplier oversight, business continuity planning, system access controls, patching and vulnerability management, and delivery of data security and protection toolkit improvement programme. Continued executive and committee oversight is required to evidence sustained system resilience, timely remediation and delivery of the Trust’s digital transformation benefits. The delay in partners adopting the Devon Wide Target Operating Model is increasing the risk to the Trust. Local governance under review to ensure mitigation.

Partnership and System

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

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

Appetite High	Tolerance > 20	Current Aggregate Risk Score -	Corporate Risks at 15 + 0	Direction ▶ Stable	Position No risk recorded

Overarching Risk Statement

CAUSE: Integrated Care System complexity, varying governance frameworks, Section 75 notice, Royal Devon University Hospitals/University Hospital Plymouth 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

Total number of risks in category = 0

Linked Corporate Risks

Work underway to review and assess risk categorisation of existing risks

Commentary

This is a new category with a high-risk appetite; no risks are currently recorded and there are no corporate risks rated 15 or above. The absence of recorded risks should not be interpreted as confirmation that the system is fully mitigated. Principal areas for active consideration include delivery of shared pathways and priorities, clarity of roles and accountabilities; collaborative decision making, system financial and workforce pressures, provider and commissioner dependencies, information sharing, and the Trust's ability to influence decisions affecting local services. Executive leads will be reviewing relevant partnership and system exposures and ensure that the material cross-organisational risks are recorded, jointly owned where appropriate, escalated through agreed governance arrangements and supported by clear controls, actions and sources of assurance.

Health Inequalities and Population Health

Signature Move: 'Living well in our neighborhoods

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

Appetite
Moderate

Tolerance
> 12

Current Aggregate Risk Score
16

Corporate Risks at 15 +
0

Direction
▶ Stable

Position
Above appetite

Overarching Risk Statement

CAUSE: Ageing population, deprivation, limited population health management data integration, historic under-investment in preventative care.

EVENT: The Trust fails to identify and address health inequalities in access, experience and outcomes.

IMPACT: Widening inequalities, poorer outcomes, failure to meet Integrated Care System objectives, regulatory scrutiny.

Total number of risks in category = 4

Likelihood	Catastrophic	0	0	0	0	1
	Major	0	1	0	0	0
	Moderate	0	0	1	1	0
	Minor	0	0	0	0	0
	Negligible	0	0	0	0	0
		Rare	Unlikely	Possible	Likely	Almost C...
Consequence						
Risk Score: ● Less than or equal to 3.00 ● Between 4.00 And 6.00 ● Between 8.00 And 12.00 ● Greater than or equal to 15.00						

Linked Corporate Risks

Work underway to review and assess risk categorisation of existing risks

Commentary

New risk category aligned to Integrated Care System Board Assurance Framework 2026/27. Baseline assessment completed and existing risks mapped. Development of population health management intelligence, inequalities metrics and governance arrangements underway to strengthen oversight and targeted action.

Current score reflects early maturity of controls and assurance.

Organisational Transition

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

Appetite
Moderate

Tolerance
> 12

Current Aggregate Risk Score
12

Corporate Risks at 15 +
0

Direction
▶ **Stable**

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 Adult Social Care mode.

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

IMPACT: Disruption to Adult Social Care services, workforce attrition, contractual disputes, regulatory scrutiny, reputational damage.

Total number of risks in category = 2

Likelihood	Consequence					
	Rare	Unlikely	Possible	Likely	Almost C...	
	Catastrophic	0	0	0	0	0
	Major	0	0	0	0	0
	Moderate	0	0	0	2	0
	Minor	0	0	0	0	0
	Negligible	0	0	0	0	0
Risk Score: Less than or equal to 3.00 Between 4.00 And 6.00 Between 8.00 And 12.00 Greater than or equal to 15.00						

Linked Corporate Risks

289

Section 75 transition

12

Commentary

The category remains within the Trust’s moderate risk appetite, with a current aggregate score of 12 and no corporate risks rated 15 or above. The risk relates to delivery of the section 75 transition, including continuity of services, workforce mapping and engagement, financial and contractual disaggregation, data and information requirements, and co-design of the future model with Torbay Council and NHS Devon. Transition governance and planning arrangement are developing; however, sustained assurance is required that responsibilities, resources, milestones, dependencies and impacts on service users and carers are clearly understood and managed through to impacts on service users and carers are clearly understood and managed through to implementation. The financial risk of the outstanding debt is an ongoing risk being managed via finance.

A review of the risk scoring is being undertaken on a monthly basis to ensure emergent issues are reflected.

Presented to:	Public Board			
Title of Report	Constitutional Amendments and Building on Governor Experience			
Date of Meeting	3rd September 2026	Author	Cath Parnell, Chief of Staff	
Executive Lead	Joe Teape, CEO	Executive Sign Off	Yes – Joe Teape	
Governance Route	Council of Governors 12 th August 2026			
Purpose of paper	For Approval	For Assurance	To Update	For Information
	X			
Executive Summary	This paper seeks Board approval for two amendments to the Trust Constitution: an enabling provision that would operate only if relevant legislation is enacted and commenced; and the replacement of the five existing staff classes with a single Staff Constituency, retaining five elected staff governor seats and current staff membership eligibility.			
	The Health Bill was introduced to Parliament on 14 May 2026. As drafted, it proposes changes to the NHS foundation trust model, including removal of the statutory requirement for foundation trusts to have members and a council of governors. The Bill remains subject to the parliamentary process and may be amended.			
	Unless and until the relevant provisions are enacted and commenced, the Council of Governors retains all current statutory and constitutional functions. Governors will continue to represent the interests of members and the public and to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board.			
	The Trust values governors’ local knowledge, representative insight and constructive challenge. These strengths help the Board understand community priorities and maintain accountability to the population it serves. The Trust is committed to ensuring these strengths are actively retained and transferred into future arrangements rather than lost through any legislative change.			
	The enabling amendment is intended to support an orderly transition and continued legal compliance if the national reforms take effect. It does not alter governors’ present role or pre-empt Parliament’s decision. In parallel, the Trust proposes an inclusive co-design process, involving governors, service			

	users, carers, staff, communities and partners, to shape future arrangements for public accountability and engagement. The Council of Governors considered the proposals on 12 August 2026. Subject to Board approval, the constitutional amendments will be progressed in accordance with the applicable statutory and constitutional requirements. Board members are asked to approve the amendments and endorse the proposed approach to co-design, recognising that the final engagement model, implementation plan, resource implications and equality impact assessment will return through the appropriate governance route.					
Recommendation	1. Approve the enabling amendment to the Constitution set out in Appendix One, noting that it would take effect only if the relevant legislative provisions are enacted and commenced. 2. Approve the replacement of the five existing staff classes with a single Staff Constituency, retaining five elected staff governor seats and current staff membership eligibility, together with the consequential amendments set out in Appendix One. 3. Endorse an inclusive co-design process, involving governors, service users, carers, staff, community representatives and partners, to develop future arrangements for public accountability and engagement.					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
						X
How this paper supports delivery of the Strategy	This paper supports the Strategy's Foundation by maintaining lawful, effective and accountable governance during legislative change. The proposed co-design approach will help ensure that service user, carer, staff and community insight continues to inform strategic decisions and the development of accessible, equitable and joined-up care.					

Board Assurance					
BAF Ref	Principal Risk		Current Score	Impact of this paper	
BAF-LG	Leadership and Governance		2x4=8	Provides positive assurance that the Trust is planning for legislative change while preserving current statutory responsibilities and community voice. Approval does not change the current BAF risk score.	
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led
					X
Compliance / Regulatory Requirements	The amendments must be implemented in accordance with the National Health Service Act 2006, the Trust Constitution and any enacted and commenced provisions of the Health Bill. The enabling provision has no effect unless and until the relevant legislation comes into force.				
Ethical or EDI implications?	The co-design process should promote accessible and inclusive participation, with particular attention to communities that experience barriers to involvement or health inequalities. An equality impact assessment will inform the final model and implementation plan.				
Assurance rating	Significant	Moderate	Limited	Inadequate	
		X			
Assurance rationale	Moderate assurance is provided because the proposed approach is legally informed, clearly conditional on legislation and supported by an inclusive transition process. Full assurance depends on the final form and commencement of the legislation, completion of the co-design and equality impact assessment, and approval of a deliverable implementation plan.				
Appendices	Appendix One – Summary of amendments to the Constitution Appendix Two – TSDFT with legal black line mark up (items for information pack)				

1. Preserving and Building on Governors' Contribution

The Council of Governors has developed substantial experience of representing diverse constituencies, raising community concerns, scrutinising the Board and translating complex organisational issues for members and the public. Governors hold trusted relationships and practical knowledge of local places, services and inequalities. The Trust is committed to ensuring these strengths are actively retained and transferred into future arrangements rather than lost through any legislative change.

For the avoidance of doubt, there is no change at this stage to governors' role, authority or responsibilities. Unless, and until, the relevant legislation is enacted and brought into force, governors will continue to hold, and must exercise, all of their current statutory and constitutional functions in full. The proposed enabling amendments to the constitution do not suspend, reduce or anticipate the removal of any current governor responsibility.

2. National Context and Proposed Enabling Provision within the Constitution

The Health Bill was introduced to Parliament on 14 May 2026. As drafted, it proposes changes to foundation trust governance, including removal of the statutory requirement for foundation trusts to have members and a council of governors. The Bill remains subject to parliamentary scrutiny and amendment. To support an orderly transition and ensure that the Constitution can remain aligned with any future statutory requirements, the Trust's external legal advisers have recommended the addition of the following clause.

'Upon legislation being passed which removes the requirement for the Trust to have a Council of Governors, all constitutional provisions concerning Governors and the Council of Governors shall become invalid, and all Governors shall be deemed removed as of the effective date set out in such legislation. In the event that Governors and the Council of Governors cease to exist at the Trust, provisions in this Constitution relating to the appointment and removal of Non-Executive Directors will be deemed to be replaced by such other process as legislation requires until the Constitution is amended.'

The proposed enabling provision is conditional. It would operate only if legislation removing the statutory requirement for a council of governors is enacted and commenced. It would not:

- anticipate Parliament's decision
- remove any current governor function prematurely

- prevent the Trust from establishing non-statutory arrangements for public, patient, staff and stakeholder voice.

Including the provision now supports continuity and legal clarity if the national reforms take effect. It reduces the risk of uncertainty during transition and enables the Trust to maintain alignment with its statutory framework.

Until the relevant statutory provisions come into force, the Council of Governors will continue to exercise all functions required by law and the Constitution.

3. Local Constitutional Amendment: Staff Constituency

Following the transfer of Children and Family Health Devon to Devon Partnership Trust and the current review of the Trust's operational structures, it is proposed that the five existing named staff classes are replaced by a single Staff Constituency. The total number of elected staff governor seats will remain five, and staff membership eligibility will not change. All eligible staff will vote across the single constituency. Related provisions on elections, eligibility, registers and annual reporting will be updated for consistency.

The proposal simplifies the current arrangements, maintains representation through five elected staff governor seats and provides resilience to future organisational change.

4. Governor Involvement in Shaping and Testing Future Models of Engagement

Subject to Board approval, the Trust will establish a co-design programme to define how it should listen, respond and demonstrate that local insight has influenced decisions. Governors' knowledge and experience will provide continuity, preserve organisational memory and support public confidence. They will work alongside service users, carers, staff, community representatives and partners to shape and test options. The programme will reflect the geographical diversity of the Trust's population and actively involve communities whose voices are less often heard.

The Trust considers governors' involvement and experience essential in helping to shape and test a future model that embeds the following principles:

- **Meaningful influence:** service users can shape priorities at an early stage and understand how their contribution has affected decisions.
- **Value and respect:** participation is accessible, well supported and recognised, with feedback closing the loop after engagement.
- **Equity and inclusion:** arrangements reflect local demographics and geography and actively address barriers to involvement.
- **Proportionate governance:** clear routes connect service user insight to the Board and its committees without creating unnecessary bureaucracy.

- **Transparency and accountability:** the Trust reports on who has been engaged, what it has heard, what has changed and where change has not been possible.

5. Summary

The proposed amendments provide legal and operational clarity while the national position develops. They do not alter governors' current functions or pre-empt Parliament's decision. The co-design programme will build on governors' expertise and ensure that future engagement and accountability arrangements are inclusive, transparent and connected to Board decision-making.

6. Proposed Next Steps

1. Complete the constitutional approval and implementation steps required under the Trust Constitution and applicable legislation.
2. Agree the membership, scope, support and timetable for the co-design programme with governors and other stakeholders.
3. Map existing engagement routes and seek views from service users, carers, staff, communities and partners, with particular attention to people whose voices are less often heard.
4. Present the preferred model, equality impact assessment, implementation plan, resource implications and measures of success through the appropriate governance route before implementation.

Appendix One – Amendments to the Constitution

The Trust has obtained external legal advice from DAC Beachcroft LLP. The amendments below are recommended to keep the Constitution legally accurate and aligned with current and potential future governance and operational arrangements.

1) Response to the Health Bill

The addition of the following clause to section 5 of Annex 4 (page 30) of the Constitution is recommended.

‘Upon legislation being passed which removes the requirement for the Trust to have a Council of Governors, all constitutional provisions concerning Governors and the Council of Governors shall become invalid, and all Governors shall be deemed removed as of the effective date set out in such legislation. In the event that Governors, and the Council of Governors cease to exist at the Trust provisions in this Constitution relating to the appointment and removal of Non-Executive Directors will be deemed to be replaced by such other process as legislation requires until the Constitution is amended’.

2) Response to organisational operational changes

It is recommended that the five separate staff classes are removed. Staff will instead form a single Staff Constituency with 5 elected Governors. To achieve this the following changes will be made:

- References throughout the Constitution to membership, elections, eligibility, registers and representation by “**class**” will be removed (paragraphs 10–12 on pages 5–6; paragraph 16.1.2 on page 7; paragraph 43.2.3(a) on page 17; and paragraph 4.1.2 of Annex 4 on page 26).
- The provision allowing the Secretary to determine an individual’s staff class will be removed (paragraph 10.6 on page 5).
- Annex 2 will be simplified to provide for a minimum Staff Constituency membership of 500 and five elected staff governor seats (page 24).
- Staff membership eligibility will remain unchanged.
- Automatic staff membership will continue, without allocation to a particular class (paragraph 14.3 on page 6).
- Staff governors will be elected by the Staff Constituency as a whole, rather than one governor being elected from each staff class.
- The membership register and annual reporting requirements will record and report on the Staff Constituency overall, rather than by staff class (paragraph 36.1.1 on page 14).
- Annex 3 will be amended to show a single Staff Constituency with five elected staff governor seats (page 25)

Presented to:	Trust Board			
Title of Report	Minimum Standards of Patient Experience for Elective Care			
Date of Meeting	3 rd September 2026	Author	Chief Nurse / Planned Care Team	
Executive Lead	Chief Operating Officer / Chief Nurse	Executive Sign Off	CEO	
Governance Route	Planned Care Quality and Performance Assurance; Quality and People Committee; Trust Board			
Purpose of paper	For Approval	For Assurance	To Update	For Information
	X	X	X	
Executive Summary	NHS England’s minimum standards of patient experience for elective care set out the basic information and support patients should receive once accepted onto an elective pathway. The current assurance position is limited: relevant programmes are underway and there are examples of good practice, particularly in gastroenterology, but the Trust cannot yet evidence consistent compliance across all elective specialties. The Board is asked to approve a Trust-wide baseline assessment and delivery plan, with a further report in January 2027 aligned to NHS England’s national stocktake. Priority actions are to standardise patient communication, strengthen escalation routes, ensure accessible and non-digital information, and establish a single Board assurance framework.			
Recommendation	The Board is asked to receive limited assurance; approve the Trust-wide baseline assessment and delivery plan; endorse standard patient communications, accessible alternatives and clear deterioration routes; agree quarterly oversight through the Quality and People Committee; and request a further report in January 2027 containing the completed baseline, key risks, delivery milestones, assurance dashboard and draft public statement.			
Link to Strategic Signature Moves	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
	X	X	X	X
How this paper supports delivery of the Strategy	The paper supports delivery of the Trust strategy by improving the experience and safety of patients waiting for planned care, strengthening pathway coordination, reducing avoidable uncertainty, supporting more consistent and responsive access, and using digital tools appropriately while maintaining accessible alternatives.			
Board Assurance				
BAF Ref	Principal Risk	Current Score	Impact of this paper	
To be confirmed	Quality, safety and access risks associated with long waits, overdue follow-up, variation in	12	The paper provides partial assurance, identifies current assurance gaps and proposes a framework to strengthen	

	communication and patient experience on elective pathways.		Board oversight of elective patient experience standards.	
Link to CQC Quality Statement	Safe	Caring	Responsive	Well-led
	X	X	X	X
Compliance / Regulatory Requirements	NHS England minimum standards of patient experience for elective care; Accessible Information Standard; national elective recovery expectations; patient safety and quality governance requirements.			
Ethical or EDI implications?	Yes. The standards require equitable access to clear information and support while waiting. Implementation must consider digital exclusion, accessible formats, interpreter needs, reasonable adjustments and the risk that variation in communication may disproportionately affect some patient groups.			
Assurance rating	Significant	Moderate	Limited	Inadequate
			X	
Assurance rationale	Limited assurance is proposed because relevant work is underway and there are positive local examples, but the Trust does not yet have a completed baseline assessment or consistent specialty-level evidence of compliance with the national standards. The paper sets out the actions required to move towards stronger assurance.			
Appendices	Appendix 1: Detailed gap analysis and implementation milestones. Appendix 2: NHS England minimum standards of patient experience for elective care. Appendix 3: Specialty-level baseline assessment and evidence matrix, to accompany the January 2027 follow-up report.			

Minimum Standards of Patient Experience for Elective Care

1. Purpose

This paper provides the Board with an overview of the NHS England minimum standards of patient experience for elective care, published in July 2026. It describes what the standards are, why they have been introduced, what they mean for Torbay and South Devon NHS Foundation Trust, the work already underway, and the further action required to ensure consistent compliance and assurance.

2. Recommendations

The Board is asked to:

1. Note the NHS England minimum standards and the requirement to assess compliance and publish an implementation statement during 2026/27.
2. The Board is asked to receive limited assurance: relevant improvement work is underway, but consistent specialty-level compliance is not yet evidenced.
3. Approve a Trust-wide specialty baseline assessment and delivery plan, prioritising high-volume and high-risk pathways.
4. Endorse standard patient communications, accessible and non-digital options, clear deterioration routes, and use of gastroenterology learning across specialties.
5. Agree quarterly reporting through planned care governance and the Quality and People Committee, with Board escalation by exception.
6. Request a further report by January 2027, aligned to NHS England's six-month national stocktake, containing the completed baseline, milestones, key risks, assurance dashboard and draft public statement.

3. Board Summary

The Board is asked to receive partial assurance with recognised gaps and approve a Trust-wide baseline assessment and delivery plan. The Trust has relevant governance and improvement work in place across planned care, outpatient transformation, patient access, digital services and patient experience.

Gastroenterology provides a strong local example of clinically led improvement that can inform wider implementation. However, consistent compliance is not yet evidenced across all elective specialties. The priority actions are to complete the specialty baseline, standardise patient communications and deterioration routes, ensure accessible and non-digital alternatives, and establish a single Board assurance framework. A further report will return in January 2027, aligned to NHS England's national stocktake. The detailed gap analysis and milestones are provided at Appendix 1.

4. Background and National Context

The NHS England minimum standards were published as part of the national elective reform programme. They respond to concerns that some patients waiting for planned care do not receive basic, timely and consistent information about their referral, their place on a waiting list or their appointment. The national expectation is that every acute trust board assesses current performance against each standard and sets out how improvement will be delivered where standards are not yet met.

National timeframe: NHS England has not set a separate fixed deadline for completing each local action. However, it will undertake a national stocktake six months after publication, in January 2027, and expects every trust to publish a compliance statement during 2026/27, followed by an annual progress statement. The proposed local milestones below are therefore designed to demonstrate credible progress at the stocktake and full reporting by 31 March 2027.

The standards are deliberately described as minimum expectations. They do not replace existing clinical prioritisation, referral management or operational performance requirements. Instead, they describe the basic patient experience that should sit around every elective pathway: clarity, acknowledgement, information, access to support and communication that helps people understand what is happening and what they should do next.

5. What the Standards Cover

Stage	Minimum expectation	What this means in practice
At referral	Patients should know that their referral has been received and accepted by secondary care.	Patients should receive clear acknowledgement and understand what the referral means, what happens next, and where to seek help.
While waiting	Patients should receive information and support while they remain on the waiting list.	Patients should know they are still waiting, be able to update the Trust if their condition changes, and receive information about support, waiting well and contact routes.
Appointment information	Patients should receive clear, timely and usable appointment information.	Patients should know when and where to attend, who they will see where possible, how to prepare, how to cancel or rebook, and how to tell us about access, communication or support needs.

6. Local Context

For Torbay and South Devon, the standards are both a patient experience requirement and an operational assurance requirement. They require us to demonstrate that patients on elective pathways receive consistent information, regardless of specialty, referral route, communication channel or level of digital access. This is particularly important given our current elective performance challenges, including long waits for Referral to Treatment, follow-up delays, diagnostic waits and pressures on cancer pathways. It will require strong collaboration between planned care services, operational teams, clinical specialties,

digital services, patient experience, communications, health inequalities leads and administrative teams.

There are also clear local opportunities. The gastroenterology outpatient transformation programme has shown that clinically and operationally led, data-driven improvement can significantly reduce waits and improve consistency. Learning from this programme should now be applied to other high-volume or high-risk specialties. The Patient Access Centre improvement work has also shown early positive indicators in staff experience and reduced patient concerns relating to responsiveness and customer service. These areas provide practical foundations for implementing the minimum standards in a way that is meaningful for patients and deliverable for teams.

The implementation of Epic and development of MY CARE also provide a route to improve how patients access appointment information, results and communications. However, digital routes must be supported by clear non-digital alternatives, including telephone and letter communication, to ensure that patients who are digitally excluded or have accessibility needs are not disadvantaged.

7. Current Position: Work Already Underway

- Planned Care Quality and Performance Assurance arrangements are in place, with executive oversight of waiting lists, Referral to Treatment performance, outpatient productivity, cancer and diagnostic performance, quality, safety, patient experience, workforce and finance.
- The Devon Health Community Elective Care Access Policy has been reviewed locally and ratified for use across Devon partners, supporting a consistent framework for fair, transparent and clinically prioritised elective access.
- Specialties undertake waiting list review and validation activities, including the use of text message validation in some services to confirm whether patients still wish to remain on the waiting list.
- Gastroenterology has delivered a significant outpatient productivity improvement programme, reducing its outpatient waiting list from approximately 1,897 to 590 before Epic implementation, with routine new outpatient waits reduced from 72 weeks to 10 weeks and urgent waits from 30 weeks to 4 weeks.
- Learning from gastroenterology has been identified as a model for wider rollout across specialties, supported by clinical champions, standardised clinic templates, consultant review of follow-up lists, review of clinic outcomes, short-notice cancellation backfill and stronger use of data.
- The Patient Access Centre has undertaken a focused staff engagement and culture improvement pilot in response to concerns about morale, turnover and responsiveness. Early indicators include improved staff metrics and fewer patient concerns relating to responsiveness and customer service.
- Patients are contacted through a variety of routes, including appointment letters, telephone contact, text messaging and digital communication where available.
- Epic and MY CARE provide further opportunities for patients to manage appointments, access information and receive digital communications, alongside the NHS App.

- The Trust has established patient experience routes, including feedback, complaints, concerns, the Friends and Family Test and the Patient Advice and Liaison Service, which provide insight into where communication is not working as well as it should.
- Clinical teams prioritise patients based on clinical need, urgency and risk, including escalation routes where a patient's condition deteriorates.
- Quality and performance reporting has identified specific risks, including ophthalmology-related patient harm associated with long waits and follow-up delays, which reinforces the need for stronger clinical risk management for prolonged waits.

8. Risks and Mitigations

Risk	Potential impact	Mitigation
Variation between specialties	Patients may experience different levels of information and support depending on which pathway they are on.	Specialty-level baseline assessment, standard templates and oversight through planned care governance.
Long waits and overdue follow-up	Patients with prolonged waits may deteriorate without timely review, particularly in high-risk specialties such as ophthalmology.	Specialty-level clinical risk review, risk stratification, escalation routes and visible reporting of high-risk cohorts.
Incomplete or inconsistent patient contact details	Patients may not receive timely updates, validation messages or appointment information.	Strengthen demographic validation and encourage patients to update contact details through booking, validation and MY CARE processes.
Digital exclusion	Patients without digital access or confidence may be disadvantaged by increased use of text, MY CARE and digital letters.	Maintain telephone and letter routes, monitor equality impact and ensure reasonable adjustments are available.
Administrative and workforce capacity	Additional communication, validation and call handling activity may increase pressure on operational and administrative teams.	Prioritise high-impact changes, use standardised templates, align with existing validation work and build on Patient Access Centre improvement learning.
Data quality and Epic transition	Data quality issues may affect waiting list accuracy, validation and assurance during and after digital transition.	Use planned care governance to monitor data quality, triangulate with specialty intelligence and ensure clear ownership of validation and reporting.
Lack of visible assurance	The Board may not be able to evidence progress or compliance against national expectations.	Develop a clear assurance framework and report progress through the relevant executive and Board committees.

9. Proposed Delivery Approach

1. Confirm executive ownership and establish a small delivery group linked to planned care governance, with input from patient experience, digital, communications, health inequalities and operational teams.

2. Complete a baseline assessment against each national standard across all elective specialties, with priority review of high-volume and high-risk areas including ophthalmology, gastroenterology, orthopaedics, cancer pathways and diagnostics.
3. Use gastroenterology outpatient transformation as a local exemplar and identify which interventions can be adapted for other specialties, including clinic template standardisation, consultant review of follow-up lists, validation, short-notice cancellation backfill and improved use of data.
4. Agree standard wording for referral acknowledgements, waiting list information and appointment communications, including clear advice on whom patients should contact if their condition deteriorates or their circumstances change.
5. Update patient-facing information, including Trust website content, MY CARE information and written materials explaining what patients can expect while waiting.
6. Strengthen the Patient Access Centre improvement plan so that call handling, responsiveness, staff support and patient communication are directly aligned with the minimum standards.
7. Review equality and accessibility implications, including reasonable adjustments, accessible formats, interpreter needs and non-digital alternatives.
8. Develop a Board assurance framework for monitoring delivery, including evidence of compliance, specialty-level progress, patient feedback, complaints themes, Patient Advice and Liaison Service themes, equality impacts and operational metrics.
9. Prepare and publish the required 2026/27 public statement on the Trust's approach to meeting the standards.

10. Board Assurance and Governance

The Board can take **partial assurance with recognised gaps**. Governance and improvement activity are established, with measurable local progress, but the Trust has not yet completed a specialty-level baseline or demonstrated consistent communication, validation, accessibility and deterioration processes across all elective pathways. The assurance table below identifies the evidence required to strengthen this position.

Oversight will sit within Planned Care Quality and Performance Assurance, with executive ownership by the Chief Operating Officer and clinical quality oversight through the Chief Nurse and Chief Medical Officer. The Quality and People Committee will receive quarterly assurance, with Board escalation for material compliance gaps, significant variation, patient harm or risks requiring intervention.

A further report should be presented by January 2027, aligned to NHS England's six-month national stocktake. It should include the completed baseline, specialty delivery milestones, draft public statement, evidence of improved patient communication and a dashboard triangulating access, clinical risk, validation, patient feedback, equality impact and Patient Access Centre responsiveness. The public statement should be approved and published by 31 March 2027.

11. Conclusion

The standards provide a practical framework to ensure that patients waiting for elective care are informed, supported and able to report changes in their condition. The Trust has relevant work underway but must now bring it together into a consistent, evidenced approach. The Board is asked to approve the proposed baseline, delivery and assurance arrangements.

Appendix 1: Detailed Gap Analysis and Implementation Milestones

This appendix provides the detailed Trust-wide gap analysis against the NHS England minimum standards. It sets out the current position, required action and proposed delivery deadline for each area. The milestones are aligned to NHS England's January 2027 national stocktake and the requirement to publish a compliance statement by 31 March 2027.

Area	Torbay current position	Further action required	Proposed deadline
Baseline assessment	Relevant improvement work exists through planned care governance, outpatient transformation, the Access Policy and specialty validation, but it is not yet fully mapped against every national patient experience standard.	Complete a Trust-wide baseline assessment by specialty and pathway, identifying compliance, evidence, variation and gaps.	30 November 2026
Standard patient communication	Letters, text messages, telephone communication and local processes are in use, but content and timing may vary between services.	Agree core wording and minimum content for referral acknowledgement, waiting list updates and appointment information.	31 December 2026
Waiting list validation	Text message validation is in use in some services, including gastroenterology, and has contributed to waiting list improvement.	Standardise validation across high-volume and high-risk specialties, including escalation where patients report deterioration or changed circumstances.	High-risk pathways by 31 December 2026; all specialties by 31 March 2027
Follow-up backlog and clinical risk	Follow-up delays remain a quality and safety concern in some specialties, including ophthalmology, where harm related to delayed follow-up has been escalated.	Ensure each specialty has a process for identifying, monitoring and prioritising high-risk patients with prolonged waits or overdue follow-up.	Immediate controls; evidenced process by 31 October 2026
Patient Access Centre	Recent cultural improvement work has shown positive early indicators, including reduced patient concerns about responsiveness and customer service.	Embed and spread learning from the pilot, focusing on consistent call handling, responsiveness, staff support and patient communication.	Improvement plan agreed by 31 October 2026; quarterly monitoring thereafter
Accessible information	Accessible Information Standard requirements apply, but processes may not	Ensure information is available in accessible formats and that	Audit by 30 November 2026; priority gaps

	be consistently visible across all elective communication.	communication needs are identified and acted on consistently.	closed by 31 March 2027
Digital inclusion	Epic, MY CARE, text messaging and digital appointment communication offer opportunities to improve access and convenience, but not all patients will be able or willing to use digital routes.	Maintain telephone and letter options, monitor equality impact and ensure digital development does not widen inequalities.	Equality review by 30 November 2026; ongoing monitoring from January 2027
Patient-facing information	Information is available in different places, including Trust materials and the website, but may not yet clearly describe the new minimum standards or what patients can expect while waiting.	Update the Trust website and patient materials to explain the minimum standards, what patients can expect and how to contact the Trust if their condition or circumstances change.	31 December 2026
Assurance and reporting	Operational reporting is in place through planned care governance and integrated performance reporting, but compliance with these patient experience standards is not yet brought together within a single assurance framework.	Develop a dashboard or assurance report covering compliance, progress, risks, complaints themes, patient feedback, equality impacts and specialty-level evidence.	First dashboard to QPC by January 2027; public statement by 31 March 2027

Presented to:	Board of Directors			
Title of Report	Our Plan for Better Care			
Date of Meeting	3 rd September 2026	Author	Head of PMO	
Executive Lead	Simon Tapley, Chief Strategy & Planning Officer	Executive Sign Off		
Governance Route	Our Plan for Better Care Oversight Group			
Purpose of paper	For Approval	For Assurance	To Update	For Information
		X	X	
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. The programme is structured across six core domains aligned to the Trust's strategy and signature moves, with clear Executive ownership through SRO-led governance.			
	While progress is being made, particularly within the Living Well in Our Neighbourhoods domain, there is an increasing level of delivery slippage across the programme as a result of competing organisational priorities. As such OPFBC Oversight Group has reviewed and refocused the programme to ensure resources and improvement activity remain targeted on the areas of greatest organisational impact. This has resulted in the streamlining and reprioritisation of work, particularly within Workstreams 2.1 (Clinical Service Reviews) and 2.2 (Improving productivity), focusing effort on high-impact specialties and pathways, strengthening alignment with existing transformation programmes, reducing duplication, and increasing local ownership of productivity improvement.			
	Delivery of Our Plan for Better Care remains critical to achieving the Trust's operational, workforce and financial objectives, contributing £21.9m 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.			
	Programme assurance continues to mature through strengthened KPI development, implementation of a revised			

	RAID escalation framework and evidence collation to support delivery assurance.					
	Overall, the programme is assessed as providing limited to moderate assurance, reflecting early progress alongside the scale and complexity of delivery still required.					
Recommendation	- 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					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
	X	X	X	X	X	X
How this paper supports delivery of the Strategy	Our Plan for Better Care provides oversight of progress in delivering the transformation required for Phase 1 of the Trust's strategy. It demonstrates how programme activity is aligned to the Trust's five signature moves and enabling priorities, ensuring delivery remains focused on achieving the Trust's strategic objectives and intended outcomes.					
Board Assurance						
BAF Ref	Principal Risk	Current Score	Impact of this paper			
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led	
	X	X	X	X	X	
Compliance / Regulatory Requirements	N/A					
Ethical or EDI implications?	N/A					
Assurance rating	Significant	Moderate	Limited	Inadequate		
		X	X			
Assurance rationale	The Limited/Moderate assurance position reflects progress made during the reporting period, balanced against ongoing delivery risks and dependencies that continue to require active management.					
Appendices	Annex 1: Our Plan for Better Care Oversight Assurance Report August 2026					

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 August 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	June 2026	July 2026	August 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		HOLD	HOLD
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 Virtual Ward & Hospital at Home Service workstream improved from Limited to Satisfactory assurance, reflecting increased confidence in delivery. A successful workstream reset and implementation of a comprehensive 90-day improvement plan have strengthened delivery arrangements through clear ownership, milestones and accountability, while reviews of key Virtual Ward sub-speciality pathways have enhanced understanding of clinical priorities and service interfaces, supporting future pathway development and service improvement.
- 2.4 Conversely, the One Devon Shared Finance workstreams assurance position has deteriorated from Satisfactory to Limited due to growing risks to the planned 1 October go-live date. Delays to the Fusion system build, ongoing data migration and code mapping challenges, unresolved system design requirements, and concerns regarding resource capacity and operational readiness continue to impact delivery

confidence. While engagement with SBS remains ongoing and preparations for training, testing and supporting systems continue, significant dependencies and outstanding issues must be resolved to support a safe and successful implementation.

- 2.5 The Acute Bed Base care Review remains on hold with associated improvement activity now incorporated within the Tower programme.
- 2.6 The programme continues to manage 84 open deliverables, with 62% reported as completed or on track and 23% in the planning phase. The proportion of deliverables reported as off track has increased to 15%. Of the 17 deliverables due for completion by the end of July, 9 were achieved, with the remaining delays concentrated within Clinical Services Review activity, Productivity improvement work, and the recovery of activity to pre-Epic levels, with mitigating actions and recovery plans actively underway. In addition, revised completion dates have been approved in month for three deliverables across Productivity, Pathway Review and Redesign and Digital First.
- 2.7 In response OPFBC Oversight group has reviewed and refocused the programme to ensure resources and improvement activity are targeted on the areas of greatest organisational impact. This has resulted in the streamlining and reprioritisation of work, particularly within Workstreams 2.1 - Clinical Service Reviews and 2.2 – Improving Productivity with further review work planned within 3.1- Pathway Review & Redesign. This will refocus effort on high-impact specialties and pathways, strengthen alignment with existing transformation programmes, and increase local ownership of productivity improvement.

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 the closure of some CIP schemes in month Our Plan for Better Care contributes £21.9m of the challenging £54.4m CIP target for 26/27 (40% of original plan). Table 2 summarises the CIP position by workstream
- 3.3 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.
- 3.4 The forecast outturn of all schemes totals £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 Latest Schemes & Forecast Outturn
1.1 Frailty expansion & community bed based care review	£ 1,225,995	£ 1,221,000	£ -	£ -	£ 666,530	£ -	£ 666,530	£ -	£ 554,470
1.2 Acute Bed Based Care Review	£ 1,206,000	£ 1,208,480	£ -	£ -	£ 577,847	£ -	£ 409,524	£ 168,323	£ 630,633
1.4 Neighbourhood infrastructure and support	£ 401,000	£ 321,000	£ -	£ -	£ 160,500	£ -	£ 160,500	£ -	£ 160,500
1.5 Adult Social Care Transition	£ 11,390,000	£ 8,685,592	£ 1,235,207	£ 1,769,662	£ 8,648,359	£ 1,291,183	£ -	£ 7,357,176	£ 37,233
2.2 Improving Productivity	£ 1,150,000	£ 650,000	£ -	£ -	£ 601,266	£ -	£ -	£ 601,266	£ 48,734
4.2 Epic implementation & benefits including MyCare	£ 5,656,312	£ 5,313,823	£ 998,111	£ 1,852,974	£ 4,314,686	£ -	£ 443,809	£ 3,870,877	£ 999,137
5.1 Workforce Transformation	£ 2,896,600	£ 2,896,600	£ 9,793	£ 829,663	£ 2,411,264	£ -	£ -	£ 2,411,264	£ 485,336
5.2 Cultural Transformation	£ 1,574,000	£ 1,574,000	£ -	£ 69,628	£ 1,494,630	£ -	£ -	£ 1,494,630	£ 79,370
Our Plan for Better Care Total	£ 25,499,907	£ 21,870,495	£ 2,243,111	£ 4,521,927	£ 18,875,082	£ 1,291,183	£ 1,680,363	£ 15,903,536	£ 2,995,413
Other Non Pay - Procurement	£ 1,915,000	£ 1,346,370	£ 190,365	£ 815,923	£ 1,710,333	£ -	£ -	£ 1,710,333	£ 363,963
Other Non Pay - Medicines Optimisation	£ 2,600,000	£ 2,461,316	£ -	£ -	£ 2,315,853	£ -	£ -	£ 2,315,853	£ 145,463
Other Care Group Schemes	£ 24,404,877	£ 28,741,586	£ 7,131,582	£ 12,511,113	£ 31,518,499	£ -	£ 6,601,792	£ 24,916,707	£ 2,776,913
Total	£ 54,419,784	£ 54,419,767	£ 9,565,058	£ 17,848,963	£ 54,419,766	£ 1,291,183	£ 8,282,155	£ 44,846,429	£ 0

4 Improvement focuses in month

- 4.1 In month, progress continues against the KPI framework, with completion nearing 100% across the programme. The majority of KPI baselines and metrics have now been agreed, with only limited outstanding activity remaining, primarily relating to delays in Epic data extraction. Targeted actions are in place to secure the remaining inputs and achieve full framework completion.
- 4.2 The revised RAID escalation framework continues to be successfully embedded across the programme, strengthening risk management and governance. Increased use by Workstream Leads and SROs is improving the timely identification and escalation of risks, assumptions, issues and dependencies requiring senior intervention, ensuring appropriate oversight of matters with strategic, cross-programme and organisational impact.
- 4.3 In addition, evidence collation activity is progressing to support delivery assurance, with the PMO systematically capturing and validating evidence for completed deliverables. This is strengthening governance, maintaining a robust audit trail, and ensuring programme outcomes can be clearly demonstrated and evidenced where required.
- 5.2 Limited programme delivery capacity, compounded by the impact of competing organisational priorities, continues to present a significant risk to OPFBC by reducing available resource and specialist expertise across key delivery areas. This has the potential to affect pace of delivery, coordination, governance and programme outcomes. Mitigating actions are underway, with the refocusing of the programme together with plans to establish a dedicated transformation function as part of the wider organisational redesign.

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 -MODERATE assurance as to those matters reviewed.

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

Presented to:	Board of Directors			
Title of Report	Torbay Hospital Tower Block: Fire Safety Improvement Programme			
Date of Meeting	03 September 2026	Author	Dawn Butler Director Estates and Facilities Management Nina Kamalarajan Head of Improvement	
Executive Lead	Joe Teape	Executive Sign Off	26.08.2026	
Governance Route	Executive Fire Safety Oversight Group			
Purpose of paper	For Approval	For Assurance	To Update	For Information
		X		
Executive Summary	The Trust remains fully committed to providing safe, high-quality care in environments that are safe for patients, staff and visitors. As part of this commitment, significant work continues to manage the challenges associated with the Tower Block at Torbay Hospital, one of the oldest buildings within the Trust's estate and a designated Higher-Risk Building under the Building Safety Act. The Board has previously recognised that the Tower Block was intended to be replaced through wider estate redevelopment plans. However, changes to national funding and programme timescales mean that the building will need to remain in use for longer than originally anticipated. The Trust has long recognised and managed the risks associated with operating an ageing building. More recent fire risk assessment work, together with ongoing engagement with Devon and Somerset Fire and Rescue Service, has provided a clearer understanding of the fire safety risks associated with continued occupation and informed a strengthened programme of risk reduction and assurance. A substantial Fire Safety Improvement Programme is now in place, supported by specialist expertise, targeted investment and enhanced governance oversight. This programme includes strengthened fire risk assessments, improvements to fire safety systems and infrastructure, enhanced staff training and preparedness, updated emergency plans, and more robust assurance and compliance arrangements. Together, these measures are designed to reduce risk as low as			

	reasonably practicable, strengthen organisational resilience and maintain safe operational conditions within the building. The Fire Safety Improvement Programme has strengthened operational fire safety within the Tower Block through clearer governance, structured action tracking, departmental fire safety folders, twice daily checks, enhanced Fire and Evacuation Warden training, Local Emergency Action Plans, evacuation action cards, grab bags, patient tracking documentation, simulation exercises, fire response team training and improved evacuation equipment readiness. The programme has also introduced a patient placement and dependency monitoring SOP, ensuring that patient dependency, evacuation capability and oxygen requirements are assessed before admission, reviewed at least twice daily and escalated through established governance arrangements. Collectively, these improvements provide greater assurance that environmental, operational and patient-related fire safety risks are being actively managed, tested and monitored. The Trust has secured £1.8m of Estates Safety Fund (ESF) funding for 2026/27 to progress the first phase of the Tower Block fire safety programme and is continuing to work closely with NHS England to secure the additional investment required to deliver the full programme of enhanced compartmentation and fire safety improvements. Current funding is supporting design development, surveys, regulatory submissions and early fire safety works, while the emerging programme is being developed to enable remediation works to be delivered through a carefully phased programme. NHS England colleagues remain engaged and supportive, recognising the importance of these critical safety works and the need for further investment as scope and costs become more certain. While the age, configuration and clinical use of the Tower Block mean that fire safety risk requires ongoing management, significant progress has been made in strengthening controls, testing their effectiveness and improving organisational preparedness. Occupancy, patient dependency and evacuation capability continue to be reviewed to support the safe operation of the building, alongside regular simulation exercises and ongoing engagement with Devon and Somerset Fire and Rescue Service. These measures provide increasing assurance that fire safety risks are being actively monitored, tested and managed while longer-term improvements are progressed. The Trust continues to review occupancy, patient dependency, evacuation capability and operational controls as part of an ongoing programme of improvement, recognising that assurance will continue to develop as further testing,

	remediation works and risk-reduction measures are completed. Alongside this work, the Trust continues to work with NHS England to secure the investment required to deliver further fire safety improvements and support the long-term modernisation of the estate.					
Recommendation	Board Assurance: The Board is asked to: - take assurance that the Trust has strengthened fire safety governance, operational controls, staff preparedness, evacuation planning, patient dependency monitoring and regulatory engagement through the Tower Block Fire Safety Improvement Programme - note that, while strengthened controls and mitigation measures are now in place, the age, configuration and clinical use of the Tower Block mean that ongoing management of fire safety risk and further estate investment remain necessary - support the continuation of executive oversight, regulatory engagement and capital planning arrangements to ensure risks continue to be reduced as far as reasonably practicable while longer-term solutions are progressed.					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
		X		X		
How this paper supports delivery of the Strategy	This paper supports the Trust Strategy by helping to maintain safe and resilient acute care within the Tower Block while longer-term estate solutions are progressed. It also strengthens staff preparedness and joined-up working by bringing together clinical, operational, estates, fire safety, governance and partner input to manage risk in a coordinated and evidence-led way.					
Board Assurance						
BAF Ref	Principal Risk	Current Score	Impact of this paper			
2878	25	25	Strengthened controls, governance, mitigation actions and ongoing investment required to reduce risk as far as reasonably practicable.			

Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led
	X				
Compliance / Regulatory Requirements	The paper supports the Trust's compliance with the Regulatory Reform (Fire Safety) Order 2005 , Firecode and Health Technical Memoranda 05 series, by setting out a structured approach to fire risk assessment, mitigation, governance and regulatory engagement for the Tower Block.				
Ethical or EDI implications?	The ethical focus of the paper is on maintaining patient, staff and visitor safety through transparent, proportionate and evidence-based management of fire safety risk.				
Assurance rating	Significant	Moderate	Limited	Inadequate	
			X		
Assurance rationale	The assurance rating is assessed as Limited. Significant progress has been made in strengthening fire safety governance, operational controls, staff preparedness, evacuation arrangements and risk monitoring. This reflects a deliberate approach to acting on a fuller understanding of the risks associated with continued occupation of the building and ensuring that mitigations remain proportionate and effective. These measures provide increased assurance that fire safety risks are being identified, managed, tested and monitored through a structured programme of improvement. The Limited assurance rating reflects the fact that the Tower Block is an ageing healthcare building which will remain in use for longer than originally anticipated. While extensive mitigations are now in place and continue to be tested, further investment in enhanced compartmentation and wider estate improvements will be required to achieve a longer-term reduction in estate-related risk. The rating therefore reflects the inherent characteristics of the building and the continuing requirement for capital investment, rather than any lack of progress in implementing mitigating actions.				
Appendices	Nil				

Torbay Hospital Tower Block: Fire Safety Improvement Programme

1. Purpose of the Report

The purpose of this report is to provide the Board with an update on the Trust's ongoing management of fire safety risk within the Tower Block at Torbay Hospital, the progress being made through the Fire Safety Improvement Programme, and the interim measures being implemented while longer-term estate redevelopment solutions are pursued.

The report provides assurance on:

- the current position in relation to fire safety risks within the Tower Block
- progress made through the Trust's Fire Safety Improvement Programme
- the actions being taken in response to the Primary Fire Risk Assessment and subsequent review of fire safety arrangements
- interim risk reduction measures being implemented to support the continued operation of the building
- the Trust's continuing commitment to providing safe care in safe environments.

The report should be read in the context of the Trust's broader estate strategy. It recognises the realities of operating modern healthcare services within an ageing building and sets out the actions being taken to support safe care while longer-term improvements to the estate are progressed.

2. Background

The Tower Block is one of the oldest parts of the Torbay Hospital estate. It is more than 50 years old and was designed and constructed to standards that differ from those expected of modern healthcare facilities. The building supports a range of clinical and operational services, including areas providing overnight patient accommodation. Its height and use also mean that it is classified as a Higher-Risk Building under the Building Safety Act, requiring additional focus on building safety, fire safety and regulatory assurance.

The Trust has recognised and managed the risks associated with the Tower Block over a number of years. These include the age and condition of the building, the complexity of its fire safety arrangements, the needs of patients occupying parts of the building, and the operational challenges associated with fire safety management in an acute healthcare environment.

The completion of the Primary Fire Risk Assessment has provided a clearer, evidence-based understanding of the fire safety risk profile within the Tower Block.

While risks associated with the age, design and condition of the building have been recognised and managed over time, the latest assessment has provided a more comprehensive picture of how those risks interact with patient dependency, evacuation capability and operational use of the building. The assessment was undertaken in accordance with the principles of HTM 05-03 Part K and considered general fire precautions, fire safety management arrangements, patient dependency, staffing and evacuation capability.

The assessment identified areas where further action, assurance and risk mitigation were required. In response, the Trust has strengthened its programme of operational, technical and governance controls, supported by specialist advice, engagement with the Fire and Rescue Service and oversight through established governance routes.

Patient, colleague and visitor safety remains the Trust's overriding priority. The Trust is taking an evidence-based and proportionate approach, informed by clinical, operational, estates, fire safety, legal and governance advice.

Separately, the Trust has recently completed a significant programme of externally funded estates safety works to the Tower Block, including structural remediation to areas of the external façade and the installation of a new roof covering. These works were delivered through national Estates Safety Funding and addressed specific building condition and safety risks. While complementary to the Trust's wider approach to estate stewardship and safety, they are separate from the fire safety matters considered within this paper.

3. Fire Safety Improvement Programme

Fire safety remains a critical priority for the Trust and is a central part of the wider programme to manage the risks associated with the Tower Block. The Trust has moved beyond routine compliance monitoring into a structured Fire Safety Improvement Programme, bringing together fire safety, estates, clinical, operational, emergency preparedness, health and safety, legal and governance expertise.

The programme provides a single framework for assessing risk, tracking delivery of actions, strengthening assurance and identifying further risk reduction opportunities.

It is designed to provide assurance that the Trust is taking a systematic approach to meeting its obligations under Firecode and relevant Health Technical Memoranda, while working towards the highest achievable standard of compliance.

The programme includes:

- completion of Primary and Secondary Fire Risk Assessments for the Tower Block in accordance with HTM 05-03 Part K
- a Strategic Fire Safety Action Plan with Red, Amber and Green reporting to track progress against identified actions

- strengthened fire safety governance, including clearer roles, responsibilities and escalation routes
- executive-level oversight through the Fire Safety Recovery Programme
- regular engagement with the enforcing authority at tactical and strategic level
- multi-disciplinary oversight through operational, clinical, estates and risk governance routes
- development of a fire safety performance dashboard covering training, audit completion and environmental checks.

This strengthened approach provides greater assurance that fire safety risks are being identified, prioritised, monitored and acted upon through a formal governance structure.

The Trust continues to maintain an open and constructive relationship with Devon and Somerset Fire and Rescue Service and other relevant regulatory bodies. There are currently no enforcement notices or formal regulatory actions in place relating to the matters described within this report. The Trust continues to work proactively and transparently with Devon and Somerset Fire and Rescue Service and other relevant regulators, sharing progress and seeking assurance regarding the effectiveness of implemented controls.

4. Assurance Regarding Patient and Staff Safety

The Trust remains fully committed to providing safe, high-quality care in environments that are safe for patients, staff and visitors. Operational use of the Tower Block is being supported by ongoing risk assessment, specialist fire safety advice, regulatory engagement, strengthened operational controls and a structured programme of improvement.

The Trust recognises that fire safety in an acute healthcare environment requires particular consideration of patient need, staffing, evacuation arrangements, escape routes and the effectiveness of fire safety systems. These factors have been considered through the Primary Fire Risk Assessment and are being addressed through the Fire Safety Improvement Programme.

The Trust will continue to communicate openly and proportionately. Communication with colleagues working in the Tower Block will be clear, supportive and focused on the actions being taken. Any decision regarding communication with patients, families or the wider public will be considered through the Executive Team and, where appropriate, the Board, informed by clinical, legal, communications, estates and fire safety advice. This approach aligns with the Trust's wider commitments to transparency and the principles set out within its Duty of Candour arrangements.

The key assurance for the Board is that fire safety risk within the Tower Block is being actively managed through an evidence-led programme of technical,

operational and governance controls. The Trust continues to test evacuation capability through simulation exercises, ward-based assurance processes and patient dependency monitoring, working closely with Devon and Somerset Fire and Rescue Service and specialist advisers to evaluate the effectiveness of existing controls and identify opportunities for further improvement. Occupancy, patient dependency and evacuation capability continue to be reviewed to support the safe operation of the building while longer-term improvements are progressed. Patient, colleague and visitor safety remains the overriding priority.

5. Longer-Term Estate Strategy

The Trust's immediate priority is to maintain the safe operation of the Tower Block through robust interim risk reduction measures. However, this does not remove the need for longer-term estate investment.

The condition of the Tower Block reinforces the case for continued capital investment in the Torbay Hospital site. The report should be read in the context of the Trust's broader estate strategy and sets out the actions being taken to support safe care while longer-term improvements to the estate are progressed.

The replacement or significant modernisation of ageing infrastructure remains central to the Trust's strategic ambition. Modern healthcare environments are necessary to support patient experience, clinical outcomes, safe staffing, operational resilience, digital transformation and long-term sustainability.

The Trust will continue to work with regional and national partners to secure the capital investment required. In the interim, the Board will continue to receive updates on the Fire Safety Improvement Programme, delivery of remedial actions, emerging risks, regulatory engagement and the wider estate strategy.

The Trust has secured £1.8m of Estates Safety Fund funding for 2026/27 to support the first phase of the enhanced fire safety programme. This funding will enable detailed design work, surveys, approvals and early remediation activity. The Trust is continuing to work closely with NHS England on the development of a longer-term programme of enhanced compartmentation works which will require careful phasing and operational planning to enable remediation activity to take place while maintaining patient services wherever possible.

Through this balanced approach, the Trust is addressing immediate safety requirements while maintaining a clear strategic focus on securing the modern healthcare facilities required for the population of Torbay and South Devon.

6. Conclusion

The Trust recognises that the Tower Block requires active risk management, strengthened governance and sustained investment. Significant progress has been made in strengthening operational controls, staff preparedness, evacuation arrangements, regulatory engagement and executive oversight. This reflects a

deliberate approach to acting on a fuller understanding of the risks associated with continued occupation of the building and ensuring that mitigations remain proportionate and effective.

However, the age and configuration of the Tower Block mean that ongoing risk management, assurance and investment remain necessary. The Trust continues to reduce risk as far as reasonably practicable through enhanced mitigation, testing and assurance processes while pursuing the investment required to deliver further fire safety improvements and longer-term estate solutions. The Board is asked to take assurance from the measures now in place, while recognising the need for continued oversight and investment to support the safe operation of the building in the years ahead.

Presented to:	Trust Board					
Title of Report	Committee Chairs' Report					
Date of Meeting	3 rd September 2026		Author	Sophie Byrne, PA to Chairman		
Executive Lead	Sarah Fox, Corporate Governance Manager		Executive Sign Off	No		
Governance Route	n/a					
Recommended Action	For Approval	For Assurance	To Update	For Information		
		X				
Executive Summary	The attached reports provide 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 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					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
						X
How this paper supports delivery of the 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.					
Board Assurance						
BAF Ref	Principal Risk		Current Score	Impact of this paper		
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led	
					X	
Compliance / Regulatory Requirements	Terms of authorisation, NHS England licence and regulations National policy, guidance					
Ethical or EDI implications?						
Assurance rating	Significant	Moderate	Limited	Inadequate		
		x				
Assurance rationale	The Chairs' reports detail the rationale for the different assurance ratings.					
Appendices	Appendix 1 - Finance and Operations Committee Chair's Report Appendix 2 – Quality and Assurance Committee Chair's Report					

Committee Chairs' Report – 26 August 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:

- Operational Performance Report – LIMITED Assurance
- Electronic Patient Record (EPR) Progress and Finance Report – MODERATE Assurance
- Month 4 Finance Report inc. ASC Debt Update and WTE and Pay Variance – MODERATE/LIMITED Assurance
- Capital Spend and Planning – 26/27 to 30/31 – MODERATE Assurance
- 2027/28 Business Planning Update – MODERATE Assurance
- Trust Investment Group Update/Business Cases – SIGNIFICANT Assurance

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

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

ASSURANCE RECOMENDATION:

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

ALERT:

- Having developed a strategic oversight view, the FOC determined that it should refocus its more immediate work across the next quarter with bespoke scrutiny of critical IY delivery issues:
 - UEC
 - RTT
 - CIP
 identifying what's driving poor performance, and what the Trust are doing about them
- EPIC data quality analysis is now complete and has concluded that incoherence across the plethora of aged systems together with the application of business rules masked real RTT positions; the true position is newly noted (approx 3% lower than previously assumed), based on the improved data quality, and now requires new trajectories to meet Mar 27 targets
- Productivity improvements to planned levels (and in some cases, beyond) across directorates for the remainder of the performance year will be crucial to IY delivery success while

	also returning expected income levels to plan; FOC to scrutinise 'top 9' RTT delivery plans • FOC to scrutinise UEC demand drivers and variation within next quarter • Planning for 27/28 has begun; FOC will wish to scrutinise the strategic assumptions upon which plans are being formed, together with some sensitivity analysis on them
ADVISE:	• GIRFT support provided, identifying opportunities for UEC improvement beyond internal work done on our Corridor Care project • Regional 'red flag' dashboard introduced to monitor SW Trusts' financial performance • FOC scrutiny of Devon Procurement System approach to / use of competition waivers deferred to Sep
ASSURE:	• Expect greater levels of BAF assurance in Sep for UEC and RTT • CIP plans' maturity continues (now £49.2m against £54.4m target), although risk of full delivery remains high with CIP recurrent run rate behind plan currently; overall base case outturn risk sits at £11.6m (also includes IY ASC and CHC overspends, plus provision for lost income)
RISK:	• Risk that combined programme of challenging IY, and complex strategic, objectives is overloading Executive; may need to defer or stop elements or whole components of Q3/Q4 activity to achieve priority objectives • Risk that change fatigue is increasing among some senior staff within directorates; personal support may be required
CELEBRATE OUTSTANDING:	• The way that the Executive has invited, and embraced, external support to help guide our focus on IY improvement opportunities for some of our current, and seemingly most intractable, problems

Committee Chairs' Report – 25th August 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:

- NHSE End of Year Safe Staffing Report 2025/2026 – SIGNIFICANT Assurance
- Feedback on Sexual Safety Task and Finish Group – LIMITED Assurance
- Torbay Adult Social Care Local Account Summary 25/26 – MODERATE Assurance
- Quality and Risk Triangulation Report – LIMITED Assurance
- Working Lives of Resident Doctors (including GOSW) – MODERATE Assurance

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

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

ASSURANCE RECOMENDATION:

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

ALERT:

- Slow progress against internal audit action plan for Sexual Safety in the Workplace. Lack of clarity on actions to be taken to address concerns about staff not raising issues or speaking up and perceived lack of confidence in organisational response, policy not updated with escalation process, training compliance whilst improved not at reasonable level. Committee asked to see progress update against action plan in October.
- Verbal update received on MS Service which remains in a vulnerable position. Considerable backlog of patients through the nursing pathway who are yet to receive consultant review. Risk stratification ongoing to ensure priority by clinical need and no significant patient harm identified as yet. 12-week recovery plan in place which committee has asked to see progress update on alongside wider paper outlining current risk and sustainability status on single-handed specialties within the Trust (which is due to QPC in October). Recognition that networked solutions across the Peninsula for fragile services may offer a more sustainable approach. ICB observer agreed to reflect this back to relevant ICB

	colleagues particularly in relation to support for MS Service. • M4 workforce overspends across all care groups. Committee asked that the next workforce performance report describes the actions in place to address the increasing reliance on temporary staffing. • Workforce strategy will be presented to QPC in Sept for recommendation to Board. Linked to continuing workforce overspends, it was noted that QPC/Board is not currently sighted on pipeline strategy (targeted recruitment, training and development to address substantive vacancies and new models of care aligned to Trust strategy).
ADVISE:	Committee received a newly formatted Quality and Risk Triangulation report based on escalation from the IQPR and Quality dashboard. Discussion on whether the quality dashboard is pulling through the appropriate metrics to highlight real areas of concern. Committee welcomed the new format and is keen to see this report mature. Internal audit reports received for information: Pre-employment checks; Bank and Agency requests and approvals. Committee requested follow-up on closure of management actions in November.
ASSURE:	Committee took: • significant assurance on End of Year Safer Staffing Report. Compliant against all 12 domains for safer staffing governance and process. Further work planned with NHSE to look at unavailability reporting and rostering. • moderate assurance on the Torbay Adult Social Care Local Account. Well received by committee - a person centred, accessible overview of adult social care provision. Feedback given on the opportunity to highlight to the public the real challenges facing the service, the organisational learning over the last 12 months and future priorities. • moderate assurance overall on the Working Lives of Resident Doctors (inc. GOSW) with limited assurance for annual leave compliance (new NHSE standard – TSD task and finish group in place) and safe working hours/rota resilience (exception reporting patterns, workload intensity, out-of-hours supervision concerns and rota gaps are material risks to resident doctor wellbeing –

	targeted actions in place, yet to see sustained improvement) • limited assurance on the Quality and Risk Triangulation report. Work is needed to review quality dashboard metrics, RAG ratings and strengthen reporting of improvement trajectories and outcomes. Report escalated the following: number of patient incidents, reported incidents (death and severe), number of healthcare associated infection (e-coli and C.Diff), patient complaint acknowledgement within 3 days, mixed sex accommodation breaches, maternity 3rd and 4th degree tears, medication incidents (and resulting in moderate or more severe harm). Improvement actions were presented but not timebound.
RISK:	
CELEBRATE OUTSTANDING:	

Presented to:	Finance and Operations Committee			
Title of Report	Operational Performance Report			
Date of Meeting	26 August 2026	Author	Chief Operating Officer	
Executive Lead	Chief Operating Officer	Executive Sign Off	Chief Operating Officer	
Governance Route	Trust Executive Group, Finance and Operations Committee, Trust Board			
Purpose of paper	For Approval	For Assurance	To Update	For Information
		X		
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 key measures for UEC performance and Elective performance.			
	Urgent & Emergency Care (UEC) Performance • UEC performance remains below the operational plan trajectory, with July 4-hour performance at 63.9% against a 75.0% plan and 12-hour waits worsening to 12.9% against the 6% target. • Overall all-type UEC attendances remain broadly in line with prior year, but ambulance demand and UTC demand increased in July, with average handover times remaining above trajectory and a further deterioration noted in August. • Development of the SDEC plan is progressing with acute medicine, with estates and infrastructure requirements being assessed and regional UEC capital funding submitted as a key enabler. Expected delivery of this programme is November 2026, however, plans to expedite are being explored • GIRFT reviews undertaken through August, including a missed opportunities audit which identified significant opportunity to manage 45% of demand through co-located UTC and further opportunities to deliver greater impacts through streaming to alternatives and maximising frailty SDEC. Plan in development to deliver co-located UTC with expected launch in October 26 at latest.			
	Elective Performance Referral To Treatment (RTT) • RTT waiting list growth remains broadly within the levels anticipated through Epic go-live modelling; however, significant data quality issues have been identified and continue to affect the reported position. Expected final position on data quality at end of August 26.			

	• RTT performance has deteriorated, driven by post-Epic data quality issues and a slower-than-planned recovery to pre-Epic activity levels. It is expected that final data quality review will identify that previous reporting had artificially inflated RTT performance by minimum of 3%. • Additional activity plans are in place for key specialties, with forecast delivery, financial alignment and expected performance impact to be confirmed with the finance team. • Once data quality issues finalised. Full recovery plan and updated trajectory to be shared internally. Commitment must be maintained to meeting end of year position at 73.8% RTT. Cancer • 28-day Faster Diagnosis Standard performance continues to improve but is behind trajectory. Performance expected to return to trajectory in September. • 62-day cancer performance improving month on month however remains significantly behind plan and recovery trajectory, despite expected improvements in dermatology. • Current end of Q2 forecasts stronger performance than at end of Q4 25/26 which should improve NOF rating on cancer metrics • 31-day cancer performance remains broadly stable and close to target, with continued monitoring required to sustain delivery. Diagnostics • Diagnostic performance (DM01) remained a challenge throughout FY25/26, and this has continued into FY26/27. The June national reported position of patients waiting over 6 weeks for diagnostics is 24.1% which is ahead of trajectory of 27.7%. This is a continued improved position from April (39.4%). The forecast for July is remaining ahead of plan (25.6%) currently at 19.1% (as at 13/08). • Risks have been identified in DEXA and MRI with plans in place.					
Recommendation	It is recommended that the Committee AGREE the overarching assurance ratings to those matters reviewed.					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
		X		X		
How this paper supports	Ensures timely access to services that are safe and provide good patient experience.					

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Torbay and South Devon
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delivery of the Strategy					
Board Assurance					
BAF Ref	Principal Risk		Current Score	Impact of this paper	
BAF PF	CRR46	20	Current position and future forecast, including actions		
	CRR570	20			
	CRR 52	15			
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led
	X		X	X	
Compliance / Regulatory Requirements	National performance compliance				
Ethical or EDI implications?					
Assurance rating	Significant	Moderate		Limited	Inadequate
				X	
Assurance rationale	Currently behind plan in most areas of operational plan when compared to expected trajectory				
Appendices					

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, the performance oversight processes led by NHSE South-West, and the contract oversight processes overseen by NHS Devon ICB.
2. Under the NHS Oversight Framework the Trust is currently in Segment 4 for Q4 2025/26; with an average score of 2.60 and ranked 102 out of 134 providers across the domain scores covering access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity. This is a worsening position from the Q3 2025/26 position where the Trust was in Segment 3 with an average score of 2.49 and a ranking of 83. As the Trust is reporting a financial deficit or in receipt of deficit support our organisation's segment can be no greater than 3. Scores across the performance domains can be found below.

Performance domains

Access to services	4 - Low performing
Finance and productivity	4 - Low performing
Effectiveness and experience	1 - High performing
Patient safety	2 - Above average
People and workforce	3 - Below average

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3. Q1 2026/27 segmentation will be available in August, that will incorporate the new metrics now agreed following consultation. Following this, we will be able to provide a 'shadow forecast score' using published metric methodology applied to national benchmark statistics and latest Trust performance data.
4. As part of the national sign off for the electronic patient record 'go live' on 3rd April 2026 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. Due to ongoing validation work this has been extended to August 2026. National teams will continue to use the Trust numbers from our weekly submission on the 29th March. As such, national benchmarking data for the period of April to July will not reflect the Trust current position for RTT.

2. Purpose of report

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

3. National Benchmarking

6. The table below reflects latest published data (as at 17/8/26) 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	Elective proportion waiting over 52 weeks	Cancer faster diagnosis	Cancer 31-day treatment	Cancer 62-day combined	Diagnostics proportion waiting over 6 weeks	A&E 4-hour performance	A&E 12-hour performance
	Rank out of 118	Rank out of 118	Rank out of 116	Rank out of 116	Rank out of 116	Rank out of 118	Rank out of 117	Rank out of 117
	Jun 2026	Jun 2026	Jun 2026	Jun 2026	Jun 2026	Jun 2026	Jul 2026	Jul 2026
Torbay And South Devon NHS Foundation Trust	66.4% 50	1.8% 84	57.1% 115	93.5% 73	53.6% 114	25.4% 82	63.9% 112	12.9% 86

Metric	Previous available rank	Latest available rank	Improved/ Worsened
RTT 18-week wait	48 (May 2026)	50 (June 2026)	Worsened
RTT 52-week wait	88 (May 2026)	84 (June 2026)	Improved
Cancer FDS	117 (May 2026)	115 (June 2026)	Improved
Cancer 31-day wait	84 (May 2026)	73 (June 2026)	Improved
Cancer 62-day wait	114 (May 2026)	114 (June 2026)	No Change
Diagnostic wait over 6wks	101 (May 2026)	82 (June 2026)	Improved
UEC – 4-hour wait	108 (June 2026)	112 (July 2026)	worsened
UEC 12-hour wait	69 (June 2026)	86 (July 2026)	worsened

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4. Urgent and Emergency Care

Oversight Framework Metric	Current NOF score	Performance Position at point of score	Current position	Forecast End of Quarter Position	Forecast Improvement or Worsening
Percentage of emergency department attendances admitted, transferred or discharged within four hours score	3.64 Q4 2025/26	66.97%	63.9%	66%-68%	Worsening/Stable
Percentage of emergency department attendances spending over 12 hours in the department score	2.26 Q4 2025/26	10.6%	12.9%	10%	Improving

UEC key performance metrics

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	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Urgent and Emergency Care																	
Ambulance handovers - time lost over 15 mins - Actual (hours)					725	943	1823	810	624	559	1283	621	755	952	1390	1363	1343
Ambulance handovers - time lost over 15 mins - Plan														641	676	623	681
Average handover time (mins) - Actual					32	38	60	33	29	27	45	30	31	38	47	49	47
Average handover time (mins) - Plan			30 mins		35	34	38	42	42	45	42	41	37	30	30	30	30
Total average time in ED (hours/minutes) - Actual			Reduction		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		457	426	655	585	549	520	918	740	734	676	839	805	950
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan														394	655	469	423
Percentage of patients waiting over 12 hours in ED - Actual					6.5%	6.1%	9.7%	8.5%	8.3%	7.5%	13.6%	12.1%	10.6%	9.8%	11.7%	11.1%	12.9%
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%		73.5%	74.1%	68.3%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.2%	64.7%	65.3%	63.9%
UEC 4-hour target (RAG against local trajectory to national target) - Plan			82%		76.0%	76.0%	76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%	75.0%
% patient discharges pre-noon - Actual					27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	14.6%	13.3%
% patient discharges pre-noon - Plan			33%		33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Percentage of inpatients with No Criteria to Reside (acute) - Actual					8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	13.7%	16.5%
Percentage of inpatients with No Criteria to Reside (acute) - Plan			<5%		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

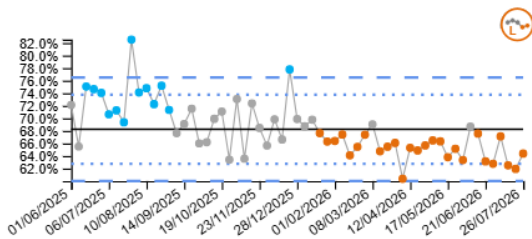
7. The Trust did not achieve the operational plan trajectory of 75.0% for 4-hour performance with performance for July 2026 at 63.9%. As part of the Epic go-live submission the forecast was for 4-hour performance to remain at the levels seen in March 2026 prior to go live due to the expected delays within the Emergency Department and with flow across the wider Trust. The Trust has seen a 2.7% reduction from the March performance to July but has seen an improvement to 64.2% so far in August (as at 11 August 2026).

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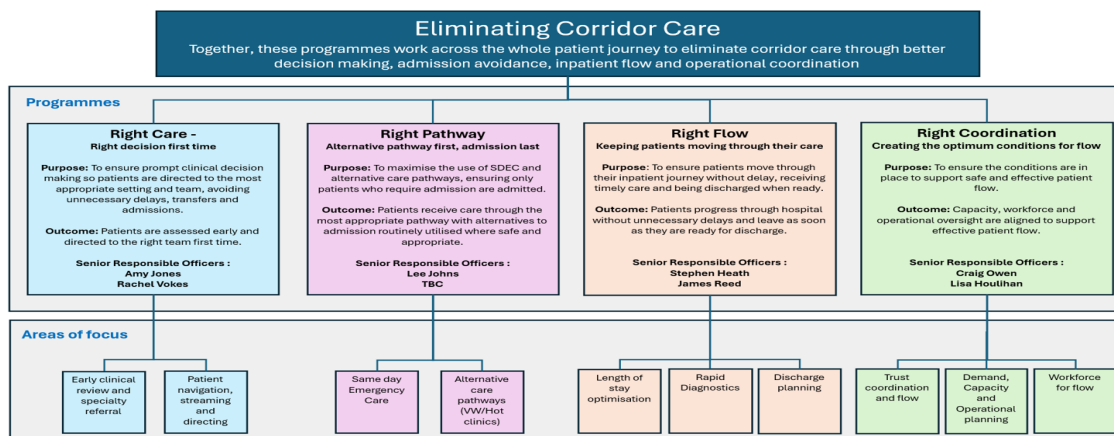
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A&E 4hr Performance - All Types (inc booked)



Data source: [Metric Focus: UEC - NHSE SW Weekly Performance Dashboard - Power BI](#) week ending 26 July 2026

8. In July 2026, the Integrated Care Organisation (ICO) managed 11,507 all type UEC attendances (July 2025 11,381). Significant activity growth been experienced at Newton Abbott UTC (increase of 5.9% from July 2025 to July 2026). The Emergency Department at Torbay Hospital however recorded 7,357 type 1 attendances which is a 1.4% decrease in activity from July 2025, however it remained the third busiest month for demand on record.
9. The number of patients waiting longer than 12 hours for admission or discharge in the emergency department increased to 12.9% (from 11.1% in June) of total attendances; Trust remains off target (6%), and the assurance rating remains as limited. The average time in department for both admitted and non-admitted patients has worsened through quarter 1 with average admitted time in department increasing to 11 hours and 18 mins, while the average non admitted time has increased to 5 hours and 41 minutes. These are both contributing to the worsening in 12-hour performance and corridor care.
10. Corridor Care remains a focus for the Trust to improve patient flow and patient experience. Senior Responsible Officers have been identified with support provided by the Improvement Team. A revised UEC improvement plan has been created and agreed covering 4 key pillars. Work is ongoing to identify and numerate the performance measures expected to be realised as the work progresses. An outline for the plan can be seen below and the full plan can be shared as required.



11. A key element of this plan will be the creation of a new Unscheduled Care Village on Level 2 of the Torquay Hospital site. This move will support the move of EAU4 from Level 4 of the Tower down to Level 2 and co-located with the other elements of AMU. Work is ongoing to identify the workforce requirements, create the pathways and the

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SOPs with an aim to manage up to 30% of the current medical 'take' through a new SDEC model with protected capacity. The work is also including the linking of virtual ward capacity, care navigation (aligned to the regional UEC letter), community capacity including UCR, and speciality in reach for cardiology, gastroenterology and respiratory. Plans remain in their infancy at present, and the expectation is that any launch of this service change would commence in November 26 based on capital works.

12. The Trust has worked alongside Getting it Right First Time (GIRFT) through August to support a re-design of the UEC improvement plan and to provide external check and challenge on our current UEC position. The Trust worked alongside local GIRFT colleagues in the first two weeks of August to support their understanding of our demand challenges, current service provision and the plan created following the corridor care event.
13. On the 11th and 12th of August GIRFT undertook a missed opportunities audit which recognised that a minimum of 45% of the activity currently being managed within the ED would be more appropriately managed within a UTC. The audit also identified that of 96 ambulance conveyances audited, 31 missed opportunities to be diverted to alternative services including the frailty service and UCR. The audit also identified that of the 44 patients sent to ED by primary care, 111 or other health care practitioners, only 5 required triage from ED and only 1 required ED care and treatment.
14. Further information and next steps is provided within the eliminating corridor care papers and the response to the regional UEC letter paper. The Trust is now working with clinical and operational leaders to investigate the opportunities of implementation a co-located UTC model and the main ED with an aim to have a clear plan in place by the end of August.

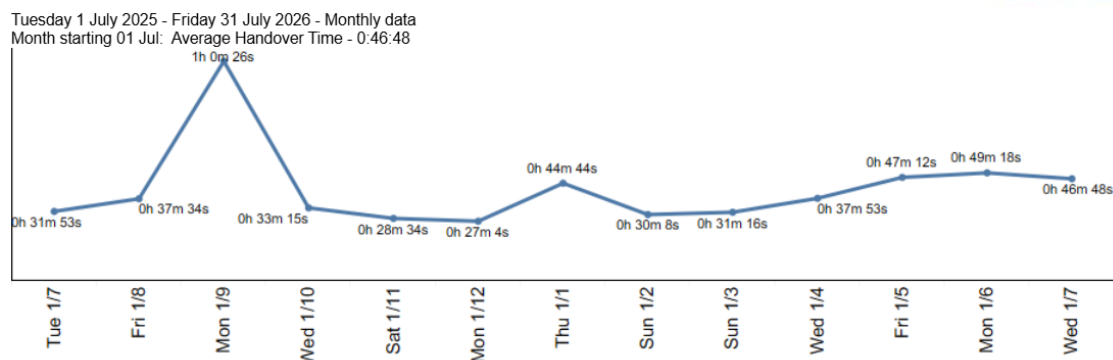
Ambulance Handover Delays

15. The total number of ambulance conveyances to the Trust in July 2026 was 2494, a 2.9% increase on handovers from July 2025 and 5.8% increase from last month.
16. The Trust ambulance handover position improved through July to an average of 46 minutes and 48 seconds per handover. The current position has worsened in August with performance up to the point of publication to an average of 55 mins 19 secs against a trajectory of 30 minutes. During July there was a decrease in the total number of delays over 45 minutes from 783 in June to 729. Continued challenges with ongoing heatwaves continue to drive additional demand and acuity with SWASFT declaring several business continuity incidents in June and July.

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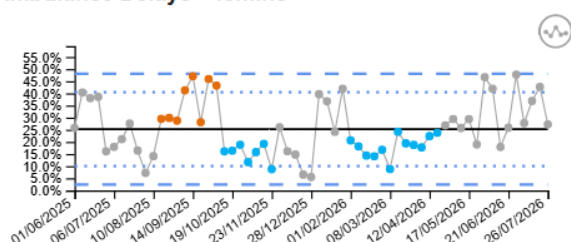


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Data Source: Ambulance average handover time: Tableau dashboard E1046

Ambulance Delays >45mins



17. 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

Operational Plan revision

In July 2026, the Trust was required to resubmit the performance and activity operational planning trajectories for planned care.

The resubmission is in response to known variations due to Epic go live and to submit a plan that reflect recovery to agreed standards. The key changes are:

- Apply the revised trajectory for Cancer 28-day standard faster diagnosis in live with submitted recovery plan to region NHSE.
- Amended RTT performance trajectory that reflects Q1 actual position and rephasing of recovery to maintain delivery of the year-end target of 73.8%
- Increase the tolerance for 52-week breaches at year end to 1% of total PTL
- Amend the volume of RTT clock start pathways reflecting initial findings that clock starts reported through Epic have reduced. Further work has continued in this area to describe the counting methodology changes between legacy and Epic RTT reporting.

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		04PLANM01	04PLANM02	04PLANM03	04PLANM04	04PLANM05	04PLANM06	04PLANM07	04PLANM08	04PLANM09	04PLANM10	04PLANM11	04PLANM12
		Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
		30/04/2026	31/05/2026	30/06/2026	31/07/2026	31/08/2026	30/09/2026	31/10/2026	30/11/2026	31/12/2026	31/01/2027	28/02/2027	31/03/2027
metric	count												
New RTT pathways (clock starts)	Count	9,289	9,319	10,010	10,566	8,425	9,790	10,254	9,059	8,335	10,036	9,418	10,065
% > 52 weeks		2.4%	2.7%	3.1%	2.9%	2.7%	2.5%	2.3%	2.0%	1.7%	1.4%	1.1%	1.0%
RTT % within 18 weeks													
Percentage of people waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	Percentage	63.30%	60.80%	57.00%	59.00%	61.00%	62.00%	63.50%	65.50%	68.50%	69.00%	71.75%	73.80%
	Percentage	47.98%	45.47%	57.45%	72.98%	76.99%	82.92%	81.02%	81.16%	81.69%	80.63%	81.02%	80.88%

Oversight Framework summary

Oversight Framework Metric	Current NOF score	Performance Position at point of score	Current position	Forecast End of Quarter 1 Position	Forecast Improvement or Worsening
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score	2.16 Q4 2025/26	66.4%	56.8%	62%	Worsening
Percentage of patients waiting over 52 weeks for elective treatment score	3.03 Q4 2025/26	1.8%	3.2%	2.7%	Worsening

Planned Care key Performance metrics

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS													
Torbay and South Devon NHS Foundation Trust													
Data RAG rated against monthly Operational Plan trajectory	Target March 2027	13 month trend	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Bold number = national data													
Elective Care													
RTT 78 week wait incomplete pathway - Actual	0		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
RTT 65 week wait incomplete pathway - Actual			97	105	110	109	84	94	83	76	47	76	135
RTT 65 week wait incomplete pathway - Plan	0		83	63	43	23	3	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual			615	618	615	647	607	663	604	607	600	799	993
RTT 52 week wait incomplete pathway - Plan	292		780	728	673	586	505	449	383	327	268	805	941
RTT % Incomplete pathways <18 wks - Actual			69.7%	69.5%	70.4%	69.3%	68.7%	67.5%	67.0%	66.8%	66.4%	66.4%	66.4%
RTT % Incomplete pathways <18 wks - Plan	73.8%		63.5%	63.8%	64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	63.3%	60.8%
RTT Wait for first appointment <18 weeks - Actual			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%		66.7%	67.2%	67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%
Cancer: 28-day FDS - Actual			70.1%	62.3%	67.3%	75.7%	76.2%	78.3%	60.6%	79.7%	75.7%	48.0%	45.5%
Cancer: 28-day FDS - Revised forecast	80.9%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	48.0%	45.5%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual			57.8%	64.5%	63.2%	70.4%	71.1%	79.8%	75.2%	67.1%	60.1%	58.5%	48.9%
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.7%		75.7%	75.2%	75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	78.1%	81.7%
Cancer: No of patients waiting >62 days to start treatment - Actual			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			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			36.7%	37.1%	36.8%	29.4%	28.4%	30.4%	35.8%	30.6%	37.4%	39.4%	34.6%
Diagnostics - proportion waiting over 6 weeks - Plan	15%						5.0%	4.0%	3.0%	3.0%	3.0%	30.6%	29.2%

14. 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 July 2026.

15. 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 before improving. At present the Trust remains ahead of waiting list forecast with the

RTT waiting list currently at 34,221 for July, however, RTT performance for July is below plan at 56.8% (unvalidated) a reduction of 9.6%.

16. Investigations into the worsening RTT performance continue as whilst overall waiting list has remained in line with forecast has identified concerns with data quality in potential duplicate or missing pathways and no identified next step and differences in how clock starts were captured in the legacy PAS compared to EPIC:
17. Since Epic go live there has been a reduction in the reported number of RTT clock starts of 20-25% weekly, and the number of patients in the 0–18-week cohort on the PTL reducing from ~22k to ~19k. A detailed investigation is being undertaken with support from TSD BI, One Devon BI, Epic and regional colleagues. The key findings are summarised below.
18. Investigation has confirmed that in the legacy systems many more clock starts were created and reported in the PTL until removed by the application of national business rules once the RTT pathway was confirmed as not reportable for RTT purposes (often at the point of booking into non RTT pathway clinic). This led to an inflated number of patients being reported in weekly and monthly waiting list snapshots in the 0–18-week bands, therefore artificially inflating RTT performance. Since Epic Go live non RTT reportable pathways are now excluded at source so have not been counted into the RTT position at any stage. It is estimated that this has had a detrimental impact on RTT performance of 3% minimum.
19. The impact on performance is therefore seen as the lower number of clock starts have reduced the number of patients in the 0-18 weeks cohort. As we are now 18 weeks beyond go live the 0–18-week cohort of the PTL will stabilise. The challenge is that the reduction in performance of circa 3% will need to be recovered to deliver the Trust operational plan commitment of 73.8% in March 2027. Finalisation of the investigation findings with further audit will be carried out and this will be concluded by the end of August 26. Further detail on areas of investigation and action can be provided.
20. At specialty level 9 specialties account for 80% of the clock start variation (3,525 of 12,999 pathways) as described below. It is noted that many of the specialties with the highest variance correlate with specialties with direct to test or direct access diagnostic pathways, and areas where business rules in legacy were applied retrospectively after clock starts had been recorded. Detail on these specialties and the performance impact is included below.

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Nine RTT specialties since go-live

Pre-Epic 31 Mar 2026 vs 10 Aug 2026 · admitted + non-admitted RTT pathways combined
ENT · Ophthalmology · Gynaecology · Oral Surgery · Pain Management · Paediatrics · Rheumatology · Urology · Cardiology

TOTAL WAITING LIST (PTL)

19,072

-582 vs 19,654 pre-Epic

WAITING 0-18 WEEKS

9,475

-3,524 vs 12,999 pre-Epic

COMBINED RTT PERFORMANCE

49.7%

-16.5 pts vs 66.1% pre-Epic

SHARE OF THE WHOLE TRUST PTL

59.1%

59.5% pre-Epic · trust PTL 32,295

Non-admitted 16,620 → 16,598 (-22) Admitted 3,034 → 2,474 (-560) Waiting 18wk+ 6,655 → 9,597 (+2,942)

Specialty	Total waiting list (PTL)			Waiting 0-18 weeks			Waiting 18 weeks+			RTT performance		
	pre-Epic	now	change	pre-Epic	now	change	pre-Epic	now	change	pre-Epic	now	change
Ophthalmology	4,680	5,442	+762	3,012	2,457	-555	1,668	2,985	+1,317	64.4%	45.1%	-19.2
ENT	3,033	3,494	+461	1,752	1,562	-190	1,281	1,932	+651	57.8%	44.7%	-13.1
Oral Surgery	2,464	2,713	+249	1,404	1,262	-142	1,060	1,451	+391	57.0%	46.5%	-10.5
Urology	2,394	2,028	-366	1,594	991	-603	800	1,037	+237	66.6%	48.9%	-17.7
Cardiology	3,064	1,963	-1,101	2,350	1,308	-1,042	714	655	-59	76.7%	66.6%	-10.1
Gynaecology	1,923	1,727	-196	1,289	955	-334	634	772	+138	67.0%	55.3%	-11.7
Pain Management	617	670	+53	352	250	-102	265	420	+155	57.1%	37.3%	-19.7
Rheumatology	863	635	-228	699	401	-298	164	234	+70	81.0%	63.1%	-17.8
Paediatrics	616	400	-216	547	289	-258	69	111	+42	88.8%	72.2%	-16.5
ALL NINE SPECIALTIES	19,654	19,072	-582	12,999	9,475	-3,524	6,655	9,597	+2,942	66.1%	49.7%	-16.5

Source: "RTT tracking.pptx" slides 2-6. PTL = 0-18wk plus 18wk+ waiters. RTT % = share of the waiting list within 18 weeks, computed from volumes. Green = movement in the right direction (PTL down, 0-18wk volume up, 18wk+ volume down, RTT % up); red = the reverse.

21. To resolve the ongoing data quality issues, daily silver meetings between operational teams and Epic are in place to identify changes needed to address the root cause of Data Quality errors and to ensure progress is being made to resolve these issues. Daily reporting is submitted to the Chief Operating Officer and the Chief Executive to demonstrate improvement and a weekly senior meeting with Epic is also in place. Progress on the improvement is shown below. In summary outstanding data quality queries in the target areas have reduced from 9,344 last month to 3,618, a reduction of 5,726 validated pathways. This position is being monitored daily and clearance is expected by end of September.

Latest Data Quality dashboard for key cohorts shown below (10/08/2026)

Data Quality Overview				
Totals across all specialties for each DQ metric. Click a metric name to jump to its detail tab. An increase (▲ red) means more outstanding issues; a decrease (▼ green) is an improvement.				
Data Quality Metric	Current Total	vs Yesterday	vs Last Week	As of
Migrated waiting lists without a pathway	695	▼ -130	▲ +422	11 Aug 2026
Pathways with No Next Step	907	▼ -84	▼ -73	11 Aug 2026
Waiting List Questionnaire Removals Outstanding	178	±0	▲ +13	11 Aug 2026
Potential Duplicate Pathways	180	▲ +22	▼ -147	11 Aug 2026
Epic Waiting Lists without a pathway	309	▲ +5	▼ -25	11 Aug 2026
Potential Duplicate Waiting Lists	1,527	▲ +12	▼ -161	11 Aug 2026

22. Work is being undertaken to ensure the Trust is returning to the levels of activity being undertaken pre-Epic go live. While progress has been made, deficits remain with specific clinicians and across specialties. A target of returning to 100% of pre-Epic activity by 20th July was set but has not been delivered with many areas reporting activity loss from core capacity of up to 20%. Reviews have been undertaken at

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speciality level to understand the barriers to return to pre Epic levels of activity. Month on month progress has been made as demonstrated in the chart below.

<u>Crude activity variance to last year - before adjustments</u>								
	variance crude				Variance %			
Setting2	April	May	June	ytd	April	May	June	ytd
Day Case & RDA	-296	-543	-85	-924	-9%	-15%	-2%	-9%
Elective	-100	-56	-65	-221	-35%	-21%	-25%	-27%
First	-3,368	-3,160	-736	-7,264	-35%	-31%	-7%	-25%
Follow-up	-11,461	-7,172	-4,379	-23,012	-40%	-27%	-16%	-28%
Grand Total	-15,225	-10,931	-5,265	-31,421	-37%	-27%	-13%	-25%

23. Actions in place include medical information officer reviews and working alongside clinicians, reviewing Epic data to understand where system delays are occurring, working with clinicians to personalise the system and resolve delays, an Epic team are joining clinical teams in clinic on a rolling programme to provide bespoke support. Work continues to maximise Epic Thrive training which will support clinical teams to maximise efficiencies within their work within the system. As of present, booking remains poor and operational teams are taking greater ownership of supporting access to training.
24. There remain concerns that not all of the activity being undertaken is being correctly processed from EPIC and included in our national activity returns. These concerns cover the volume of activity split between acute and community waiting list and mapping into the correct settings of care with the possible impacts this could have on the income position. A joint review is being undertaken between finance, One Devon BI, and operational teams at present.
25. The piece of work detailed above will inform recovery action plans regarding contracted income and activity levels that triangulate to performance delivery. The agreed plan is to recover all lost activity due to Epic go live in the second half of the year. Plans have been developed between operational teams and finance to ensure most cost-effective schemes to support recovery with surgical plans receiving triple lock agreement in August and medicine and families and communities plans due for scrutiny at Trust Investment Group on 19th August 26. Significant activity delivery is expected across ophthalmology and ENT in August and September following triple lock approval.
26. The committee is asked to agree that assurance is **limited** against delivery of the overall RTT standard (target 73.8% March 2027) and within this the 65 weeks wait elimination and 52 week wait reduction standards to 1%. The committee is also asked to note the risks articulated, particularly the expected activity recovery requirements for Epic stabilisation.

6. Cancer and Diagnostics

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Oversight Framework summary

Oversight Framework Metric	Current NOF score	Performance Position at point of score	Current position *Local data	Forecast End of Quarter Position	Forecast Improvement or Worsening
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral score	3.45 Q4 2025/26	71.8%	57.1% * (June 2026)	77%-80%	Improving
Percentage of patients treated for cancer within 62 days of referral score	2.98 Q4 2025/26	67.8%	53.9% * (June 2026)	68%-70%	Stable/Improving

24. The 28-day faster diagnosis June performance trajectory of 57.4% was not met with performance at 57.1%. The July forecast is an improvement to 65% which is behind the July operational plan trajectory of 72.98%, with further improvement to 70% expected in August. The improvements at present continue to be driven by recovery in dermatology, however issues in urology and gynaecology continue to limit the impact of this recovery.

Month	March 2026	April 2026	May 2026*	June 2026	July 2026	August 2026	September 2026
26/27 Submitted Plan (July resubmission)	79%	48%	45.5%	57.4%	73.0%	77.0%	82.9%
Revised Forecast (May)	76%	50%	57%	52%	64%	73%	83%
<u>Current Forecast</u>	<u>76%</u>	<u>48%</u>	<u>49%</u>	<u>59%</u>	<u>65%</u>	<u>70%</u>	<u>80%</u>

25. The key specialty driving the highest volume of activity is Dermatology which has experienced a demand increase of 15% in excess of planned levels. The below charts describe the volume of activity for Urgent Suspected Cancer appointments, against last year and FDS recovery. Currently skin recovery is ahead of schedule and expected to improve significantly further in July in line with the trajectory.

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
<u>Current Forecast (June)</u>	<u>31%</u>	<u>27%</u>	<u>46%</u>	<u>60%</u>	<u>80%</u>
<u>FDS forecast wait, at month end (June)</u>	<u>48 days</u>	<u>35 days</u>	<u>25 days</u>	<u>20 days</u>	<u>15 days</u>

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26. The Trust 62 day position continues to underperform against expected trajectory although improvement is being delivered month on month currently. The current July 26 forecast is ~65% with an improvement to 68% in September. This performance would remain behind the trajectory detailed below.

	April 2026	May 2026	June 2026	July 2026	August 2026
62-day Submitted plan	78.1%	81.7%	78.8%	79.2%	79.9%
Revised forecast	60%	55-60%	70%	72%	75%

27. To support swifter recovery there is a plan to deliver greater activity in gynaecology through additional outpatient and ultrasound capacity. This plan will be reviewed at Trust Investment Group on 19th August 26. In addition to this, recovery plans are being delivered in urology with additional nurse led cystoscopy and LUTS services agreed. Recruitment and training is ongoing with associated recovery trajectories being developed. Histology delays had impacted urology performance and while additional consultant workforce has been appointed, outsourcing has been agreed to support recovery until end of October 26.

28. Diagnostic performance (DM01) remained a challenge throughout FY25/26, and this has continued into FY26/27. The June national reported position of patients waiting over 6 weeks for diagnostics is 24.1% which is ahead of trajectory of 27.7%. This is a continued improved position from April (39.4%). The forecast for July is remaining ahead of plan (25.6%) currently forecasting 19.1%.

Month Summary	31/07/2026			
Diagnostic Modality Description	% Breach	+ 6 weeks	Total Waiters	
Additional WLMDS Diagnostic Tests	40.2%	159	396	improvement
Audiology - Audiology Assessments	6.6%	24	365	deterioration
Cardiology - Echocardiography	10.2%	51	499	improvement
Colonoscopy	21.1%	79	375	improvement
Computed Tomography	2.5%	21	853	on target
Cystoscopy	10.6%	15	142	improvement
DEXA Scan	52.0%	204	392	deterioration
Flexi Sigmoidoscopy	21.0%	21	100	improvement
Gastroscopy	22.4%	83	371	no change
Magnetic Resonance Imaging	22.1%	252	1,139	improvement
Neurophysiology - peripheral neurophysiology	17.8%	13	73	deterioration
Non-obstetric ultrasound	32.7%	798	2,441	improvement
Respiratory physiology - sleep studies	4.0%	1	25	on target
Urodynamics - pressures & flows	20.0%	6	30	improvement
Grand Total	24.1%	1,727	7,201	improvement

29. Risks have been identified to ongoing diagnostics recovery including staffing within DEXA and equipment issues within MRI. A plan is in place for a sustainable staffing resolution in DEXA with the service transferring to radiology within Q3 of 26/17. Short term solutions continue to be investigated ahead of this move. Within MRI, a chiller unit requires replacement in one of the MRI scanners and at present the scanner can only operate at 75% of capacity to mitigate risk of failure. Capital funding has been identified to replace the unit, however this will not be able to take place ahead of winter and a definitive date is not yet confirmed. Trajectories are being created for the ongoing capacity issues and the recovery for when the scanner can operate at 100%.

30. 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 **satisfactory** assurance on diagnostic performance at present based on 3 predicted months of improvement in line with trajectory 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	No change	Limited
UEC 12 Hour Performance	Limited	No change	Limited
RTT 65-week waiters	Limited	No Change	Limited
RTT 18 week, RTT 52-week total waiting list size, % first appointment	Limited	No Change	Limited

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within 18 weeks			
Cancer Performance	Limited	No Change	28- day and 31-day – Satisfactory 62-day - Limited
Diagnostic Performance	Satisfactory	No change	Satisfactory

Presented to:	Finance and Operations Committee			
Title of Report	Monthly Finance Report			
Date of Meeting	26 th August 2026	Author	Andrea Wright Director of Operational Finance	
Executive Lead	James Corrigan Chief Finance Officer	Executive Sign Off	Yes	
Governance Route	Monthly financial performance information and assessment of risks to delivery of the financial plan and underlying position are presented to the Finance and Operations Committee for update and assurance.			
Recommended Action	For Approval	For Assurance	To Update	For Information
		☒	☒	
Executive Summary	The Trust finance report seeks to provide assurance to the Finance and Performance Committee on the position at Month 4 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 July shows a month end position of £8.2m deficit, as planned. The position excluding DSF is £27.5m deficit at the end of July, as planned. The Trust was on plan overall, but with the following significant variances noted within this balanced position: costs of cover and lost income from Industrial Action (£0.4m adverse to plan) offset with non-recurrent balance sheet flex released to meet these costs (£0.4m favourable to budget), a provision against contract income was made to recognise activity lost through EPR implementation (£2.9m adverse to plan). These adverse variances were offset by other favourable budget variances (£2.9m favourable to plan) mainly undrawn reserves funding for inflation and growth. Adverse variances on frontline budgets were offset by underspends on corporate budgets, but the combined overspend on ASC and CHC packages of care £0.6m presents an ongoing risk reflecting recent high cost packages of care. EPR implementation has significantly disrupted the Trust's operational productivity and ability to accurately capture and quantify contract earnings. Trust included a provision for underperformance against contract of c£2.9m in the position. Latest analysis suggests that the variance to contract (including some high level assumptions about corrections due to data quality and counting and coding issues) may be closer to £1.8m. The Trust is working at pace to identify and address issues, recover lost productivity and to project required activity levels and costs to deliver RTT performance The Trust is forecasting delivery of the planned outturn but recognises forecast risks to delivery of between £11.6m in the base case and up to £27.2m in the downside risk assessment (with £7.2m risk to the ULP in the base case and £13.9m in the 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 4 the Trust has recognised CIP delivery of £9.6m against a £9.6m target (£0.0m variance to plan). Since the plan was submitted intensive work is continuing to be undertaken on developing the CIP plans. Fully developed plans			

	have increased by £0.1m and low risk schemes have increased by £0.3m. The Trust is forecasting full delivery of the £54.4m target. The Trust is reporting a cash balance of £12.8m as at 31st July 2026, £7.7m lower than planned, primarily due to a delay in receiving £6.2m regular contractual receipts from Torbay Council for M4, not received until after ledger close. 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 4 the Trust has spent £6.0m of capital compared to plan of £6.7m, an underspend of £0.8m. The Trust is forecasting to spend up to capital limits, including an additional £2.3m National PDC Capital including Tower Fire Safety and SDEC schemes. The Finance Committee is requested to agree the overall assurance level relating to the financial position of the Trust as MODERATE assurance on financial performance and LIMITED assurance on CIP, financial risks and workforce.					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
						☒
How this paper supports delivery of the Strategy	This report supports the Trust’s strategic objectives to achieve financial sustainability.					
Board Assurance						
BAF Ref	Principle Risk		Current Score	Impact of this paper		
Finance C1	Risks to financial sustainability, CIP delivery and adequacy of cash balances are identified Trust risks.		12	Robust financial information and forecasting is key to ensure the financial sustainability and ensuring efficient use of the Trust resources		
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led	
					☒	
Compliance / Regulatory Requirements	The Trust submits monthly financial returns on the financial position, forecast, CIP delivery and workforce to NHS England.					
Ethical Implications ? EDI implications?	None identified					

Assurance rating	Significant	Moderate	Limited	Inadequate
		☒ Assurance on financial performance		
Assurance rating	Significant	Moderate	Limited	Inadequate
			☒ Assurance on CIP, forecast risks and workforce	

Presented to:	Finance & Operations Committee			
Title of Report	Electronic Patient Record (EPR) Progress and Finance Report			
Date of Meeting	26/8/2026	Author	Kevin Pirie-EPR Operational Director and Mark Tucker Head of Financial Strategy	
Executive Lead	Sam Wadham- Sharpe SRO	Executive Sign Off		
Governance Route	EPR Finances have been shared at both CIDG and also the One Devon EPR Programme Board			
Purpose of paper	For Approval	For Assurance	To Update	For Information
		X		X
Executive Summary	Progress of the Electronic Patient Record (EPR) implementation/Stabilisation Current overall status is “Watch”. This is based on the most recent Epic Monthly Progress Report, which can be seen in Appendix 1. Areas reporting “WATCH” status (TSD related) • TSD’s elective performance remains below pre-live baselines. Contributing factors have been identified as: ○ RTT counting / reporting ○ Activity recovery Further details are reported in Key notes slide RTT Reporting Material differences between legacy systems and Epic recording and reporting of RTT activities have been identified. 9 specialties are particularly impacted. In the last 2 weeks these specialties have been investigated by Trust and Epic teams to determine the cause of differences between pre and post Epic performance reporting. See key notes. Activity See performance report			

Benefits Realisation

Cash-releasing benefits are currently managed through the Programme Management Office (PMO) and are supported by established governance, reporting and escalation processes. Ideally, we would like to extend this approach to the management of non-cash-releasing and societal benefits, providing a single, consistent framework for benefits oversight and performance monitoring. Agreement has not yet been reached across all key stakeholders, so a dedicated meeting has been scheduled to progress discussions and confirm the future benefits realisation management approach.

The Benefits Realisation Group continues to provide oversight of benefits activity and is regularly reviewing escalations and issues raised by benefit owners. In parallel, Information Officers and the Change Team are actively engaging with frontline services to identify and validate emerging benefits that have not yet been formally captured within the benefits register.

The EPR and PMO teams continue to work closely with benefit owners to strengthen benefit definitions, refine delivery measures, and develop robust delivery plans. This support is intended to improve the quality of benefits tracking, increase accountability for delivery, and ensure that benefits realisation remains focused on measurable operational and strategic outcomes.

Programme Finances

There are no variances showing for capital in Month 4. This is because there was no phasing undertaken in the FBC and so focus is on reviewing expected spend against the total budget value of £7.985m.

For revenue, the in-month People variance is because we have stopped capitalising Programme staff costs from M4 but, we have incurred extra costs relating to M1-3 ie covering for Go Live, which are a one-off additional expense. Software is showing underspent and this is a mix of timing issues with invoices from suppliers and costs being lower than planned in the FBC. Data is showing an underspend, and this is likely to continue, although the exact value is still to be confirmed.

Further detail can be seen in Appendix 1.

Recommendation	The Committee is asked to acknowledge that moderate assurance is provided on EPR progress					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
					X	
How this paper supports delivery of the 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.					
Board Assurance						
BAF Ref	Principal Risk	Current Score	Impact of this paper			
Quality, Safety and Patient Experience	Ineffective reporting would impact on visibility of patient safety issues.		The networked EPR enables standardisation of pathways across Devon based on best practice.			
Leadership and Governance	Issues around data quality will undermine effective leadership decisions		An efficient and effective EPR will support Leadership decisions within the Trust and offer improved governance.			
Performance	Deterioration in delivery of key Constitutional standards		The many operational benefits of a single EPR will support better performance across all constitutional standards			
People and Culture	Staff are not proficient in using Epic, impacting on confidence and		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.			

	efficiency of working				
Strategy and Business Intelligence	Failure to establish robust governance of the 1 Devon Program for the long term limits the 1 Devon ambitions that are underpinned by the Epic EPR				Signature development in Devon's Strategy and transformation plans. Greatly improved insight from our data.
Finance	System-wide transformation initiatives do not deliver benefits				Critical enabler for the development of best practice standardised pathways and reductions in variation.
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led
Compliance / Regulatory Requirements	N/A				
Ethical or EDI implications?	N/A				
Assurance rating	Significant	Moderate	Limited	Inadequate	
		x			
Assurance rationale	There are significant challenges with DQ and reporting, however these issues are understood and progress is being made ahead of our planned return to RTT reporting.				
Appendices	Appendix 1 – Epic Monthly Progress Report Appendix 2 – EPR Programme Finance Report				



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Quality and People Committee Appraisal and Revalidation Report

Date of meeting	Date report produced
28th July 2026	2 nd July 2026

Author(s)		Report approved by	
Name and title:	Dr Rebecca Green, Trust Appraisal Lead, Dr Rosie Davis, Deputy Trust Appraisal Lead	Name and title:	Dr Catherine Lissett, Chief Medical Officer
		Date:	20/07/2026

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

Executive summary

This report provides the annual appraisal and revalidation assurance return for Torbay and South Devon NHS Foundation Trust and Rowcroft Hospice and confirms compliance with the Medical Profession (Responsible Officers) Regulations. The report demonstrates that appropriate Responsible Officer, appraisal, revalidation and governance arrangements are in place to support doctors in maintaining professional standards and fitness to practise.

Key areas of assurance include:

- Responsible Officer, Appraisal Lead and Deputy Appraisal Lead arrangements remain in place and are supported by Medical Workforce systems and governance processes.
- All GMC revalidation recommendations were submitted within expected timescales, with no late recommendations, no non-engagement referrals and no doctors failing to revalidate.
- Systems exist to support clinical governance, appraisal quality assurance, management of concerns, employment checking and professional standards.

The report also highlights areas requiring continued attention:

- There remain 51 unapproved missed appraisals. These are being robustly followed up y potentially using the “REV6 referral process” if required. This is a new approach, learning from other trusts that highlights to the GMC that a doctor is not engaging in appraisal despite encouragement and support.
- The Trust does not currently have sufficient trained appraisers to meet future demand and continues to rely on retired appraisers to support delivery.
- Increasing numbers of locally employed and locum doctors require enhanced identification, support and engagement with appraisal and revalidation processes. Of the 51 unapproved missed appraisals, 17 relate to locally employed or locum doctors.

Overall, the report provides **Satisfactory Assurance** that statutory appraisal and revalidation arrangements are in place and operating effectively, whilst recognising ongoing work to strengthen appraisal capacity, improve completion rates and enhance oversight of locally employed and locum medical staff.

Appendices

Appendix 1: NHS England Annual Board Report and Statement of Compliance (FQAI Return 2025/26)

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

Key recommendations and actions requested

The Committee is asked to:

- Note the contents of the report.
- Take **Satisfactory Assurance** regarding appraisal and revalidation arrangements.
- Note the risks relating to appraiser capacity, missed appraisals and oversight of locally employed and locum doctor
- Support the proposed actions to strengthen appraisal resilience and quality assurance arrangements.

How does this report further our Trust strategy?

The report supports delivery of the Trust strategy by ensuring that doctors remain professionally supported, competent and fit to practise. Robust appraisal and revalidation arrangements provide assurance regarding the quality and safety of

clinical care, support continuous professional development, strengthen clinical leadership and contribute to a culture of learning and improvement. The report also supports compliance with statutory and regulatory requirements associated with professional standards.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Supports delivery of safe and effective medical care through maintenance of professional standards and clinical competence.
Quality of services provided	Provides assurance that systems are in place to support appraisal, revalidation, governance, professional development and management of concerns regarding medical staff.
Sustainable and efficient use of resources	Supports delivery of safe and effective medical care through maintenance of professional standards and clinical competence.

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Provides assurance that doctors maintain professional standards and that concerns are identified and managed appropriately.
Leadership and Governance	Supports the Responsible Officer function and demonstrates compliance with regulatory requirements and governance standards.
Performance	Contributes to effective workforce oversight and monitoring of professional practice.
People and Culture	Supports professional development, appraisal, inclusion, wellbeing and a learning culture.
Strategy and Business Intelligence	Provides assurance regarding medical workforce governance and workforce risks.
Finance	Effective governance and revalidation arrangements reduce the risk of regulatory

intervention, workforce instability and associated costs.

Risk

Risks lodged on Datix:

No specific Datix risk is identified

External Standards affected by this report and associated risks

- *Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013).*
- *GMC revalidation requirements.*
- *NHS England Framework of Quality Assurance for Responsible Officers and Designated Bodies (FQAI).*
- *NHS England professional standards and appraisal requirements.*

Failure to maintain effective appraisal and revalidation arrangements could result in regulatory

This report includes the following assurance recommendations:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Appraisal and Revalidation	Satisfactory	Stable

Presented to:	Quality and People Committee			
Title of Report	Improving Lives of Resident Doctors: Integrated 10 Point Plan, Postgraduate Medical Education (PGME) Quality Assurance Annual Report 2025/26 and Guardian of Safe Working Hours (GOSW) Report			
Date of Meeting	25 th August 2026	Author	Dr Kate Lissett, Chief Medical Officer, with contributions from Dr Josh Tulley, Resident Doctor Peer Lead; Mr Jeremy White, Postgraduate Medical Education Manager; Ms Jacqui Rees Lee, Director of Medical Education; Dr Elizabeth Ginn, Associate Director of Medical Education (Quality); Miss Amanda Lee	
Executive Lead	Chief Medical Officer	Executive Sign Off	Dr Kate Lissett, Chief Medical Officer 18/08/2026	
Governance Route	Resident Doctor Representative Committee; 10 Point Plan local working group; Guardian Oversight Group; Postgraduate Medical Education Committee; Quality and People Committee.			
Purpose of paper	For Approval	For Assurance	To Update	For Information
	X	X	X	
Executive Summary	Executive Summary This paper consolidates the August 2026 Resident Doctor 10 Point Plan update, the Postgraduate Medical Education Quality Assurance Annual Report 2025/26 and the August Guardian of Safe Working Hours report into one integrated assurance paper. Since the April update, the Trust has maintained overall moderate assurance against the 10-Point Plan, with strengthened resident doctor leadership through the re-election of Dr Josh Tulley as Resident Doctor Peer Lead and continuation of Dr Kate Lissett as named senior lead, alongside a named Non-Executive Director link through the Chair of the Quality and People Committee. The strongest areas of assurance are the governance structure for resident doctor voice, avoidance of unnecessary statutory and mandatory training repetition, exception-reporting governance and timely reimbursement of course-related expenses. Work schedules and rota information are			

	reported as generally compliant, although compliance monitoring is being centralised and a small number of exceptions have required direct communication with affected resident doctors. The key new risk since April is annual leave. NHS England has now published national minimum standards for resident doctor annual leave, including fair management of annual leave, the ability for every resident doctor to request two consecutive weeks away within each 12-month period, professionalisation of the rota manager role, improved e-rostering and preferential rostering. The Trust meets some requirements locally, but significant cross-speciality implementation work remains; a task and finish group chaired by the Resident Doctor Peer Lead has been established to deliver a plan before August 2027. The PGME annual quality report provides moderate assurance. External quality activity in 2025/26 was satisfactory across the NHSE MEQR (Medical Education Quality Review), Haematology/Oncology triggered visit, Obstetrics and Gynaecology follow-up meetings and response to General Medical Council (GMC), National Training Survey (NTS) written comments. Foundation quality panel outcomes show improvement in that there are no inadequate posts in 2026 compared with one in 2025; however, 12 of 46 posts require improvement, with deterioration or continuing concern in Acute Medicine, Emergency Medicine, General Psychiatry, General Surgery, Colorectal Surgery and Geriatric Medicine / Simpson Ward. General Practice (GP) training feedback is strong overall, with 9 of 12 hospital posts and 22 of 25 GP practices graded excellent in 2026. The GoSWH data continues to show material operational risk. The April integrated report identified 192 exception reports in a 12 week period following national reforms, with recurrent unscheduled late finishes, acute ward hotspots, nine safety concern reports and evidence of workforce/rota gap pressure rather than isolated events. The August GoSWH dataset records a small reduction with 176 exception reports (in a longer reporting period) however, until targeted action demonstrates a sustained reduction in recurrent late finishes, immediate safety concerns, rota gaps and hotspot ward pressure, this is limited assurance

	Nationally, resident doctor workforce reform remains high profile. NHS England's July / August 2026 communication asked trusts to ensure a Resident Doctor Peer Lead is in place, work schedules and rota information are issued in line with the Code of Practice, annual leave is arranged in line with minimum standards, payroll processes are checked and rotating doctors are not asked to repeat statutory and mandatory training unnecessarily. The wider national resident doctors offer includes pay reform, reimbursement of mandatory training-related costs, additional training places, continuing action on working conditions, lead employer model development and Medical Education and Training Review alignment. NHS England will also launch 19 rotational training pilots in August 2026 involving approximately 210 resident doctors to test more stable, predictable and manageable approaches to rotations. Overall, the Committee is asked to take Moderate assurance overall, with Limited assurance specifically in relation to annual leave implementation and safe working hours/rota resilience. The Committee should note that resident doctor voice and governance are strengthening, PGME quality remains broadly positive, but exception-reporting patterns, workload intensity, out-of-hours supervision concerns and rota gaps remain material risks to resident doctor wellbeing, training experience, patient safety and financial control.
Recommendation	The Committee is asked to: 1. Receive and note the integrated resident doctor workforce and education report. 2. Agree the overall assurance rating of Moderate, recognising Limited assurance for annual leave compliance and safe working hours/rota resilience. 3. Note the continuing high volume of exception reports in the August GoSWH dataset, with 176 reports supplied for this reporting period. 4. Note the recurrent exception-reporting hotspots, including speciality, grade, outcome and ward-level themes from the August GoSWH appendix, and that plans are in place at speciality level to review and support. 5. Support the annual leave task and finish group to deliver compliance with NHS England minimum standards before August 2027.

Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
			X			
How this paper supports delivery of the Strategy	This paper supports the Trust strategy by strengthening assurance over the experience, wellbeing, education and safe working conditions of resident doctors. Resident doctors are central to safe service delivery, rota resilience, future workforce supply and the quality of acute and specialist care. The report triangulates resident doctor voice, PGME quality data, GMC NTS themes, GoSWH exception reporting and national policy requirements so the Committee can identify where local controls are effective and where targeted action is required. The paper supports the strategic priority of caring, skilled people ready for tomorrow by evidencing progress in resident doctor leadership, education governance, avoidance of training duplication and access to reimbursement, while identifying areas where workload, annual leave, out-of-hours support and rota gaps continue to affect wellbeing and retention. It also supports foundation-level governance by aligning local reporting to national 10 Point Plan requirements, contract reforms and the Trust’s assurance-rating framework.					
Board Assurance						
BAF Ref	Principal Risk	Current Score	Impact of this paper			
	Quality, safety and patient experience.		Exception-reporting data indicates recurrent operational pressure and rota gaps with potential patient-safety and fatigue implications. PGME quality processes provide positive assurance but require targeted follow-up for placements requiring improvement.			
[	Workforce sustainability, staff wellbeing and safe staffing.		The paper provides moderate assurance that governance and controls exist for resident doctor experience, PGME quality and exception reporting, but identifies limited assurance in annual leave compliance and safe working hours.			
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led	
	X	X	X	X	X	

Compliance / Regulatory Requirements	This paper supports compliance with NHS England's Resident Doctor 10 Point Plan, NHS England annual leave minimum standards, the resident doctor contract / Terms and Conditions of Service Version 13 exception-reporting reforms, GMC standards for medical education and training, and CQC quality statements on safe, effective, caring and well-led services.			
Ethical or EDI implications?	No specific EDI implications identified			
Assurance rating	Significant	Moderate	Limited	Inadequate
		X		
Assurance rationale				
Appendices	Appendix 1: 10-point plan - Improving the working lives of Resident Doctors Appendix 2 Postgraduate Medical Education Quality Assurance Annual Report Summary 2025-2026 Appendix 3: Guardian of safe working data set.			

Quality and People Committee

Perinatal Quality and Safety Report

Date of meeting	Date report produced
28 th July 2026	

Author(s)		Report approved by	
Name and title:	Perinatal Leadership Team	Name and title:	Nicola McMinn Chief Nurse Joanna Bassett Director of Midwifery

Date:

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

Executive summary
This quarterly report provides oversight and assurance on the safety, quality and effectiveness of maternity and neonatal services at Torbay and South Devon NHS Foundation Trust for Quarter 1, April to June 2026. It aligns with the NHS England Perinatal Quality Oversight Model, the Three-Year Delivery Plan for Maternity and Neonatal Services, the Maternity Incentive Scheme and associated national safety requirements. The report brings together intelligence on clinical outcomes, patient safety incidents, perinatal mortality and morbidity, workforce, training, service-user and staff feedback, improvement activity and national standards. It demonstrates continued progress in strengthening perinatal governance, leadership visibility, safety champion engagement and improvement delivery, including progression from targeted support to regional oversight following the June 2026 Mat Neo Insight Visit. Key risks and areas requiring continued oversight include maternity mandatory training recovery following EPIC implementation, neonatal qualified in specialty workforce fragility, obstetric scanning capacity, neonatal estate constraints, QIS staffing, data quality and reporting from EPIC, and delivery of improvement actions linked to national maternity reports and the Maternity Incentive Scheme Year 8 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
Overall maternity and neonatal safety, quality and governance	Satisfactory with areas requiring continued focused oversight	Improving

Appendices

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

Key recommendations and actions requested

The Committee is asked to receive the report, note the progress and risks described, and take satisfactory assurance that maternity and neonatal safety, quality and governance arrangements are in place and continue to be strengthened. The Committee is also asked to note the areas requiring continued oversight, particularly training recovery, workforce fragility, data quality, neonatal capacity constraints, and delivery of Maternity Incentive Scheme Year 8 requirements.

How does this report further our Trust strategy?

The report supports the Trust's purpose by providing Board and Committee oversight of maternity and neonatal safety, experience, outcomes and improvement activity. It ensures that risks affecting women, babies and families are visible, that learning is acted upon, and that services continue to focus on safe, personalised, equitable and compassionate care.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Supports improved outcomes for women, babies and families through oversight of perinatal safety, mortality and morbidity, preterm birth, smoking in pregnancy, fetal growth surveillance, reduced fetal movements, inequalities, service-user feedback and MNVP engagement. The report also highlights themes linked to deprivation and ethnicity, supporting targeted action to reduce unwarranted variation and improve equity of care.

Quality of services provided	Provides assurance on the safety, quality and effectiveness of maternity and neonatal services through oversight of incidents, PMRT, MNSI, complaints, compliments, CQC MUST DO actions, Saving Babies' Lives Care Bundle, MIS/CNST, training compliance, safe staffing, neonatal care pathways, and implementation of learning from national reports. It strengthens floor-to-board visibility of risks, learning and improvement actions.
Sustainable and efficient use of resources	Identifies workforce, estate, training, digital/data quality and capacity risks that may affect safe and sustainable service delivery. It supports prioritisation of resources for areas such as midwifery staffing, neonatal QIS capacity, obstetric scanning, triage, emergency equipment, EPIC optimisation and compliance with national standards, helping the Trust target investment where it will have greatest impact.

Impact on BAF Objectives	
BAF Objective	Impact
Quality, Safety and Patient Experience	Direct impact through oversight of perinatal safety, outcomes, incidents, learning, service-user feedback and delivery of national maternity and neonatal standards.
Leadership and Governance	Supports strengthened perinatal governance, Board Safety Champion oversight, floor-to-board reporting and delivery of the Maternity and Neonatal Improvement Plan.
Performance	Highlights performance risks including training compliance, obstetric scanning capacity, EPIC data quality and delivery against maternity safety standards.
People and Culture	Provides visibility of workforce, wellbeing, staff feedback, psychological safety and leadership visibility themes.

Strategy and Business Intelligence	Aligns with national maternity strategy, the Perinatal Quality Oversight Model, the Three-Year Delivery Plan and Maternity Incentive Scheme requirements.
Finance	Identifies areas with potential financial implications, including workforce investment, estate constraints, national compliance requirements and CNST/MIS delivery

Risk

The report supports oversight of national and regulatory maternity and neonatal standards including the NHS England Perinatal Quality Oversight Model, Three-Year Delivery Plan for Maternity and Neonatal Services, Maternity Incentive Scheme Year 8, Saving Babies’ Lives Care Bundle, CQC maternity requirements, Ockenden and Amos report recommendations, MNSI, PMRT, MOSS and relevant neonatal service specifications. Risks relate to compliance, evidence, data quality, workforce capacity, estates constraints and the ability to demonstrate sustained improvement.

Risks lodged on Datix:

The main associated risks relate to evidencing sustained compliance, maintaining training and workforce standards, demonstrating robust Board oversight, responding to national learning, addressing CQC “must do” actions, ensuring timely investigation and review of perinatal harm, maintaining neonatal QIS and estate standards, and resolving data quality issues following EPIC implementation.

External Standards affected by this report and associated risks

This report provides assurance against a range of national maternity and neonatal standards, including the NHS England **Perinatal Quality Oversight Model**, the **Three-Year Delivery Plan for Maternity and Neonatal Services**, the **Maternity Incentive Scheme Year 8 / CNST requirements**, the **Saving Babies’ Lives Care Bundle v3**, **CQC maternity inspection requirements**, **Ockenden and Amos national maternity report recommendations**, **MNSI referral and investigation requirements**, **PMRT/MBRRACE-UK reporting standards**, **MOSS surveillance arrangements**, **BAPM neonatal staffing and service standards**, and relevant **NHSE neonatal service specifications**.

General - No Additional Protection



Torbay and South Devon
NHS Foundation Trust

Presented to:	Trust Executive Group					
Title of Report	NHSE End of Year Safe Staffing Report 2025/2026					
Date of Meeting	20 th August 2026		Author	Nicola McMinn - CNO		
Executive Lead	Nicola McMinn - CNO		Executive Sign Off	Nicola McMinn - CNO		
Governance Route						
Purpose of paper	For Approval	For Assurance		To Update	For Information	
		X				
Executive Summary	The NHS England Southwest review provides positive external assurance that the Trust’s safer staffing arrangements are aligned with the National Quality Board framework and Developing Workforce Safeguards. The Trust meets all twelve of the national standards and the review supports an overall significant assurance position.					
Recommendation	The Trust Executive Group is asked to note the NHS England findings, take significant assurance from the external review and endorse completion of the identified actions through the established safer staffing and workforce governance arrangements.					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimagining acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
						X
How this paper supports delivery of the Strategy	Supports the Foundation by strengthening workforce governance, assurance and accountability for delivery of safe, effective and sustainable care.					
Board Assurance						
BAF Ref	Principal Risk		Current Score	Impact of this paper		
BAF-QS	Quality, Safety, Clinical outcomes and Patient Experience		3x4=12	Positive - Provides significant assurance that safer staffing controls are effective. No change to the current BAF score is proposed.		
Link to CQC Quality Statement	Safe	Caring		Responsive	Effective	Well-led
	X					X
Compliance / Regulatory Requirements	National Quality Board safe, sustainable and productive staffing guidance; NHS England Developing Workforce Safeguards; Care Quality Commission Regulation 18 (Staffing); and the requirement for transparent biannual staffing reviews and Board oversight.					

General - No Additional Protection



Torbay and South Devon
NHS Foundation Trust

Ethical or EDI implications?	Safe staffing decisions should be fair, transparent and based on patient need. Workforce plans should consider differential impacts on staff groups, flexible-working requirements and health inequalities, while avoiding disproportionate reliance on particular groups or temporary workers.			
Assurance rating	Significant	Moderate	Limited	Inadequate
	X			
Assurance rationale	Significant assurance is supported by the positive external review, which confirms compliance with all 12 national standards and effective safer staffing governance and controls.			
Appendices	NHSE - Torbay and South Devon Healthcare Foundation Trust Safer Staffing End of Year Report 2025/26			

Torbay and South Devon Healthcare Foundation Trust Safer Staffing End of Year Report 2025/26



Torbay and South Devon Healthcare Foundation Trust Safer Staffing End of Year Report 2025/26

Background

The National Quality Board (NQB) (2016) and Developing Workforce Safeguards (2018) set out mandatory requirements of Trust Boards to ensure that staffing levels are based on patients' needs, acuity, and risks, which are monitored from 'ward to board' and will enable NHS provider boards to ensure that the right staff with the right skills are in the right place at the right time.

- Trust Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard including Care Hours Per Patient Day (CHPPD). Trusts should report on this to their board every month and the results are published on the Trusts' internet page.
- An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
- As stated in Care Quality Commission's (CQC) well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
- Given day-to-day operational challenges, we expect Trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance, and staff experience must be clearly described in these risk assessments.
- Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

As part of the establishment review, the Chief Nursing Officer must confirm in a statement to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable, using the triangulated approach to staffing decisions as detailed below.

Torbay and South Devon Healthcare Foundation Trust Safer Staffing End of Year Report
2025/26



In order to provide quality assurance that these requirements were being met, the Chief Nursing Officer for NHS England established the Faculty for Safer Staffing. Each region has been tasked with undertaking a gap analysis of the NHS Provider organisations in their region, to ensure that they are meeting these requirements.

The South West (SW) Safer Staffing Team have used the gap analysis to generate a baseline heat map of safer staffing assurance across the region, covering 21 organisations. This includes acute, mental health, learning disabilities and community services. NHSE SW Safer Staffing Advisor rated the safer staffing gap analysis responses as per NQB guidance. They then reported the safer staffing gap analysis results to National Safer Staffing Team via a heat map showing compliance, partial compliance and non-compliance. Following the heat map report submission, the NHSE National Safer Staffing Team have requested a deeper dive to identify the evidence that was not presented or could not be found. The Regional Safer Staffing Team is in the process of undertaking meetings with all 21 providers across the South West and updating the gap analysis records as they gain evidence that the requirements are being met. They are also providing support to these organisations and will be working towards ensuring that all organisations are providing safe and effective staffing for high quality patient care.

The NHSE South West Safer Staffing Team meet regularly with the National Safer Staffing Team to discuss the assurance of safe staffing across the South West region. The reports from the SW Safe Staffing Team will also feed into the South West Quality Group.

Torbay and South Devon Healthcare Foundation Trust Safer Staffing End of Year Report 2025/26

Torbay and South Devon Healthcare Foundation Trust (TSD)

Below is the heat map for TSD with details for their initial submission and how their compliance has been updated post initial meeting and following the six-month review.

Safer Staffing Topic	Compliance	Compliance After Initial Meeting	Compliance After 6 monthly Review Meeting	Comments
1.NQB guidance	Compliant	Compliant	Compliant	
2.Triangulation	Compliant	Compliant	Compliant	
3.Evidence based tools utilisation	Compliant	Compliant	Compliant	The Trust are using SNCT and CNSST
4. No tool manipulation	Compliant	Compliant	Compliant	
5. Monthly Actual Vs Planned staff reporting	Compliant	Compliant	Compliant	
6. Annual statement	Compliant	Compliant	Compliant	
7. Workforce plan	Partial Compliance	Partial Compliance	Compliant	
8. Bi-annual establishment reviews	Compliant	Compliant	Compliant	
9. Quality dashboards	Partial Compliance	Compliant	Compliant	
10. Quality Impact Assessments	Partial Compliance	Compliant	Compliant	
11. Risk management & escalation	Partial Compliance	Compliant	Compliant	
12. Board awareness	Compliant	Compliant	Compliant	

The outcome of the 6-month review meeting shows that the Trust have become compliant in all 12 domains.

Further actions and issues noted from the meeting are:

- The Trust have a meeting booked with Simon Fuller, from WTE at NHSE SW

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	Constitutional Arrangements and Building on Governor Experience Minimum Standards of Patient Experience for Elective Care			Review of Board Workplan
For Review						
	Patient Story Our Plan for Better Care Planning 2026-27 April Update Strategy Report	Patient Story Our Plan for Better Care	Patient Story Our Plan for Better Care Tower Fire Risk	Patient Story Our Plan for Better Care SDH Developments Annual Report and Accounts	Patient Story Our Plan for Better Care	Patient Story Our Plan for Better Care
Reports from Board Sub Committees, Charity and Subsidiaries						
Audit						
Charity				Charity Committee Annual Report/video		
Finance and Performance	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status	Operational Performance Finance EPR Status
Quality and People	Perinatal Quality and Safety Report Maternity Staff Bi-Annual Report WRES/WDES Health Inequalities	Perinatal Quality and Safety Report Mortality Scorecard	Perinatal Quality and Safety Report Mortality Scorecard NHSE Safer Staffing Report Working Lives of Resident Doctors Annual Revalidation Report	Perinatal Quality and Safety Report Maternity Staffing Bi-Annual Report Children Safeguarding Annual Report Adult Safeguarding Annual Report Patient Experience Annual Report Working Lives of Resident Doctors 7 Hour Standards and 7 Day Working 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 Working Lives of Residents Doctors
Consent Items						
	Review of Directors' Interests					
Closing Matters						
	Questions received from members of the public AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	Questions received from members of the public AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	Questions received from members of the public AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	Questions received from members of the public AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	Questions received from members of the public AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting	Questions received from members of the public AOB/Review of Meeting BAF (matters for review or escalation) Board Workplan Date and Time of Next Meeting
Future Items						
Items for Information	IPQR 72 Hours Standards and & Day Working Report Cultural Insights Review Group Freedom to Speak Up Bi-Annual Report 2025 National Staff Survey Working Lives of Resident Doctors	IPQR Clinical Audit Forward Plan Medicines Optimisation Annual Report End of Life Annual Report Cultural Insights Report Clinical Audit Forward Plan 2025 National Staff Survey	IPQR Mortuary Report	IPQR Cultural Insights Report Freedom to Speak Up Bi-Annual Report National Maternity Triage Specification Review of CNST compliance	IPQR Research and Development Annual Report Patient Safety Incidents Annual Report CQC National Inpatient Survey Cultural Insights Report	IPQR 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 3 September 2026

Time: 12.30 pm - 2.30 pm

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

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TSDFT Public Board of Directors - Information Pack

Board Room, Hengrave House



03/09/2026 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

- Trust Constitution (mark up) (item 2.1)
- Our Plan for Better Care Report Appendix (item 4.1)

Finance and Operations Committee

- Integrated Performance and Quality Report (item 5.1.1)
- Monthly Finance Report Appendix (item 5.1.2)
- Electronic Patient Record Progress Report (item 5.1.3)

Quality and People Committee

- Appraisal and Revalidation Report (item 5.2.1)
- Working Lives of Resident Doctors (item 5.2.2)
- Perinatal Quality and Safety Report Appendix (item 5.2.3)
- Mortuary Report



Torbay and South Devon NHS Foundation Trust

Constitution

~~Approved on 01 May 2024 (minor amendment to numbering post October 2023 review)~~

Torbay and South Devon NHS Foundation Trust –Constitution ~~May 2024~~September 2026

DAC Beachcroft LLP

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1. DEFINITIONS AND INTERPRETATION

- 1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this Constitution bear the same meaning as in the 2006 Act. References in this constitution to legislation include all amendments, replacements, or re-enactments made.
- 1.2 References to legislation include all regulations, statutory guidance or directions. Headings are for ease of reference only and are not to affect interpretation.

1.3 In this Constitution the following definitions apply:

2006 Act	means the National Health Service Act 2006.
Accounting Officer	means the person who from time to time discharges the functions specified in paragraph 25(5) of schedule 7 to the 2006 Act.
Annual Members Meeting	is defined in paragraph 13 of this Constitution.
Annual Report	means the document prepared by the Trust pursuant to paragraph 43 of schedule 7 to the 2006 Act.
Appointed Governor(s)	means a member of the Council of Governors who is not an Elected Governor and who has been appointed in accordance with this Constitution.
Board of Directors	means the Board of Directors of the Trust comprising of the Executive Directors and the Non-Executive Directors.
Chair	means the chairperson of the Trust appointed in accordance with paragraph 27 of this Constitution.
Constitution	means this constitution together with each annex attached.
Council of Governors	means the Council of Governors as constituted in this Constitution in accordance with paragraph 7 of schedule 7 to the 2006 Act.
Director	means a member of the Board of Directors.
Director Code of Conduct	means any code of conduct applicable to all Executive Directors, Non-Executive Directors and such other persons as set out therein, as amended from time to time.
Elected Governor	means a Public Governor or a Staff Governor.

Executive Director	means an executive member of the Board of Directors of the Trust appointed pursuant to paragraph 30 of this Constitution.
Financial Year	means a period beginning on 1 April and finishing on the following 31 March.
Governor	means a member of the Council of Governors.
Governor Code of Conduct	means any code of conduct accepted by and applicable to all Governors, as amended from time to time.
Independence Criteria	means the indicative criteria set out at provision 2.6 of the Provider Code of Governance or such other guidance produced which the Trust must have regard to from time to time.
Lead Governor	means the governor appointed by the Council of Governors as Lead Governor in accordance with Annex 4.
Member	means a member of the Trust.
Model Election Rules	means the rules for the conduct of elections for a member of Council of Governors of Trust published by NHS Providers and set out at Annex 8.
NHS Body	means an NHS foundation trust and any body set out in section 9(4) of the 2006 Act.
NHS England	means the body corporate known as NHS England, established under section 1H of the 2006 Act.
NHS Provider Licence	means provider licence number: 110102 issued to the Trust by NHS England (as amended).
Non-Executive Director	means a non-executive member of the Board of Directors of the Trust appointed pursuant to paragraph 27 of this Constitution.
Principal Purpose	means the purpose set out in Section 43(1) of the 2006 Act and paragraph 3 of this Constitution.
Provider Code of Governance	means the "Code of governance for NHS provider trusts" published by NHS England, as may be amended from time to time.
Public Constituency	is defined in paragraph 9 of this Constitution.
Public Governor	means a member of the Council of Governors elected by the members of one of the Public Constituencies.

Secretary	means the secretary of Trust or any other person appointed to perform the roles and responsibilities as set out in any role description issued by the Trust, this Constitution and Appendix A of the Provider Code of Governance.
Staff Constituency	is defined in paragraph 10 of this Constitution.
Staff Governor	means a member of the Council of Governors elected by the members of the Staff Constituency.
Trust	is defined in paragraph 2 of this Constitution.
Trust Headquarters	Torbay Hospital, Lowes Bridge, Torquay TQ2 7AA.
Vice Chair	means the vice chairperson of the Trust appointed in accordance with paragraph 28 of this Constitution.

2. NAME

The name of the foundation trust is Torbay and South Devon NHS Foundation Trust (the **Trust**).

3. PRINCIPAL PURPOSE

- 3.1 The Principal Purpose of the Trust is the provision of goods and services for the purposes of the health service in England.
- 3.2 The Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.
- 3.3 The Trust may provide goods and services for any purposes related to:
 - 3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and
 - 3.3.2 the promotion and protection of public health.
- 3.4 The Trust may also carry on activities other than those mentioned in paragraph [3.3](#) above for the purpose of making additional income available in order to better carry on its Principal Purpose.

4. POWERS

- 4.1 The Trust is to have all the powers of an NHS foundation trust set out in the 2006 Act.
- 4.2 In the exercise of its powers the Trust shall have regard to:
 - 4.2.1 section 63A of the 2006 Act (duty to have regard to wider effect of decisions), also referred to as the “Triple Aim”;

4.2.2 section 63B of the 2006 Act (duties in relation to climate change); and

4.2.3 guidance published by NHS England.

4.3 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.4 Subject to any restriction contained in this Constitution or in the 2006 Act, any of these powers may be delegated to a committee of Directors or to an Executive Director.

5. JOINT WORKING WITH RELEVANT BODIES

5.1 The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the relevant bodies set out in Section 65Z5(1) of the 2006 Act.

5.2 Where a function is exercisable jointly, the relevant bodies may arrange for the function to be exercised by joint committee as set out in section 65Z6 of the 2006 Act.

6. JOINT FINANCIAL OBJECTIVES

6.1 The Trust must:

6.1.1 seek to achieve any financial objectives set under section 223L of the 2006 Act;

6.1.2 exercise their functions with a view to ensuring that, in respect of each Financial Year, limits specified by NHS England are not exceeded as set out in section 223M of the 2006 Act;

6.1.3 comply with any NHS England directions pursuant to section 223N of the NHS Act; and

6.1.4 comply with section 223LA with regard to expenditure limits, if and when that section comes into force.

7. MEMBERSHIP AND CONSTITUENCIES

7.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

7.1.1 a Public Constituency; or

7.1.2 a Staff Constituency.

8. APPLICATION FOR MEMBERSHIP

8.1 Subject to paragraph [12](#), an individual who is eligible to become a member of the Trust may do so on application to the Trust.

9. **PUBLIC CONSTITUENCY**

- 9.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.
- 9.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.
- 9.3 The minimum number of members in each Public Constituency is specified in Annex 1.

10. **STAFF CONSTITUENCY**

- 10.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member provided that they:
 - 10.1.1 are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
 - 10.1.2 have been continuously employed by the Trust under contract of employment for at least 12 months.
- 10.2 For the purposes of this paragraph [10](#), Chapter 1 of Part XIV of the Employment Rights Act 1996 (Continuous Employment) shall apply when determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the Trust.
- 10.3 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.
- 10.4 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.
- 10.5 ~~The Staff Constituency shall be divided into descriptions of individuals who are eligible for membership. The minimum number of members of the Staff Constituency, each description of individuals being, is specified within Annex 2 and being referred to as a class within the Staff Constituency.~~
- 10.6 ~~The Secretary shall make a final decision about the class of which an individual is eligible to be a member.~~
- 10.7 ~~The minimum number of members in each class of the Staff Constituency is specified in Annex 2.~~

11. **AUTOMATIC MEMBERSHIP BY DEFAULT – STAFF**

11.1 An individual who is:

- 11.1.1 eligible to become a member of the Staff Constituency, and
- 11.1.2 invited by the Trust to become a member of the Staff Constituency ~~and a member of the appropriate class within the Staff Constituency~~, shall become a Member as a member of ~~the Staff Constituency and appropriate class within~~ the Staff Constituency without an application being made unless they inform the Trust that they do not wish to become a Member.

12. **RESTRICTION ON MEMBERSHIP**

- 12.1 An individual who is a member of a constituency, ~~or of a class within a constituency~~, may not while membership of that constituency ~~or class~~ continues, be a member of any other constituency ~~or class~~.
- 12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.
- 12.3 An individual must be at least fourteen years old to become a Member.
- 12.4 Further provisions as to the circumstances in which an individual may not become or continue as a Member are set out in Annex 6.

13. **ANNUAL MEMBERS' MEETING**

- 13.1 The Trust shall hold an annual meeting of its members (the **Annual Members' Meeting**). The Annual Members' Meeting shall be open to members of the public.
- 13.2 Further provisions about the Annual Members' Meeting are set out in Annex 7.

14. **COUNCIL OF GOVERNORS – COMPOSITION**

- 14.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.
- 14.2 The composition of the Council of Governors is specified in Annex 3.
- 14.3 The members of the Council of Governors, other than the Appointed Governors, shall be chosen by election by their constituency ~~or, where there are classes within a constituency, by their class within that constituency~~. The number of Governors to be elected by each constituency, ~~or, where appropriate, by each class of each constituency~~, is specified in Annex 3.

15. COUNCIL OF GOVERNORS – ELECTION OF GOVERNORS

- 15.1 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules.
- 15.2 The Model Election Rules as published from time to time form part of this Constitution. The Model Election Rules current at the date of this Constitution are set out at Annex 8.
- 15.3 A subsequent variation of the Model Election Rules shall not constitute a variation of the terms of this Constitution for the purposes of paragraph [46](#). An updated version of the Constitution may be published by the Secretary incorporating any revised Model Election Rules.
- 15.4 An election, if contested, shall be by secret ballot.

16. COUNCIL OF GOVERNORS - TENURE

16.1 Elected Governors

- 16.1.1 An Elected Governor may hold office for a period of up to three years.
- 16.1.2 An Elected Governor shall cease to hold office if they cease to be a member of the constituency ~~or class~~ by which they were elected.
- 16.1.3 Subject to paragraph [16.1.4](#), an Elected Governor shall be eligible for re-election at the end of their term.
- 16.1.4 An Elected Governor may not serve on the Council of Governors for more than nine years in aggregate. For the avoidance of doubt, this covers all constituencies such that once an Elected Governor has served for nine years in any one constituency or across a mixture of several Constituencies they are no longer eligible to stand for election in any constituency or be appointed to the Council of Governors.

16.2 Appointed Governors

- 16.2.1 An Appointed Governor may hold office for a term of up to three years.
- 16.2.2 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.
- 16.2.3 An Appointed Governor shall be eligible for re-appointment at the end of their term.

17. **COUNCIL OF GOVERNORS – DISQUALIFICATION AND REMOVAL**

- 17.1 The following may not become or continue as a member of the Council of Governors:
- 17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
 - 17.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
 - 17.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it; or
 - 17.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.
- 17.2 Governors must be at least sixteen years (16) of age at the date they are nominated for election or appointment.
- 17.3 Further provisions as to the circumstances in which an individual may not become or continue as a Governor are set out in Annex 4.

18. **COUNCIL OF GOVERNORS – DUTIES OF GOVERNORS**

- 18.1 The general duties of the Council of Governors are to:
- 18.1.1 hold the non-executive directors individually and collectively to account for the performance of the Board of Directors;
 - 18.1.2 represent the interests of the Members as a whole and the interests of the public; and
 - 18.1.3 feedback information about the Trust, its vision and its performance to Members, the public and stakeholder organisations.
- 18.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

19. **COUNCIL OF GOVERNORS – MEETINGS OF GOVERNORS**

- 19.1 The Chair, or, in their absence the Vice Chair, shall preside at meetings of the Council of Governors.
- 19.2 In the absence of both the Chair and the Vice Chair at a meeting of the Council of Governors, the Governors present shall nominate another non- executive director to preside over that meeting.

19.3 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

19.4 For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

20. **COUNCIL OF GOVERNORS – STANDING ORDERS**

The standing orders for the practice and procedure of the Council of Governors shall be read alongside this Constitution.

21. **COUNCIL OF GOVERNORS - CONFLICTS OF INTEREST OF GOVERNORS**

21.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

21.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

22. **COUNCIL OF GOVERNORS – TRAVEL EXPENSES**

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

23. **COUNCIL OF GOVERNORS – FURTHER PROVISIONS**

Further provisions with respect to the Council of Governors are set out in Annex 4.

24. **BOARD OF DIRECTORS – COMPOSITION**

24.1 The Trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

24.2 The Board of Directors is to comprise:

24.2.1 a non-executive Chair

24.2.2 Non-Executive Directors; and

24.2.3 Executive Directors.

24.3 One of the Executive Directors shall be the Chief Executive.

24.4 The Chief Executive shall be the Accounting Officer.

- 24.5 One of the Executive Directors shall be the finance director
- 24.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).
- 24.7 One of the Executive Directors is to be a registered nurse or a registered midwife.
- 24.8 At least half of the Board of Directors (excluding the Chair) should be Non-executive Directors. In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in their absence, the Vice Chair), shall have a casting vote at meetings of the Board of Directors.
- 24.9 The post of an Executive Director may be held by two individuals (provided that the provisions of this paragraph [24](#) are met in respect of required qualifications) on a job share basis. Where such an agreement is in force the two individuals may only exercise one vote between them at any meeting of the Board of Directors. In the case of disagreements, no vote may be cast.
- 24.10 The Trust may appoint other individuals who may receive a standing invite to attend meetings of the Board of Directors, but such individuals shall not be members of the Board of Directors, shall not have a vote and shall not count towards any quorum requirements.

25. **BOARD OF DIRECTORS – GENERAL DUTY**

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

26. **BOARD OF DIRECTORS – QUALIFICATION FOR APPOINTMENT AS A NON-EXECUTIVE DIRECTOR**

- 26.1 A person may be appointed as a Non-Executive Director only if:
 - 26.1.1 they are a member of a Public Constituency, or
 - 26.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university; and
 - 26.1.3 they are not disqualified by virtue of paragraph [31](#) below.
- 26.2 On first appointment, re-appointment for each further term and throughout their term of office, the Chair and Non-Executive Directors are required to meet the Independence Criteria. In circumstances where, in relation to the Chair or a Non-Executive Director, the Independence Criteria are not met but the Board of Directors considers that the individual in question is independent this will be explained in the Annual Report.

27. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF CHAIR AND OTHER NON-EXECUTIVE DIRECTORS

- 27.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors. In doing so, the Council of Governors shall take into account the Provider Code of Governance.
- 27.2 Removal of the Chair or another Non-Executive Directors shall require the approval of three-quarters of the members of the Council of Governors.
- 27.3 Subject always to the Provider Code of Governance, the maximum tenure for any individual holding the office of Non-Executive Director shall be nine years in aggregate unless exceptional circumstances apply. For the avoidance of doubt, exceptional circumstances shall be determined on a case by case basis.
- 27.4 In a situation where a Non-Executive Director becomes the Chair, the maximum tenure runs from the time of first appointment to the position of Non-Executive Director.

28. BOARD OF DIRECTORS – APPOINTMENT OF VICE CHAIR

- 28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Vice Chair.
- 28.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice Chair by giving notice in writing to the Chair. The Council of Governors may consequently appoint another Non-Executive Director as Vice Chair in accordance with this Constitution.

29. BOARD OF DIRECTORS – APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

- 29.1 The Board of Directors shall appoint one of the independent Non-Executive Director (as set out in the Provider Code of Governance) to be the Senior Independent Director in consultation with the Council of Governors, for such a period not exceeding the remainder of their term as a Non-Executive Director, as they may specify on appointing them.
- 29.2 The Senior Independent Director will be available to Governors if they have concerns that the Chair is unable to resolve.

30. BOARD OF DIRECTORS – APPOINTMENT AND REMOVAL OF THE CHIEF EXECUTIVE AND OTHER EXECUTIVE DIRECTORS

- 30.1 The Non-Executive Directors shall appoint or remove the Chief Executive.
- 30.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

- 30.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Director shall appoint or remove the other Executive Directors.

31. BOARD OF DIRECTORS – DISQUALIFICATION

- 31.1 The following may not become or continue as a member of the Board of Directors:

- 31.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
- 31.1.2 a person in relation to whom a moratorium period under a debt relief order applied (under Part 7A of the Insolvency Act 1986);
- 31.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it; or
- 31.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

- 31.2 Further provisions as to the circumstances in which a person may not become or continue as a member of the Board of Directors are set out in Annex 5.

32. BOARD OF DIRECTORS – MEETINGS

- 32.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.
- 32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors. Minutes of meetings of the Board of Directors held in private shall be provided as required by the Provider Code of Governance unless exceptional circumstances apply which shall be determined on a case by case basis.

33. BOARD OF DIRECTORS – STANDING ORDERS

The standing orders for the practice and procedure of the Board of Directors shall be read alongside this Constitution.

34. BOARD OF DIRECTORS - CONFLICTS OF INTEREST OF DIRECTORS

- 34.1 The duties that a director of the Trust has by virtue of being a director include in particular:
- 34.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.
 - 34.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.
- 34.2 The duty referred to in paragraph [34.1.1](#) is not infringed if:
- 34.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or
 - 34.2.2 the matter has been authorised in accordance with this Constitution.
- 34.3 The duty referred to in paragraph [34.1.2](#) is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.
- 34.4 In paragraph [34.1.2](#), “third party” means a person other than:
- 34.4.1 the Trust, or
 - 34.4.2 a person acting on its behalf.
- 34.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extend of that interest to the other directors.
- 34.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.
- 34.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.
- 34.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.
- 34.9 A director need not declare an interest:
- 34.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;
 - 34.9.2 if, or to the extent that, the directors are already aware of it;
 - 34.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered:
 - (a) by a meeting of the Board of Directors; or

- (b) by a committee of the directors appointed for the purpose under this Constitution.

34.10 A matter shall have been authorised for the purposes of paragraph [34.2.2](#) if:

- 34.10.1 the Board of Directors by majority disapplies the provision of the Constitution which would otherwise prevent a director from being counted as participating in the decision-making process;
- 34.10.2 the director's interest cannot reasonably be regarded as likely to give rise to a conflict of interest; or
- 34.10.3 the director's conflict of interest arises from a permitted clause (as determined by the Board of Directors) from time to time.

35. **BOARD OF DIRECTORS – REMUNERATION AND TERMS OF OFFICE**

35.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

35.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

36. **REGISTERS**

36.1 The Trust shall have:

- 36.1.1 a register of Members showing, in respect of each Member, the Constituency to which they belong ~~and, where there are classes within it, the class to which they belong;~~
- 36.1.2 a Register of Members of the Council of Governors;
- 36.1.3 a Register of Interests of Governors;
- 36.1.4 a Register of Directors; and
- 36.1.5 a Register of Interests of the Directors.

36.2 The Secretary shall be responsible for compiling and maintaining the registers, and the registers may be kept in either paper or electronic form. Removal from any register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 14 days of receipt.

37. ADMISSION TO AND REMOVAL FROM THE REGISTERS

- 37.1 The Secretary shall add to the register of Members the name of any individual who is accepted as a Member under the provisions of this Constitution. The Secretary shall remove from the register of Members the name of any Member who ceases to be entitled to be a Member.

38. REGISTERS – INSPECTION AND COPIES

- 38.1 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member, if the Member so requests.
- 38.2 So far as the registers are required to be made available:
- 38.2.1 they are to be available for inspection free of charge at all reasonable times; and
- 38.2.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.
- 38.3 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

39. DOCUMENTS AVAILABLE FOR PUBLIC INSPECTION

- 39.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
- 39.1.1 a copy of the current constitution;
- 39.1.2 a copy of the latest annual accounts and of any report of the auditor on them; and
- 39.1.3 a copy of the latest Annual Report.
- 39.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:
- 39.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.
- 39.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.
- 39.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

- 39.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
- 39.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.
- 39.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.
- 39.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
- 39.2.8 a copy of any final report published under section 65I (administrator's final report),
- 39.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.
- 39.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.
- 39.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.
- 39.4 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.
- 40. **AUDITOR**
 - 40.1 The Trust shall have an auditor.
 - 40.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.
 - 40.3 A person may only be appointed as the auditor if they (or, in the case of a firm, each of its members) are a member of one or more of the bodies referred to in paragraph 23(4) of schedule 7 to the 2006 Act.
 - 40.4 The auditor is to carry out their duties in accordance with schedule 10 to the 2006 Act.
- 41. **AUDIT COMMITTEE**

The Trust shall establish a committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.
- 42. **ACCOUNTS**

- 42.1 The Trust must keep proper accounts and proper records in relation to the accounts.
- 42.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.
- 42.3 The accounts are to be audited by the Trust's auditor.
- 42.4 The Trust shall prepare in respect of each Financial Year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.
- 42.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

43. ANNUAL REPORT, FORWARD PLANS AND NON-NHS WORK

- 43.1 The Trust shall prepare an Annual Report and send it to NHS England.
- 43.2 The Annual Report must
 - 43.2.1 review the extent to which the Trust has exercised its functions in accordance with the plans published under:
 - (a) section 14Z52 of the 2006 Act (joint forward plans for integrated care board and its partners); and
 - (b) section 14Z56 of the 2006 Act (joint capital resource use plan for integrated care board and its partners),
 - 43.2.2 review the extent to which the Trust has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) of the 2006 Act (views about how functions relating to inequalities information should be exercised);
 - 43.2.3 give information:
 - (a) on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the ~~classes of the~~ Staff Constituency is representative of those eligible for such membership;
 - (b) on any occasions in the period to which the report relates on which the council of governors exercised its power under paragraph 10C of schedule 7 to the 2006 Act;
 - (c) on the remuneration of the directors and on the expenses of the Governors and the directors;
 - (d) on the impact that income received by the Trust otherwise than from the provision of goods and services for the purposes of the health service in England has had

on the provision by the Trust of goods and services for those purposes; and

(e) on any other matter which NHS England requires.

43.3 The Trust shall give information as to its forward planning in respect of each Financial Year to NHS England.

43.4 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

43.5 In preparing the document, the directors shall have regard to the views of the Council of Governors.

43.6 Each forward plan must include information about:

43.6.1 the activities other than the provision of goods and services for the purpose of the health service in England that the Trust proposes to carry on; and

43.6.2 the income it expects to receive from doing so.

43.7 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in paragraph [43.6.1](#) the Council of Governors must:

43.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its functions; and

43.7.2 notify the directors of the Trust and its determination.

43.8 A Trust which proposes to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the provision of goods and services for the purpose of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

44. PRESENTATION OF THE ANNUAL ACCOUNTS AND REPORTS TO THE GOVERNORS AND MEMBERS

44.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

44.1.1 the annual accounts

44.1.2 any report of the auditor on them

44.1.3 the Annual Report.

44.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

44.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of paragraph [44.1](#) with the Annual Members' Meeting.

45. INSTRUMENTS

45.1 The Trust shall have a seal.

45.2 The seal shall not be affixed except under the authority of the Board of Directors.

45.3 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

46. AMENDMENT OF THE CONSTITUTION

46.1 The Trust may make amendments to this Constitution only if:

46.1.1 more than half of the members of the Council of Governors voting approve the amendments, and

46.1.2 more than half of the members of the Board of Directors voting approve the amendments.

46.2 Amendments made under paragraph [46.1](#) take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as this Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

46.3 Where an amendment is made to this Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

46.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

46.3.2 the Trust must give the members an opportunity to vote on whether they approve the amendment.

46.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

46.5 Amendments by the Trust to this Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with schedule 7 of the 2006 Act.

46.6 The following amendments to ancillary documents shall not be considered amendments to the Trust's Constitution and shall not be required to follow the process set out above:

46.6.1 new versions of the Model Election Rules which will be notified in accordance with paragraph 15.3 above;

46.6.2 amendments to the standing orders for the practice and procedure of the Council of Governors and the standing orders for the practice and procedure of the Board of Directors shall be made in accordance with those standing orders;

46.6.3 amendments to any Director Code of Conduct which will follow the amendment process in that document; and

46.6.4 amendments to any Governor Code of Conduct which will follow the amendment process in that document.

47. MERGERS ETC. AND SIGNIFICANT TRANSACTIONS

47.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

47.3 In paragraph 47.2, the following words have the following meanings:

47.3.1 "Significant Transaction" means a transaction which meets any one of the tests below:

(a) the total asset test; or

(b) the total income test; or

(c) the capital test (relating to acquisitions or divestments).

47.3.2 The total asset test is met if the assets which are the subject of the transaction exceed 25% of the total assets of the Trust.

47.3.3 The total income test is met if, following the completion of the relevant transaction, the total income of the Trust will increase or decrease by more than 25%.

47.3.4 The capital test is met if the gross capital of the company or business being acquired or divested represents more than 25% of the capital of the Trust following completion (where "gross capital" is the market value of the relevant company or business's shares and debt securities, plus the excess of current liabilities over current assets, and the Trust's total taxpayers' equity).

47.3.5 For the purposes of calculating the tests in this paragraph [47.3](#) figures used for the Trust assets, total income and taxpayers' equity must be the figures shown in the latest published audited consolidated accounts.

47.4 A transaction:

47.4.1 excludes a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the Trust);

47.4.2 excludes any agreement or changes to healthcare services carried out by the Trust following a reconfiguration of services led by the commissioners of such services;

47.4.3 excludes any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the Trust.

47.5 The Trust may enter into Material Transactions provided that it has sought the views of the Council of Governors. A "Material Transaction" for the purposes of this paragraph [47.5](#) shall mean a transaction which meets one of the following tests:

47.5.1 the total asset test; or

47.5.2 the total income test; or

47.5.3 the capital test (relating to acquisitions or divestments).

where the definitions set out in paragraph 47.3 will apply, except that instead of the threshold being 25% it shall be "greater than 10%".

48. ELECTRONIC COMMUNICATIONS

48.1 Meetings of the Trust may be conducted by electronic means (in whole or in part) provided that each person attending has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication where the meeting is hybrid.

48.2 A meeting at which one or more persons attends by way of electronic means the meeting will be deemed to be held at such a place as said meeting shall resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of persons attending the meeting are physically present, or in default of such a majority, the place at which the chair of the meeting is physically present.

48.3 Meetings held by electronic means remain subject to requirements in respect of quorum. For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

- 48.4 The minutes of a meeting held in this way must state that it was held by electronic means and that all persons were all able to hear each other and were present throughout the meeting.
- 48.5 Meetings open to the public, if held by electronic means, should be open to public attendance by such means.
- 48.6 For the purposes of this paragraph "electronic means" shall include telephone, video conference or any other such electronic methods, which allows all participating persons in the meeting to hear and interact with each other.

49. **INDEMNITY**

To the extent permissible by law, the Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, the Council of Governors, the Board of Directors and the Secretary.

50. **DEFECTIVE APPOINTMENTS**

Acts done by the Trust or of a committee or by a person acting as a director or Governor shall not be invalidated by the subsequent realisation that the appointment of any such director or Governor person acting as a director or Governor was defective.

ANNEX 1

THE PUBLIC CONSTITUENCIES

The Trust has four (4) Public Constituencies as follows:

Areas comprising the Public Constituency	Local Authority areas/or local authority electoral areas falling within the following Electoral Wards	Minimum number of Members	Number of elected Governors
South Hams	South Hams District Council	Five hundred (500)	Three (3)
Torbay	Torbay Unitary Authority	Five hundred (500)	Seven (7)
Teignbridge	Teignbridge District Council	Five hundred (500)	Seven (7)
Rest of the South West Peninsula	All electoral wards in Cornwall, Devon, Dorset, Somerset and Bristol not included in the above Public Constituencies (which for the avoidance of doubt includes all wards within the district and unitary councils within those areas)	Ten (10)	One (1)

For ease of reference, a map identifying the footprint of the Trust is provided below:



ANNEX 2 THE STAFF CONSTITUENCY

The minimum number of members of the Staff Constituency is divided into shall be 100.

There shall be five (5) classes as follows: elected Governors from the Staff Constituency.

~~Classes comprising the Staff Constituency~~	~~Minimum number of Members~~	~~Number of elected Governors~~
~~Families and Communities~~	~~One hundred (100)~~	~~One (1)~~
~~Medicine and Urgent Care~~	~~One hundred (100)~~	~~One (1)~~
~~Planned Care and Surgery~~	~~One hundred (100)~~	~~One (1)~~
~~Children and Family Health Devon~~	~~One hundred (100)~~	~~One (1)~~
~~Professional Support Services~~	~~One hundred (100)~~	~~One (1)~~

ANNEX 3**COMPOSITION OF COUNCIL OF GOVERNORS**

The Council of Governors is to comprise:

Constituency	Number of seats on the Council of Governors
Elected Governors	
Public constituency	18
South Hams and Plymouth	Three (3)
Torbay	Seven (7)
Teignbridge	Seven (7)
Rest of the South West Peninsula	One (1)
Staff constituency	5
~~Families and Communities~~	~~One (1)~~
~~Medicine and Urgent Care~~	~~One (1)~~
~~Planned Care and Surgery~~	~~One (1)~~
~~Children and Family Health Devon~~	~~One (1)~~
~~Professional Support Services~~	~~One (1)~~
Appointed Governors	9
Devon County Council	One (1)
South Hams District Council	One (1)
Teignbridge District Council	One (1)
Torbay District Council	One (1)
NHS Devon Integrated Care Board	One (1)
Devon Partnership NHS Trust	One (1)
University of Exeter Medical School	One (1)
Plymouth University Peninsula School of Medicine and Dentistry	One (1)
Devon Carers Strategy Board or Torbay Carers Strategy Steering Group	One (1)
Total	32

ANNEX 4

Additional Provisions – Council of Governors

1. Elected Governors

A Member of the Public Constituency may not vote at an election for a public governor unless at the time of voting they have made and returned a declaration in the form specified in the Model Election Rules, that they are qualified to vote as a Member of the Public Constituency.

2. Appointed Governors

2.1 The Secretary (or such person as they may nominate) shall contact each relevant organisation in writing regarding the appointment of the Governor by it.

2.2 For the purposes of this paragraph [2](#) “relevant organisation” shall mean any local authority, university or other partnership organisation which is eligible to appoint a Governor to the Council of Governors under this Constitution.

3. Lead Governor

3.1 The Council of Governors shall appoint one of its public Governors as the Lead Governor in accordance with the conditions of appointment set out in the Lead Governor role description approved by the Council of Governors.

3.2 The Lead Governor shall have the responsibilities, and perform the tasks, set out in the Lead Governor role description.

3.3 The term of the Lead Governor shall be one (1) year.

4. Further provisions as to eligibility to be a Governor

4.1 In addition to paragraph [17](#) of this Constitution, a person may not become or continue as a Governor if:

4.1.1 they are not a Member;

4.1.2 in the case of a public governor or staff governor they cease to be a Member of the Constituency ~~or Class~~ from which they were elected;

4.1.3 in the case of an appointed governor, the organisation which appointed them terminates that appointment;

4.1.4 they are a person who is not a fit and proper person as required by the NHS Provider Licence;

4.1.5 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their

- name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;
- 4.1.6 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;
 - 4.1.7 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;
 - 4.1.8 they are the spouse, partner, parent, child of, or occupant of the same household as a director or a member of the Council of Governors;
 - 4.1.9 they are a member of a local authority's Overview and Scrutiny Committee covering health matters or hold a role at a local authority which involves the review or scrutiny of health matters;
 - 4.1.10 they are a director of the Trust;
 - 4.1.11 they are a governor, non-executive director (including the chair) or, executive director (including the chief executive officer) of another NHS Body, unless they are appointed by an appointing organisation which is a NHS Body or the Chair agrees to them becoming, or continuing as, a governor of the Trust in exceptional circumstances;
 - 4.1.12 they have within the preceding two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a NHS Body;
 - 4.1.13 they are a person whose tenure of office as a Chair or as a member or director of a NHS Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
 - 4.1.14 they have previously been removed as a Governor of the Trust;
 - 4.1.15 they have previously been removed as a governor from another NHS foundation trust;
 - 4.1.16 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of any Governor Code of Conduct;
 - 4.1.17 they have committed a serious breach of the Governor Code of Conduct;

- 4.1.18 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a governor;
 - 4.1.19 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
 - 4.1.20 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales, and they have not subsequently had their name included in such a list;
 - 4.1.21 they are deemed a vexatious or persistent complainant or litigant against the Trust without reasonable cause; or
 - 4.1.22 they have failed to repay (without good cause) any amount of monies properly owed to the Trust.
- 4.2 For the purposes of this Annex 4 "a vexatious or persistent complainant" shall be as defined in the Trust's Feedback Complaints and Patient Advice and Liaison (PALS) Policy (or such other policy that may replace it from time to time). In the event of a dispute regarding whether an individual is a vexatious or persistent complainant, the Chair in consultation with the Senior Independent Director shall make the final decision.
- 4.3 A person holding office as a Governor shall immediately cease to do so if:
- 4.3.1 they resign by notice in writing to the Secretary;
 - 4.3.2 they become disqualified from office under paragraph [17](#) of this Constitution or under paragraph [4.1](#) of this Annex 4;
 - 4.3.3 they fail to attend two meetings of the Council of Governors in a period of one year unless the Lead Governor, Chair and Secretary are satisfied that:
 - 4.3.3.1 the absence was due to a reasonable cause; and
 - 4.3.3.2 they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.
 - 4.3.4 they have refused to undertake any training which the Council of Governors requires all governors to undertake unless the Lead Governor, Chair and Secretary are satisfied that the refusal was due to a reasonable cause; or

- 4.3.5 they are removed from the Council of Governors by a resolution passed under paragraph [5](#) below.
- 4.4 For the purposes of 4.3 [3.1](#) and 4.3 [4](#):
 - 4.4.1 an absence will ordinarily be considered to be due to a reasonable cause if it is due to:
 - 4.4.1.1 a conflict with work or personal commitments in circumstances where the Trust has changed the date of the meeting of the Council of Governors at short notice;
 - 4.4.1.2 ill health (provided that the Governor in question, or someone on their behalf, has advised the Secretary of such circumstances as soon as reasonably practicable); or
 - 4.4.1.3 a personal or family emergency.
 - 4.4.2 For the avoidance of doubt, work commitments will not be considered a reasonable cause unless the Trust has changed the date of the meeting of the Council of Governors at short notice.
 - 4.4.3 Instances of ill health will be reviewed on a case-by-case basis in consultation between the Lead Governor, Secretary, the Chair and the affected Governor with a view of acting in the best interests of the Trust.
- 4.5 Where a Governor becomes disqualified for appointment under this paragraph [4](#) or paragraph [17](#) of this Constitution, they shall notify the Secretary in writing without delay upon becoming aware the grounds for disqualification. Any failure to notify the Secretary of grounds for disqualification pursuant to this paragraph [4.5](#) shall result in such individual becoming ineligible to become a Governor at any future point.
- 4.6 If it comes to the notice of the Secretary that at the time of their appointment or later a Governor is disqualified, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

5. Removal of Governor from office

- 5.1 A Governor may be removed from the Council of Governors by a resolution approved at a meeting of the Council of Governors by not less than three-quarters of the Governor present and voting on the grounds that:
 - 5.1.1 they have acted in a manner detrimental to the interests of the Trust or otherwise bring the Trust into disrepute; or

5.1.2 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor, for example because:

5.1.2.1 the individual's continuation as a Governor would be likely to prejudice the ability of the Trust to fulfil its principal purpose or discharge its duties and functions;

5.1.2.2 the individual's continuation as a Governor would be likely to prejudice the Trust's work with other persons or body within whom it is engaged or may be engaged in the provision of goods and services;

5.1.2.3 the individual's continuation as a Governor would be likely to adversely affect public confidence in the goods and services provided by the Trust;

5.1.2.4 it would not be in the best interests of the Council of Governors for the individual to continue as a Governor / the individual has caused or is likely to cause prejudice to the proper conduct of the Council of Governors' affairs; or

5.1.2.5 the individual has failed to comply with the values and principles of the NHS, the Trust or this Constitution.

5.2 The Council of Governors will agree a process for investigating complaints against a Governor which may lead to a removal of a Governor under this paragraph 5.

5.3 Upon legislation being passed which removes the requirement for the Trust to have a Council of Governors, all constitutional provisions concerning Governors and the Council of Governors shall become invalid, and all Governors shall be deemed removed as of the effective date set out in such legislation. In the event that Governors, and the Council of Governors cease to exist at the Trust provisions in this Constitution relating to the appointment and removal of Non-Executive Directors will be deemed to be replaced by such other process as legislation requires until the Constitution is amended.

6. Vacancies amongst Governors

6.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

Appointed Governors

6.2 Where the vacancy arises amongst the Appointed Governor, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office or to commence a new term of office.

Elected Governors

- 6.3 Where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either:
- 6.3.1 to call an election within three months to fill the seat for the remainder of that term of office;
 - 6.3.2 to call an election to fill the seat for a new term of office;
 - 6.3.3 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office; or
 - 6.3.4 if the unexpired period of the term of office is less than twelve months, to leave the seat vacant until the next elections are held.
- 6.4 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or in the appointment or election of the Governor attending the meeting.

7. Dispute Resolution

- 7.1 In the event of any dispute between the Council of Governors and the Board of Directors:
- 7.1.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;
 - 7.1.2 if the Chair is unable to resolve the dispute they shall appoint a special committee comprising equal numbers of directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute; and
 - 7.1.3 if the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

ANNEX 5

Additional Provisions – Board of Directors

1. Disqualification of directors

- 1.1 In addition to paragraph 31 of this Constitution, a person may not become or continue as a Director if:
 - 1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;
 - 1.1.2 they (or an organisation of which they were a director) have been found guilty of an offence under the Modern Slavery Act 2015;
 - 1.1.3 they (or an organisation of which they were a director) have been found guilty of an offence under the Bribery Act 2010 or any other applicable law relating to fraud, financial crime or terrorist financing;
 - 1.1.4 they are the spouse, partner, parent, child of, or occupant of the same household as a Director or a member of Council of Governors;
 - 1.1.5 they are a member of a local authority's Overview and Scrutiny Committee covering health matters;
 - 1.1.6 they are a Governor;
 - 1.1.7 they are a governor, non-executive director (including the Chair) or, executive director (including the chief executive officer) of another NHS Body, unless:
 - 1.1.7.1 in the case of an executive director other than the Chief Executive, the Chair, following consultation with the Chief Executive;
 - 1.1.7.2 in the case of the Chief Executive, the Chair, following consultation with the Board of Directors;
 - 1.1.7.3 in the case of a non-executive director other than the Chair, the Chair following consultation with the Council of Governors; or
 - 1.1.7.4 in the case of the Chair, the Senior Independent Director, following consultation with the Board of Directors and the Council of Governors,
 agrees to them becoming, or continuing as, a Director;

- 1.1.8 they are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of the NHS, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- 1.1.9 in the case of a non-executive Director, they have refused, without reasonable cause, to fulfil any training requirement established by the Board of Directors;
- 1.1.10 they lack capacity within the meaning of the Mental Capacity Act 2005 to carry out all the duties and responsibilities of a Director;
- 1.1.11 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;
- 1.1.12 they have had their name removed from a list maintained under regulations pursuant to sections 91 (Persons performing primary medical services), 106 (Persons performing primary dental services), 123 (Persons performing primary ophthalmic services), or 146 (Persons performing local pharmaceutical services) of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list;
- 1.1.13 they are deemed a vexatious or persistent complainant (as defined in Annex 4) or litigant against the Trust without reasonable cause;
- 1.1.14 they have failed to repay (without good cause) any amount of monies properly owed to the Trust; or
- 1.1.15 they fail to satisfy the fit and proper persons requirements for directors as detailed in Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as may be amended from time to time.
- 1.2 Where a Director becomes disqualified for appointment under paragraph [1](#) of this Annex or paragraph 31 of this Constitution, they shall notify the Trust Secretary in writing of such disqualification.
- 1.3 If it comes to the notice of the Trust Secretary that at the time of their appointment or later the Director is so disqualified, they shall immediately declare that the Director in question is disqualified and notify them in writing to that effect.
- 1.4 Where a Director is disqualified their tenure of office shall automatically terminate and they shall cease to hold office with immediate effect.

2. Expenses

- 2.1 The Trust may reimburse executive Directors travelling and other costs and expenses incurred in carrying out their duties at such rates as the Remuneration Committee decides. These are to be disclosed in the annual report.

ANNEX 6

Further Provisions - Membership

1. Restriction on membership

- 1.1 In addition to paragraph [12](#) of this Constitution, the following restrictions on Membership apply:
 - 1.1.1 The following will not be eligible to become or continue a Member:
 - 1.1.1.1 they have been required to notify the police of their name and address as a result of being convicted or cautioned under the Sexual Offences Act 2003 or other applicable legislation or their name appears a Barred List as defined in the Safeguarding Vulnerable Groups Act 2006;
 - 1.1.1.2 an individual who exhibits inappropriate conduct (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors), including those who have been identified as the perpetrators of a serious incident involving violence, assault or harassment against Trust staff; and/or
 - 1.1.1.3 a person who is a deemed a vexatious or persistent complainant or litigant against the Trust (as defined in Annex 4) without reasonable cause (as agreed by a majority of the governors present and voting at a meeting of the Council of Governors).

2. Termination of Membership

- 2.1 A Member shall cease to be a Member if:
 - 2.1.1 they resign by notice in writing to the Trust Secretary;
 - 2.1.2 they cease to be eligible to continue to as a Member under paragraph [1.1.1](#) of this Annex 6 or paragraph [12](#) of this Constitution;
 - 2.1.3 they are expelled from Membership under paragraph [1.1](#) of this Annex 6; or
 - 2.1.4 they die.
- 2.2 The Trust shall give any Member at least fourteen days' written notice of a proposal to remove them from the Trust membership under this paragraph [2](#) of Annex 6. The Trust shall consider any representations made by the Member during that notice period, and the Secretary shall decide whether to remove the Member. Within fourteen days after receiving notice of the Secretary's decision, a person wishing to dispute

the decision may require the Secretary to refer the matter to the Council of Governors to determine whether the decision was fair and reasonable taking all relevant matters into account. Where a Member does not ask the Secretary to refer their proposed removal to the Council of Governors, they shall cease to be a Member fourteen days after receiving notice of the Secretary's decision. Where a Member does ask the Secretary to refer their proposed removal to the Council of Governors, they shall continue to be a Member until the Council of Governors has reached a decision on their membership and provided them with notice. The decision of the Council of Governors shall be final.

- 2.3 An individual member removed under paragraph [2.2](#) may make a request to the Secretary that their membership removal be reviewed and their eligibility to be a member be considered no sooner than 12 months from the date of the removal.
- 2.4 When making a request under paragraph [2.3](#) the individual must make such a request in writing to the Secretary and outline whether they wish to be considered as eligible to be a member and the reasons for the requested review. The Trust shall endeavour to issue a decision in writing within 28 days of receipt of the request. The Trust's decision shall be final and any further requests for review may only be made after intervals of at least two further years.

ANNEX 7

Annual Members Meeting

- 1.1 The Trust shall hold a members' meeting for all Members (called the **Annual Members Meeting**) within six months of the end of the financial year of the Trust.
- 1.2 Any members' meeting other than the Annual Members' Meeting shall be called a 'Special Members Meeting'.
- 1.3 Both Annual Members' Meetings and Special Members' Meetings shall be open to all Members, members of the Council of Governors and members of the Board of Directors, together with representatives of the Trust's Auditors, and to members of the public. The Trust may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend any such meeting.
- 1.4 The Board of Directors may convene an Annual Members' Meeting or a Special Members' meeting when it thinks fit. The Council of Governors may request the Board of Directors to convene a members' meeting.
- 1.5 The agenda shall set out the business to be conducted at the meeting. No business other than that set out in the Agenda shall be considered at any members' meeting.
- 1.6 The Board of Directors (or at least one (1) member of the Board of Directors) shall present to the members of the Annual Members' Meeting:
 - 1.6.1 the annual accounts;
 - 1.6.2 any report of the auditor on them;
 - 1.6.3 the Annual Report;
 - 1.6.4 a report on steps taken to secure that (taken as a whole) the actual membership of the Trust is representative of those eligible for such membership;
 - 1.6.5 the progress of the membership plan; and
 - 1.6.6 the results of any election and appointments to the Council of Governors, and any other reports or documentation it considers necessary or otherwise required.
- 1.7 The Trust shall give notice of all members' meetings:
 - 1.7.1 by notice prominently displayed at the Trust's headquarters;
 - 1.7.2 by notice on the Trust's website;
 - 1.7.3 by notice communicated by email to the Members; and

- 1.7.4 to the Council of Governors, Board of Directors and the Trust's Auditors, stating whether the meeting is an Annual Members' Meeting or a Special Members' Meeting including the time, date, place of the meeting, and the business to be dealt with at the meeting at least 14 working days before the date of the relevant members' meeting (or, in the case of an Annual Members' Meeting, at least 21 working days before the date of the relevant meeting).
- 1.8 Accidental omission to give notice of a members' meeting or to send, supply or make available any document or information relating to the meeting, or the non-receipt of any such notice, document or information by a person entitled to receive any such notice, document or information shall not invalidate the proceedings at that meeting.
- 1.9 The Chair or in their absence, the Vice Chair, shall preside at all members' meetings of the Trust. If neither the Chair nor the Vice Chair is present, the Governors present shall elect one of the Non-Executive Directors to act as Chair. If no Non-Executive Director is present, the Governors present shall elect one of their number to act as the meeting Chair. If no Governor is willing to act as Chair or if no Governor is present within fifteen minutes after the time appointed for holding the meeting, the members present and entitled to vote shall choose one of their number to act as Chair.
- 1.10 The quorum for a members' meeting shall be twenty (20) members present and entitled to vote. If a quorum is not present within thirty (30) minutes from the time appointed for the meeting, the meeting shall stand adjourned for a minimum of seven (7) days until such time as the Board of Directors determine.
- 1.11 No such meeting shall become incompetent to transact business by lack of a quorum arising after the chair has been taken.
- 1.12 The Chair may, with the consent of a members' meeting at which a quorum is present (and shall, if so directed by the meeting), adjourn a members' meeting from time to time and from place to place or for an indefinite period.
- 1.13 A resolution put to the vote at a members' meeting shall be decided on a show of hands.
- 1.14 Every Member registered who is present shall have one vote. No proxies will be admissible.
- 1.15 The Trust's Auditor shall act as scrutineers in event of any voting.
- 1.16 No business shall be transacted at an adjourned meeting other than business which might properly have been transacted at the meeting had the adjournment not taken place.
- 1.17 If the Board of Directors, in its absolute discretion, considers that it is impractical or unreasonable for any reason to hold a members' meeting

at the time, date or place specified in the notice calling that meeting, it may move and/or postpone the general meeting to another time, date, and/or place.

- 1.18 Unless exceptional circumstances apply, in the case of a members' meeting is adjourned or postponed for fourteen (14) days or more, at least seven (7) working days' notice shall be given, specifying the time and place of the adjourned members' meeting and the general nature of the business to be transacted. Otherwise, it shall not be necessary to give any such notice.
- 1.19 The Board of Directors may make any such arrangement and impose any restriction it considers appropriate to ensure the security of a members' meeting.
- 1.20 Any approval to speak at a members' meeting must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. No proposal, speech or any reply may exceed three (3) minutes unless the Chair directs otherwise. In the interests of time, the Chair may, in their absolute discretion, limit the number of replies, questions or speeches which are heard at any one members' meeting.
- 1.21 A person who has already spoken on a matter at a members' meeting may not speak again at that meeting in respect of the same matter except (i) in exercise of a right of reply or (ii) on a point of order, or (iii) at the Chair's discretion.
- 1.22 The ruling of the Chair on any matter of procedure or a point of order shall be final.

ANNEX 8

Model Election Rules



Our Plan for Better Care

Torbay and South Devon NHS Foundation Trust
August 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



Torbay and South Devon
NHS Foundation Trust

Domain / Workstream	May 2026	June 2026	July 2026	August 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			HOLD	HOLD
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:

- The Virtual Ward & Hospital at Home Service workstream has improved from Limited to Satisfactory assurance, reflecting increased confidence in delivery and continued progress against key milestones. Neighbourhood Teams Infrastructure & Support remains at Limited assurance but has made significant progress and is expected to move to Satisfactory following the resolution of the paused Bed Based Care workstream.
- The One Devon Shared Services Finance workstream has been downgraded from Satisfactory to Limited Assurance due to increasing concerns regarding SBS delivery readiness for the planned 1 October 2026 go-live, alongside reduced confidence that the proposed solution will fully meet TSDFT's business and operational requirements.



The Transformation Programmes Impact to CIP (M4)



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 Latest Schemes & Forecast Outturn
1.1 Frailty expansion & community bed based care review	£ 1,225,995	£ 1,221,000	£ -	£ -	£ 666,530	£ -	£ 666,530	£ -	-£ 554,470
1.2 Acute Bed Based Care Review	£ 1,206,000	£ 1,208,480	£ -	£ -	£ 577,847	£ -	£ 409,524	£ 168,323	-£ 630,633
1.4 Neighbourhood infrastructure and support	£ 401,000	£ 321,000	£ -	£ -	£ 160,500	£ -	£ 160,500	£ -	-£ 160,500
1.5 Adult Social Care Transition	£ 11,390,000	£ 8,685,592	£ 1,235,207	£ 1,769,662	£ 8,648,359	£ 1,291,183	£ -	£ 7,357,176	-£ 37,233
2.2 Improving Productivity	£ 1,150,000	£ 650,000	£ -	£ -	£ 601,266	£ -	£ -	£ 601,266	-£ 48,734
4.2 Epic implementation & benefits including MyCare	£ 5,656,312	£ 5,313,823	£ 998,111	£ 1,852,974	£ 4,314,686	£ -	£ 443,809	£ 3,870,877	-£ 999,137
5.1 Workforce Transformation	£ 2,896,600	£ 2,896,600	£ 9,793	£ 829,663	£ 2,411,264	£ -	£ -	£ 2,411,264	-£ 485,336
5.2 Cultural Transformation	£ 1,574,000	£ 1,574,000	£ -	£ 69,628	£ 1,494,630	£ -	£ -	£ 1,494,630	-£ 79,370
Our Plan for Better Care Total	£ 25,499,907	£ 21,870,495	£ 2,243,111	£ 4,521,927	£ 18,875,082	£ 1,291,183	£ 1,680,363	£ 15,903,536	-£ 2,995,413
Other Non Pay - Procurement	£ 1,915,000	£ 1,346,370	£ 190,365	£ 815,923	£ 1,710,333	£ -	£ -	£ 1,710,333	£ 363,963
Other Non Pay - Medicines Optimisation	£ 2,600,000	£ 2,461,316	£ -	£ -	£ 2,315,853	£ -	£ -	£ 2,315,853	-£ 145,463
Other Care Group Schemes	£ 24,404,877	£ 28,741,586	£ 7,131,582	£ 12,511,113	£ 31,518,499	£ -	£ 6,601,792	£ 24,916,707	£ 2,776,913
Total	£ 54,419,784	£ 54,419,767	£ 9,565,058	£ 17,848,963	£ 54,419,766	£ 1,291,183	£ 8,282,155	£ 44,846,429	£ 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 **£21.9m** (40% of the total plan).

Year to date delivery stands at **£2.2m**, with full year delivery transacted of **£4.5m** and a forecast outturn of **£18.9m**, leaving a variance of **£3m** against the latest schemes target.

Since the development of the original plan, CIP schemes under the Our Plan for Better Care Programme have reduced by £3.6m, from £25.5m, following the recommended closure of several high-risk schemes, predominantly within the ASC workstream. This has been mitigated through the identification of additional Care Group schemes, resulting in no material impact on the overall CIP position.

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 position of these schemes reported by Finance totals **£35.5m** bringing the total forecast outturn position to **£54.4m** in line with the overall CIP target.



The Transformation Programmes Impact to CIP (M3)



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	£ -	£ -	£ 723,580	£ -	£ 96,000	£ 627,580	£ 497,420
1.2 Acute Bed Based Care Review	£ 1,206,000	£ 1,208,480	£ -	£ -	£ 598,886	£ -	£ 409,524	£ 189,362	£ 609,594
1.4 Neighbourhood infrastructure and support	£ 401,000	£ 321,000	£ -	£ -	£ 321,000	£ -	£ 321,000	£ -	£ -
1.5 Adult Social Care Transition	£ 11,390,000	£ 9,554,003	£ 898,298	£ 1,395,751	£ 9,106,164	£ 1,000,238	£ 644,583	£ 7,461,343	£ 447,839
2.2 Improving Productivity	£ 1,150,000	£ 650,000	£ -	£ -	£ 650,000	£ -	£ -	£ 650,000	£ 0
4.2 Epic implementation & benefits including MyCare	£ 5,056,312	£ 5,302,017	£ 894,820	£ 1,634,422	£ 4,718,342	£ -	£ 703,312	£ 4,015,030	£ 583,675
5.1 Workforce Transformation	£ 2,896,600	£ 2,896,600	£ -	£ -	£ 2,754,662	£ -	£ -	£ 2,754,662	£ 141,938
5.2 Cultural Transformation	£ 1,574,000	£ 1,574,000	£ -	£ -	£ 1,574,000	£ -	£ -	£ 1,574,000	£ -
Our Plan for Better Care Total	£ 24,899,907	£ 22,727,100	£ 1,793,118	£ 3,030,173	£ 20,446,634	£ 1,000,238	£ 2,174,419	£ 17,271,977	£ 2,280,466
Other Non Pay - Procurement	£ 1,915,000	£ 1,346,370	£ 106,182	£ 424,782	£ 1,386,836	£ -	£ -	£ 1,386,836	£ 40,466
Other Non Pay - Medicines Optimisation	£ 2,600,000	£ 2,461,316	£ -	£ -	£ 2,315,853	£ -	£ -	£ 2,315,853	£ 145,463
Other Care Group Schemes	£ 25,004,877	£ 27,884,566	£ 4,885,801	£ 10,041,106	£ 30,270,029	£ -	£ 6,725,204	£ 23,544,825	£ 2,385,463
Total	£ 54,419,784	£ 54,419,352	£ 6,785,101	£ 13,496,061	£ 54,419,351	£ 1,000,238	£ 8,899,623	£ 44,519,491	£ 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 **£22.7m** (42% of the total plan).

Year to date delivery stands at **£1.8m**, with full year delivery of **£3m** and a forecast outturn of **£20.4m**, leaving a variance of **£2.3m** against the latest schemes.

Since M2, CIP schemes under the *Our Plan for Better Care* Programme have reduced by £0.8m, from £23.5m, following the recommended closure of several high-risk schemes, predominantly within the ASC workstream. This has been mitigated through the identification of additional Care Group schemes, resulting in no material impact on the overall CIP position.

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 **£34m** bringing the total forecast outturn position to **£54.4m** in line with the overall CIP target.



RAID Management



RISKS

- At the start of the reporting period, there were 75 risks. During this period, **11 new risks** were identified and **10 risks were closed**. Of the closed risks, 6 were successfully mitigated and are no longer considered a threat to delivery, while 4 materialised and are now being actively managed through the programme's issue management processes.
- Overall, the risk profile has remained stable, with ongoing monitoring and management arrangements in place. There are **3 risks identified for escalation** which can be found on slide 8.

ASSUMPTIONS

- At the start of the reporting period, 58 assumptions.. During the period, **9 new assumptions** were identified, predominantly relating to the Frailty Hub and Pathology workstreams. **3 assumption were closed**.
- A total of **11 assumptions have been assessed as requiring escalation** and are presented on slide 9 for review and consideration.

ISSUES

- At the start of the reporting period, there were 16 issues. During this reporting cycle, **6 new issues were recorded**, 5 of which originated from previously identified risks that subsequently materialised. 5 issues have been closed. 7 issues are currently classified as critical, and a total of **10 issues have been escalated** during the period and can be found on slide 11.

DEPENDENCIES

- During this reporting period, 91 existing dependencies were recorded within the OPFBC RAID log and shared with Senior Responsible Owners (SROs) for review and validation. A further **7 new dependencies** were identified, and **5 have been approved for closure**. **7 dependencies have assessed as requiring escalation**, see slide 11. This reflects the continued interdependencies across programme workstreams and the need for active oversight and management.

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

Domain / Workstream	No. of Risks*	No. of Assumptions*	No. of Issues*	No. of Dependencies*
1.0 Living Well in our Neighbourhoods	29	23	5	38
1.1 Frailty Expansion and Community Bed-Base Care Review	4	8	0	9
1.2 Acute Bed-Base Care Review	4	1	0	6
1.3 Virtual Ward & Hospital at Home Service	4	3	1	4
1.4 Neighbourhood Teams Infrastructure & Support	6	3	3	6
1.5 Adult Social Care Transition	7	4	0	8
1.6 Innovation & Evaluation Hub	2	4	1	5
2.0 Reimagining Acute & Specialist Care	23	20	9	34
2.1 Clinical Services Review	11	5	1	17
2.2 Improving Productivity	2	2	1	5
2.3 Pathology	10	13	7	12
3.0 Joined-up Care, Every Step of the Way	1	4	2	2
3.1 Pathway Review and Redesign	1	4	2	2
4.0 Smart use of technology for better care	10	9	0	10
4.1 Digital First	2	5	0	6
4.2 Epic Implementation & Benefits, including MY CARE	8	4	0	4
5.0 Caring, skilled people ready for tomorrow	5	4	1	5
5.1 Workforce Transformation	4	2	1	5
5.2 Culture Transformation	1	2	0	0
6.0 Strategic Enablers	8	4	0	4
6.1 One Devon Shared Services – Finance	8	4	0	4
Total	76	64	17	93

*The table totals only includes open entries



RAID Escalations

Definitions			
Movement in month – Key:			
	New Risk		A decrease in risk score
	The score remains the same		A rise in risk score

RISK* – In August, 4 risks shown in the table below have been identified by SROs for escalation:

Workstream	Our Plan For Better Care (OPFBC) Risk Register			Initial Risk Score	Treatment / Mitigation Actions	Action Owner	Target completion Date	Action Status	Current Risk Score	Target risk Score	Risk Trend
	Trigger (Why something may happen)	Risk (What could happen)	Impact (Likely consequence if left untreated)								
2.2 Productivity including Best Practice	Insufficient dedicated resource, analytical capacity, or technical expertise.	Productivity initiatives are poorly designed, slow to progress, or not robustly evidenced.	Limiting the workstream's ability to identify, deliver, and sustain credible productivity improvements.	16	1) Secure dedicated, ring-fenced resource for the Productivity workstream, with clear time commitment agreed by line managers.	Alan Welch		In Progress	16	8	
2.3 Pathology	Further joint discussion required around assumptions/caveats used in Full Business Case	The joint discussion / joint plan may not be deliverable	Lead to misaligned objectives, delays in implementation, fragmented decision-making, and reduced confidence among stakeholders, impacting the timely achievement of programme outcomes and benefits.	16	Maintain alignment through robust joint governance, shared planning, clear accountabilities, regular stakeholder engagement, and proactive management of risks, issues, and interdependencies to support timely delivery of programme outcomes and benefits.	Ria McCoy		In Progress	16	8	
6.1 One Devon Shared Services - Finance	SBS unable to deliver the programme. TSDFT not assured that SBS are ready.	System not ready resulting in delay of go live date for 1st October.	Financial Impact if SBS are ready but TSDFT are not satisfied. SBS does not go live 1st October. ONE Devon Finance Hub would be delayed.	12	1) Carry on with Unit 4 as a financial system until SBS programme ready. 2) If all other Trusts are in agreement to delay, then the financial implication should fall with SBS. 3) SBS are currently working on an action plan to address concerns to ensure no delay.	Andrea Wright		In Progress	12	4	
1.5 Adult Social Care Transition	New -IT transition costs have not yet been fully identified or reflected in financial forecasts.	IT transition cost pressure may not be fully identified or reflected in financial forecasts.	The Trust may face unplanned cost pressure if detailed IT costs, including equipment, licensing, network requirements, system access and data transfer, exceed the current top-level assumption.	9	RT/AD/PS to capture the potential IT transition Cost Pressure as a financial risk.	Lisa Heard		In Progress	9	6	

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



RAID Escalations



ASSUMPTIONS* – In August, 11 assumptions shown in the table below have been identified by SROs for escalation:

Workstream & Assumption Reference	Description of Assumption
1.1 Frailty Hub – A060 (NEW)	Sufficient HR/Recruitment capacity need to be available to deliver recruitment timescales.
1.1 Frailty Hub – A061 (NEW)	Consultation can be processed and completed within the programme timeline.
1.3 Virtual ward & Hospital at home service – A010	The expansion of heart failure is reestablished.
1.3 Virtual ward & Hospital at home service – A012	There will not be any additional funding, so efficiencies will have to be delivered within existing budget.
1.4 Neighbourhood infrastructure & support – A007	Neighbourhood footprints will be agreed.
1.4 Neighbourhood infrastructure & support – A008	Primary care engagement sustained.
2.3 Pathology – A059 (NEW)	TSD ASL model and specifications for each discipline developed on the assumption the Gadeon House CSL will operate 08:00 to 20:00, 7 days/week
2.3 Pathology – A064 (NEW)	Blood Sciences and Microbiology acute-site areas are assumed to be broadly fit for purpose.
2.3 Pathology – A065 (NEW)	Histopathology: Specimen drop-off at Torbay will continue on the same basis as the current set-up, including Poundbury. Frozen sections are planned activity and will be brought down from the CSL as required. Portacabin demolition does not appear to be included in the current business case. RDUH will provide the Gadeon House IT environment for the third floor.
2.3 Pathology – A066 (NEW)	Current transport costing is based on diesel vans and excludes electric vehicle charging.
2.3 Pathology – A067 (NEW)	Utilities, waste, security and wider building revenue costs treated as assumptions until the basis of recharge is confirmed.

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



RAID Escalations



Torbay and South Devon
NHS Foundation Trust

ISSUES* – In August, 11 issues shown in the table below have been identified by SROs for escalation:

Workstream & Issue Reference	Issue Description	Issue Category	Likely consequence if left untreated	Action Plan
1.3 Virtual ward & Hospital at home service - I-020 (NEW)	Heart failure virtual ward is reestablished alongside trust wide urgent care transformation.	Concerning	Inability to establish Heart Failure Virtual Ward (HFVW).	1. Review meeting 10/9/2026.
1.4 Neighbourhood infrastructure & support – I009	IG / Data sharing routes – Activity is measured by performance not by outcomes.	Concerning	Measuring activity primarily through performance metrics rather than outcomes risks obscuring the true value and impact of delivery, limiting the ability to demonstrate improvements in patient experience, population health, and system transformation. This may lead to misaligned priorities and reduces confidence in whether strategic objectives are being achieved.	1. Develop Baselines/dashboard/evaluation measures
1.4 Neighbourhood infrastructure & support – I010	Workforce planning tools – do not have a plan for interface of workforce.	Concerning	The absence of a defined workforce interface plan creates a risk to coordinated delivery across services, leading to potential gaps, duplication, and inefficiencies in workforce utilisation.	1. Develop action learning sets to test workforce integration. There are also conversations about workforce contract changes in community.
1.4 Neighbourhood infrastructure & support – I011	Lack of Investment and contractual changes.	Concerning	Presents a material risk to organisational performance, financial sustainability, and service delivery outcomes.	1. Sourcing additional funding, data sharing and governance commitments
2.1 Clinical Services Review – 017 (NEW)	Pathway redesign, data validation, modelling and option development will be incomplete or delayed. If clinical, operational, corporate or system partners do not have sufficient capacity	Critical	Affecting workstream's delivery quality and pace.	1. Mitigation to recover this is linked to restructures which is going to take some time to resolve so short-term options under consideration
2.2 Productivity including Best Practice – 019 (NEW)	Insufficient dedicated resource, analytical capacity, or technical expertise cause productivity initiatives to be poorly designed, slow to be progressed, or are not robustly evidenced.	Concerning	Limiting the workstream's ability to identify, deliver, and sustain credible productivity improvements.	1. Mitigation to recover this are being managed by SRO and Workstream Lead.
2.3 Pathology – I012	RIBA 5 completion for Histopathology is currently October 2027.	Critical	The programme would not the fixed deadline to vacate the existing portacabin by the end of August 2027.	1. Identify options to accelerate or run activity in parallel. Escalate through programme governance. 2. Check whether dependant project dates could be delayed.
2.3 Pathology – I013	Equipment installation, validation and supplier collaboration timescales are currently unknown and have not yet been fully aligned to the Gadeon House critical path.	Concerning	Could affect operational readiness, equipment validation, staff training, digital readiness, cutover planning and the Histopathology relocation timetable.	1. Confirm equipment installation, validation and supplier collaboration timescales. 2. Align to the RIBA, digital, operational readiness and relocation critical path. Escalate through programme governance if they affect the 31/07/2027 portacabin vacation deadline.
2.3 Pathology – I021 (NEW)	Total capital position is materially higher than previously anticipated.	Critical	May affect affordability, funding route and governance readiness.	1. Escalate senior review of capital affordability and funding options.
3.1 Pathway Review and Redesign – I006	Limited clinical and managerial capacity to engage consistently in pathway review activity.	Critical	Pathway redesign milestones are delayed, with slippage in delivery timelines.	1. Secure protected clinical time for pathway review activity, agreed via job planning or SPA allocation. 2. Plan engagement around operational cycles (e.g. avoiding known peak pressure periods).
5.1 Workforce Plan & Transformation – I022 (NEW)	People Digital programme delivery: Unresolved technical issues with wave 2 and resourcing issues linked to LMS.	Critical	Delay to programme rollout and inability to realise planned benefits.	1. Independent review of the original People Digital Business Case. 2. Implement targeted enhancements to the existing systems to address issues with system functionality and capability. 3. Address LMS resourcing gaps (reallocation / additional capacity). 4. Independent review of the Peoples Digital Business Case

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



RAID Escalations

Definitions			
Movement in month – Key:			
	New Risk		A decrease in risk score
	The score remains the same		A rise in risk score

DEPENDENCIES* – In August, 7 dependencies shown in the table below have been identified by SROs for escalation:

Workstream & Dependency Reference	Category	Dependency	What is required
1.1 Frailty Hub – D093 (NEW)	Dependencies with other workstreams.	Staff consultation period for clinical team.	Dedicated capacity and prioritisation of operational resources.
1.1 Frailty Hub – D094 (NEW)	Dependencies with other workstreams.	Interdependencies with operational leadership team utilising the same workforce / capacity.	Prioritisation and resource allocation.
1.5 Adult Social Care – D095 (NEW)	Dependencies within workstreams.	Several workstream activities depend on understanding what remains with Health.	Health model assumptions need to be clarified by the end of September.
1.5 Adult Social Care – D096 (NEW)	Dependencies within workstreams.	IT and infrastructure planning remains dependent on confirmed staff scope, locations, system requirements, device assumptions and any residual Trust access needs.	Confirmation staff scope, locations, system requirements, device assumptions and any residual Trust access needs.
1.5 Adult Social Care – D097 (NEW)	Dependencies within workstreams.	Financial modelling remains dependent on clearer TUPE, estates, contracts and post-transfer support assumptions.	Clarification of TUPE, estates, contracts and post-transfer support assumptions.
1.5 Adult Social Care – D098 (NEW)	Dependencies within workstreams.	Estates planning remains dependent on confirmed staff numbers, occupancy methodology and any proposed Council location changes.	Confirmation staff numbers, occupancy methodology and any proposed Council location changes.
2.1 Clinical Services Review – D092 (NEW)	Dependencies within workstreams.	This workstream is dependent on, and closely aligned with, the Clinical Pathway Review and Productivity workstreams.	Key findings and recommendations will be shared across workstreams to inform decision-making, avoid duplication, and support coordinated service improvement. Interdependencies will be actively managed to ensure alignment of outputs, timelines, and objectives.

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



Programme Risks

Definitions

Movement in month – Key:

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



Torbay and South Devon
NHS Foundation Trust

Programme Management Office (PMO) Risk Register <i>'RISK - an uncertain or set of events that, should it occur, will have a effect on the achievement of objectives. A risk is measured by a combination of the probability of a perceived threat or opportunity occurring, and the magnitude of its impacts on objectives'</i>			Risk ID	Risk Category	Initial risk score <i>Risk</i>	Treatment Plan	Treatment / Mitigation Actions	Action Owner	Target completion Date	Action Status	Current Risk Level <i>Risk</i>	Target risk level after mitigation <i>Risk</i>
Trigger (Why something may happen)	Risk (What could happen)	Impact (Likely consequence if left untreated)										
Competing Priorities Competing operational, clinical and transformation priorities i.e. scale & impact of epic related issues and volume of reorganisation programmes	Reduce staff capacity and focus for OPFBC development programmes	Leading to delays, reduced quality of input and risk to assurance timelines	1	Strategy & Transformation Risk	16	Reduce	Secure formal Executive agreement that the OPFBC is a priority	CPSO	30/04/2026	Complete	16	12
							Confirm OPFBC status within the Trust's strategic objectives and transformation portfolio	CPSO	30/04/2026	Complete		
							Assign clearly accountable SROs with authority to resolve prioritisation conflicts	CPSO/PMO	30/04/2026	Complete		
							Ensure clear reporting lines into Executive and governance forums	PMO	30/04/2026	Complete		
							Ring-fence dedicated OPFBC programme capacity	PMO	31/05/2026	In Progress		
							Consider the use temporary or specialist external support where internal capacity is constrained	PMO	On-going	Not Due		
							Track OPFBC delivery against clear milestones and critical path to identify slippage early	Workstream Leads/PMO	On-going	Not Due		
Interdependencies Programme is dependent on progress, funding, or decisions from other programmes or partners	If interdependent programmes, resources or decisions are delayed, reduced, or not delivered as planned, the OPFBC/CIP cannot be implemented in full or at pace	Failure to realise intended benefits. Delayed transformation. Risk to system credibility and stakeholder confidence	4	Financial Risk	9	Reduce	Formal dependency mapping	Business Director/Head of PMO	31/05/2026	In Progress	9	9
							Strong programme governance	Head of PMO	On-going	In Progress		
							Early and ongoing stakeholder engagement	All	31/05/2026	In Progress		
							Clear accountability for dependencies	Head of PMO	31/05/2026	In Progress		
							Delivery plans to take account of dependency timescales	Business Director/Head of PMO	31/05/2026	In Progress		



RAID Escalations

Definitions			
Movement in month – Key:			
	New Risk		A decrease in risk score
	The score remains the same		A rise in risk score

RISK* – In August, 3 risks shown in the table below have been identified by SROs for escalation:

Workstream & Risk Reference	Risk Description	Initial Risk Score	Mitigations	Current Risk Score	Risk Trend
2.2 Productivity including Best Practice - R051	Risk: Productivity initiatives are poorly designed, slow to progress, or not robustly evidenced. Cause: Insufficient dedicated resource, analytical capacity, or technical expertise. Consequence: Limiting the workstream's ability to identify, deliver, and sustain credible productivity improvements.	16	1. Secure dedicated, ring-fenced resource for the Productivity workstream, with clear time commitment agreed by line managers. <i>(In Progress)</i> 2. Supplement internal capacity with specialist support where gaps exist. <i>(In Progress)</i> 3. Define and maintain a minimum viable skill set required to progress design, implementation, and assurance. <i>(In Progress)</i>	16	
2.3 Pathology - R083 (NEW)	Risk: The joint discussion / joint plan may not be deliverable Cause: Further joint discussion required around assumptions/caveats used in Full Business Case Consequence: Lead to misaligned objectives, delays in implementation, fragmented decision-making, and reduced confidence among stakeholders, impacting the timely achievement of programme outcomes and benefits.	16	1. Maintain alignment through robust joint governance, shared planning, clear accountabilities, regular stakeholder engagement, and proactive management of risks, issues, and interdependencies to support timely delivery of programme outcomes and benefits. <i>(In Progress)</i>	16	
6.1 One Devon Shared Services – Finance - R084 (NEW)	Risk: System not ready resulting in delay of go live date for 1st October. Cause: SBS unable to deliver the programme. TSDFT not assured that SBS are ready Consequence: Financial Impact if SBS are ready but TSDFT are not satisfied. SBS does not go live 1st October. ONE Devon Finance Hub would be delayed.	16	1. Carry on with Unit 4 as a financial system until SBS programme ready. 2. If all other Trusts are in agreement to delay, then the financial implication should fall with SBS. 3. SBS are currently working on an action plan to address concerns to ensure no delay.	16	

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



RAID Escalations



ASSUMPTIONS* – In August, 11 assumptions shown in the table below have been identified by SROs for escalation:

Workstream & Assumption Reference	Assumption Description
1.1 Frailty Hub – A060 (NEW)	Sufficient HR/Recruitment capacity need to be available to deliver recruitment timescales.
1.1 Frailty Hub – A061 (NEW)	Consultation can be processed and completed within the programme timeline.
1.3 Virtual ward & Hospital at home service – A010	The expansion of heart failure is reestablished.
1.3 Virtual ward & Hospital at home service – A012	There will not be any additional funding, so efficiencies will have to be delivered within existing budget.
1.4 Neighbourhood infrastructure & support – A007	Neighbourhood footprints will be agreed.
1.4 Neighbourhood infrastructure & support – A008	Primary care engagement sustained.
2.3 Pathology – A059 (NEW)	TSD ASL model and specifications for each discipline developed on the assumption the Gadeon House CSL will operate 08:00 to 20:00, 7 days/week
2.3 Pathology – A064 (NEW)	Blood Sciences and Microbiology acute-site areas are assumed to be broadly fit for purpose.
2.3 Pathology – A065 (NEW)	Histopathology: Specimen drop-off at Torbay will continue on the same basis as the current set-up, including Poundbury. Frozen sections are planned activity and will be brought down from the CSL as required. Portacabin demolition does not appear to be included in the current business case. RDUH will provide the Gadeon House IT environment for the third floor.
2.3 Pathology – A066 (NEW)	Current transport costing is based on diesel vans and excludes electric vehicle charging.
2.3 Pathology – A067 (NEW)	Utilities, waste, security and wider building revenue costs treated as assumptions until the basis of recharge is confirmed.

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



RAID Escalations



ISSUES* – In August, 10 issues shown in the table below have been identified by SROs for escalation:

Workstream & Issue Reference	Issue Description	Issue Category	Likely consequence if left untreated	Action Plan
1.3 Virtual ward & Hospital at home service - I-020 (NEW)	Heart failure virtual ward is reestablished alongside trust wide urgent care transformation.	Concerning	Inability to establish Heart Failure Virtual Ward (HFVW).	1. Review meeting 10/9/2026.
1.4 Neighbourhood infrastructure & support – I009	IG / Data sharing routes – Activity is measured by performance not by outcomes.	Concerning	Measuring activity primarily through performance metrics rather than outcomes risks obscuring the true value and impact of delivery, limiting the ability to demonstrate improvements in patient experience, population health, and system transformation. This may lead to misaligned priorities and reduces confidence in whether strategic objectives are being achieved.	1. Develop Baselines/dashboard/evaluation measures
1.4 Neighbourhood infrastructure & support – I010	Workforce planning tools – do not have a plan for interface of workforce.	Concerning	The absence of a defined workforce interface plan creates a risk to coordinated delivery across services, leading to potential gaps, duplication, and inefficiencies in workforce utilisation.	1. Develop action learning sets to test workforce integration. There are also conversations about workforce contract changes in community.
1.4 Neighbourhood infrastructure & support – I011	Lack of Investment and contractual changes.	Concerning	Presents a material risk to organisational performance, financial sustainability, and service delivery outcomes.	1. Sourcing additional funding, data sharing and governance commitments
2.1 Clinical Services Review – 017 (NEW)	Pathway redesign, data validation, modelling and option development will be incomplete or delayed. If clinical, operational, corporate or system partners do not have sufficient capacity	Critical	Affecting workstream's delivery quality and pace.	1. Mitigation to recover this is linked to restructures which is going to take some time to resolve so short-term options under consideration
2.2 Productivity including Best Practice – 019 (NEW)	Insufficient dedicated resource, analytical capacity, or technical expertise cause productivity initiatives to be poorly designed, slow to be progressed, or are not robustly evidenced.	Concerning	Limiting the workstream's ability to identify, deliver, and sustain credible productivity improvements.	1. Mitigation to recover this are being managed by SRO and Workstream Lead.
2.3 Pathology – I012	RIBA 5 completion for Histopathology is currently October 2027.	Critical	The programme would not the fixed deadline to vacate the existing portacabin by the end of August 2027.	1. Identify options to accelerate or run activity in parallel. Escalate through programme governance. 2. Check whether dependant project dates could be delayed.
2.3 Pathology – I013	Equipment installation, validation and supplier collaboration timescales are currently unknown and have not yet been fully aligned to the Gadeon House critical path.	Concerning	Could affect operational readiness, equipment validation, staff training, digital readiness, cutover planning and the Histopathology relocation timetable.	1. Confirm equipment installation, validation and supplier collaboration timescales. 2. Align to the RIBA, digital, operational readiness and relocation critical path. Escalate through programme governance if they affect the 31/07/2027 portacabin vacation deadline.
2.3 Pathology – I021 (NEW)	Total capital position is materially higher than previously anticipated.	Critical	May affect affordability, funding route and governance readiness.	1. Escalate senior review of capital affordability and funding options.
3.1 Pathway Review and Redesign – I006	Limited clinical and managerial capacity to engage consistently in pathway review activity.	Critical	Pathway redesign milestones are delayed, with slippage in delivery timelines.	1. Secure protected clinical time for pathway review activity, agreed via job planning or SPA allocation. 2. Plan engagement around operational cycles (e.g. avoiding known peak pressure periods).

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



RAID Escalations

Definitions			
Movement in month – Key:			
	New Risk		A decrease in risk score
	The score remains the same		A rise in risk score

DEPENDENCIES* – In August, 7 dependencies shown in the table below have been identified by SROs for escalation:

Workstream & Dependency Reference	Category	Dependency	What is required
1.1 Frailty Hub – D093 (NEW)	Dependencies with other workstreams.	Staff consultation period for clinical team.	Dedicated capacity and prioritisation of operational resources.
1.1 Frailty Hub – D094 (NEW)	Dependencies with other workstreams.	Interdependencies with operational leadership team utilising the same workforce / capacity.	Prioritisation and resource allocation.
1.5 Adult Social Care – D095 (NEW)	Dependencies within workstreams.	Several workstream activities depend on understanding what remains with Health.	Health model assumptions need to be clarified by the end of September.
1.5 Adult Social Care – D096 (NEW)	Dependencies within workstreams.	IT and infrastructure planning remains dependent on confirmed staff scope, locations, system requirements, device assumptions and any residual Trust access needs.	Confirmation staff scope, locations, system requirements, device assumptions and any residual Trust access needs.
1.5 Adult Social Care – D097 (NEW)	Dependencies within workstreams.	Financial modelling remains dependent on clearer TUPE, estates, contracts and post-transfer support assumptions.	Clarification of TUPE, estates, contracts and post-transfer support assumptions.
1.5 Adult Social Care – D098 (NEW)	Dependencies within workstreams.	Estates planning remains dependent on confirmed staff numbers, occupancy methodology and any proposed Council location changes.	Confirmation staff numbers, occupancy methodology and any proposed Council location changes.
2.1 Clinical Services Review – D092 (NEW)	Dependencies within workstreams.	This workstream is dependent on, and closely aligned with, the Clinical Pathway Review and Productivity workstreams.	Key findings and recommendations will be shared across workstreams to inform decision-making, avoid duplication, and support coordinated service improvement. Interdependencies will be actively managed to ensure alignment of outputs, timelines, and objectives.

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



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				Key Performance Indicators - *reflect Frailty Expansion business case but are subject to further iteration in line with community outcomes framework		Baseline	Target	Current Position	Trend
Harbour Service: ✓ The 7-Day Frailty business case was approved at Private Trust Board on 02/07/2026. ✓ Mobilisation has commenced, with initial activity focused on workforce capacity planning and recruitment pipeline development. ✓ Expansion of direct ambulance referral pathways to improve access and flow into Same Day emergency Care (SDEC). ✓ Ambulatory Head Injury Pathway Standard Operating Procedure (SOP) completed with Medical Examiner approval. Community X-ray service: ✓ Procurement has been completed, with Mobile Medical Diagnostics Ltd appointed as the most suitable provider and the contract awarded on 24th July 2026. ✓ Standard operating procedure finalised for external staff. ✓ Health Level 7 IT integration is underway following commencement on 27 July 2026, with service launch agreed for 24 August 2026. Corridor Care support: ✓ Redirection policy to identify and support older patients living with frailty passed to MUEC Care Group for adoption.				Reduced attendances from care homes in ED (av/daily attendance)		4	2	2	↔
				80% of patients have a CGA (*awaiting Epic data correlation)		0	80%	TBC	
				Transfer rate from NAH into Acute Site between 10-30%		0%	<30%	34%	↓
				Reduction number of patients with 3+ acute admissions ≤90 days EOL		44	TBC	TBC	TBC
RAID Group		Score/ Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)						
Assumption			A-060 (NEW) - Sufficient HR/Recruitment capacity need to be available to deliver recruitment timescales.						
Assumption			A-061 (NEW) - Consultation can be processed and completed within the programme timeline.						
Dependency		Dependencies with other workstreams (Workforce / OD)	D-093 (NEW) Staff consultation period for clinical team - Dedicated capacity and prioritisation of operational resources. Liaison with Medical recruitment to confirm timescale.						
Dependency		Dependencies with other workstreams (Operations)	D-094 (NEW) Interdependencies with operational leadership team utilising the same workforce / capacity.						
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
27-001	Totnes Hospital Bed Reconfiguration	1,129,995	1,125,000	0	626,530	28.66	28.66	0.00	28.66	
	Totnes bed closure- catering/ food service	96,000	96,000	0	40,000	1.40	1.40	0.00	0.00	



1.2 Bed Based Care Review


Torbay and South Devon
NHS Foundation Trust

Delivered
✓ A request was made by the Workstream Lead (WSL) on 22/06/2026 to close or pause the workstream due to sustained system pressures. There is currently no viable route to progress toward ward closure, driven by continued high demand, reliance on escalation, decant and discharge lounge capacity, and significant Emergency Department pressures, including extreme wait times. These challenges are further compounded by internal fire safety constraints impacting capacity and flow. In addition, frailty pathways are not yet fully embedded, with benefits unlikely to be realised before November 2026, coinciding with anticipated winter pressures. ✓ The proposal was presented to the SRO on 23/06/2026, with support for a six-month pause to allow assessment of the impact of the Frailty Service expansion before any decision on permanent closure is made. This was subsequently approved by OPFBC Oversight group on 15/07/2026.

Next Steps

Key Performance Indicator	Baseline	Target	Current Position	Trend
Bed occupancy				
Length of stay improvement				
4hrs, 12hrs, Ambulance handovers				

RAID Group	Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>

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



1.3 Virtual Ward & Hospital at Home Service



Torbay and South Devon
NHS Foundation Trust

Delivered				
Good progress has been made in advancing the Virtual Ward (VW) programme: ✓ Reviews of key VW sub-speciality pathways, including gastroenterology, frailty, cardiology, end-of-life care and diabetes, have been completed, providing greater clarity on clinical priorities, service interfaces and opportunities for pathway development. ✓ Programme delivery arrangements have also been strengthened through establishment of a comprehensive action plan and 90-day improvement sprint. Clear ownership, milestones and accountability have been agreed, providing a more structured approach to delivery and supporting focused implementation of identified priorities.				

Key Performance Indicators			Baseline	Target	Current Position	Trend
- Released bed occupancy rates for <0-3 day LOS - Reduced 30 day re-admission rate % patients receiving medication review - Total number of adverse events per 1,000 bed days - Compliance rate: % of successful biometric readings			Input: % active virtual ward beds utilised daily against capacity Output: total number of bed days saved per month Input: Number of days a patient remains on virtual ward Output: Ratio of step-up (avoided) v step down (early discharges) Input: % active virtual ward beds utilised daily against capacity Output: total number of bed days saved per month Input: Number of days a patient remains on virtual ward Output: Ratio of step-up (avoided) v step down (early discharges) Note - Current limitations in extracting information from the Electronic Patient Record system are delaying the establishment of KPI baseline positions, target setting and performance reporting			
RAID Group	Score / Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>				
Assumption		A-010 - Heart failure is re-established and must align with trust-wide transformation; the co-ordination function remains linked with Harbour.				
Assumption		A-012 - Additional funding is required for wider transformation but must be aligned.				
Issue	Concerning	I-020 (NEW) - Heart failure virtual ward is reestablished alongside trust wide urgent care transformation. Inability to establish Heart Failure Virtual Ward (HFVW) Action Plan: Review meeting 10/09/2026.				
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
To be confirmed in discussion with Finance Business Partner.										



1.4 Neighbourhood Teams Infrastructure & Support



Delivered	Key Performance Indicators					Baseline	Target	Current Position	Trend	
Progress has continued at pace across the Neighbourhood Transformation Programme, with significant activity focused on strengthening strategic alignment, governance and delivery planning. ✓ Attendance at the national Claire Fuller Next Steps Conference on 10/07/2026 enabled identification of priority actions and support requirements to inform local programme development and alignment with emerging national direction. ✓ The Executive, Non-Executive Director and Senior Leadership Team Neighbourhood Reference Group met on 14/072026 to review and challenge the proposed outcomes framework and key performance indicators, helping to refine measures of success and strengthen alignment with programme objectives. ✓ A Non-Executive Director co-creation and Board Development session was completed on 24/072026, providing strategic input into programme development, with agreed follow-up actions to support delivery and governance. ✓ The outcomes framework and benefits realisation methodology were presented to the Integrated Neighbourhood Team Programme Board, providing a structured approach to measuring impact, tracking delivery of benefits and supporting programme oversight. ✓ Delivery oversight arrangements have been agreed, with clear governance, performance tracking and escalation routes established to strengthen accountability, support timely decision-making and maintain programme delivery momentum. ✓ Established delivery oversight arrangements, including governance, performance tracking and escalation routes.. ✓ Progressed sub-specialty reviews to identify opportunities for community model development. ✓ Launched a workforce action learning approach through the South Integrated Neighbourhood Team Programme Board to support workforce transformation and shared learning. ✓ Falls prevention end-to-to system wide pathway and opportunity mapping under development for patients >50years including all partners to review prevention, education and training provision.	Flat growth rate across UEC demand (current forecast 6.5%)					Oversight to note - Assuming a flat growth attendance rate keeping a watching brief on NEL admission rate eg: shift to adverse may not be a poor indicator of flow.				
	Reduction in Type 1 ED Attendances (baseline 25/26)					84,981	84,981	(Est) 90,404	↓	
	Reduction in ambulance conveyance to ED.					26, 107	23, 766	-	↓	
	Further KPIs TBC following wider evaluation (see next period)									
RAID Group		Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>							
Assumption			A-007 - Neighbourhood footprints are agreed, there is a potential for minor border refinements but are not expected to materially affect delivery.							
Assumption			A-008 - Primary care engagement sustained (Update: Primary care engagement must be sustained as system-wide KPI ownership / lead-provider arrangements are still to be confirmed through collaborative governance.							
Issue		Concerning	I-009: IG/data sharing routes - activity measured by performance, not outcomes. Accountability unclear impact and outcomes not evidenced. Action Plan: Develop baselines, dashboard and evaluation measures.							
Issue		Concerning	I-010: Workforce planning tools - no clear workforce interface plan. Risk of workforce gaps, duplication and MDT capacity constraints. Action Plan: Run action learning sets; continue workforce contract discussions.							
Issue		Concerning	I-011: Investment and contractual changes - funding/data-sharing/governance commitments unresolved. Action Plan: Source funding and secure data-sharing / governance commitments.							
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	160,500	1.48	1.48	0.00	0.00	
	Impact of Integrated Neighbourhood Coordination	80,000	0	0	0	0.00	0.00	0.00	0.00	



1.5 Adult Social Care



Torbay and South Devon
NHS Foundation Trust

Delivered
The Adult Social Care Transition Programme continues to make steady progress across governance, workforce, finance, operational, and enabling workstreams, with programme assurance arrangements continuing to mature. ✓ Governance processes have been strengthened through rationalisation of the action log and alignment of longer-term activities within the delivery plan, providing greater clarity and oversight of programme delivery. ✓ HR and TUPE preparations remain a key focus, with staff, location and activity mapping progressing. Formal consultation is provisionally planned for 8 September, pending Council confirmation and alignment with the LiquidLogic go-live. Staff engagement continues through regular communications, Q&A sessions and confidential support arrangements to address ongoing workforce concerns. ✓ Financial planning continues jointly with the Council, including month-end processes, forecasting and analysis of client debt. However, completion of detailed financial modelling remains dependent on greater certainty regarding TUPE outcomes, estates requirements, contractual arrangements and post-transfer support assumptions. ✓ Operational workstreams are progressing across Continuing Healthcare, Intermediate Care, front door and coordination functions. Development of a clearer future-state health operating model by the end of September is expected to provide critical direction for a number of dependent workstreams. ✓ Estates scoping has also advanced, with most properties now identified as either in or out of scope, although further validation of staffing levels, occupancy assumptions and potential location changes is required.. ✓ Legal and governance activity continues at pace, with the Transfer Agreement brief issued to external legal advisers and regular fortnightly legal catch-ups in place. Still awaiting Council Data Protection Officer (DPO) comments on the first Data Sharing and Processing Agreement (DSPA) ✓ Contracts and Commissioning Key Performance Indicators (KPIs) have been updated. Providers have been asked to register on the Council portal, with around one-third compliance reported. ✓ Data and analytics work has delivered key milestones, including completion of the statutory returns and reporting catalogue, while further work is underway to define reporting, access, licensing and IT integration requirements. ✓ IT engagement continues between Trust and Council teams, although progress is dependent on confirmation of workforce, location, system, device and residual access requirements.

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
11 schemes	6,200,000	8,500,000	1769662	8001759	0.00	5.00	0.00	5.00	
1 scheme	5,190,000	185,592	0	646,600	0.00	0.00	0.00	0.00	

Key Performance Indicator			Baseline	Target	Current Position	Trend
See slide 17 & 18 for detail.						
RAID Group	Score/ Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)				
Dependency	Dependencies within workstreams	D-095 (NEW) - Several workstream activities depend on understanding what remains with Health. Action: Health model assumptions need to be clarified by the end of September.				
Dependency	Dependencies within workstreams	D-096 (NEW) - IT and infrastructure planning remains dependent on confirmed staff scope, locations, system requirements, device assumptions and any residual Trust access needs. Action: Confirmation staff scope, locations, system requirements, device assumptions and any residual Trust access needs.				
Dependency	Dependencies within workstreams	D-097 (NEW) - Financial modelling remains dependent on clearer TUPE, estates, contracts and post-transfer support assumptions. Action: Clarification of TUPE, estates, contracts and post-transfer support assumptions.				
Dependency	Dependencies within workstreams	D-098 (NEW) -Estates planning remains dependent on confirmed staff numbers, occupancy methodology and any proposed Council location changes. Action: Confirmation staff numbers, occupancy methodology and any proposed Council location changes.				
Next Steps						
• Programme governance will focus on strengthening assurance and reporting arrangements, improving visibility of off-track milestones, and maintaining alignment between the action log, KPI reporting and delivery plan.HR and Staffing will confirm the formal consultation launch position with the Council, finalise consultation materials, progress partnership forum arrangements and support staff engagement through planned drop-in sessions and coordinated communications. • Finance: Progress financial modelling, debt analysis and impact assessment as key assumptions are confirmed. • Operations: Advance care coordination work and agree the future health model by the end of September. • Estates: Confirm occupancy and location assumptions to clarify property, cost and workforce implications. • Legal & Governance: Progress the Transfer Agreement, data-sharing arrangements, PARIS archiving and Liquid Logic requirements. • Contracts & Commissioning: Finalise transfer plans for remaining contracts and improve provider portal compliance. • Data & Analytics: Develop reporting, access, Power BI licensing and training arrangements. • IT & Infrastructure: Continue planning for data transfer, systems access, devices and infrastructure requirements. • Engagement & Communications: Maintain staff communications, TUPE information, newsletters and confidential support arrangements.						



1.5 Adult Social Care – Proposed KPIs

Workstream	KPI	Value	Numerator	Value	Denominator	Value
Human Resources & Staffing	% of colleagues assessed for scope of transfer	52%	No of colleagues assessed for scope of transfer	328	No initial staff identified	629
	% of colleagues agreed with Council for transfer	62%	No of colleagues agreed with council for transfer	204	No of colleagues assessed for scope of transfer	328
	% Achievement of key TUPE milestones due completed on time	50 %	No of key milestones due completed on time	1/10	No of key milestones due	2/10
Estates	% of buildings accommodating ASC staff that are leased/freehold	79%	No of properties with tenancy details	11	No Buildings accommodating ASC staff	14
	% cost of occupation reviewed	79%	No occupation cost reviewed	11	No Buildings accommodating ASC staff	14
Contracts & Commissioning	% ASC Contracts reviewed	100%	No ASC Contracts reviewed	411	No ASC Contracts	411
	% ASC Contracts with plan agreed	99%	No ASC Contracts with plans	408	No ASC Contracts	411
	% ASC Providers set up TC Digital Platform Account	33%	No ASC Contracts with Digital Platform set up	135	No applicable ASC Contracts	408
	% Health Contracts reviewed	100%	No Health Contracts reviewed	34	No Health contracts	34
	% Health Contracts with plan agreed	100%	No Health Contracts with plans	34	No Health contracts	34
Finance	Residual Cost Value remaining with TSD post transfer (Staffing, Estates and reduced flow capability)	Unknown	NA	NA	NA	NA
	% Debt Cases with agreed ownership (No)	0%	No Debt Cases with agreed ownership	0	No Debt Cases	1,380
	% Debt Cases with agreed ownership (£)	0%	£ Debt Cases with agreed ownership	0	£ Debt Cases	~£16m
	% Court of Protection Orders reviewed	0%	No Court of Protection Orders reviewed	0	No Court of Protection Orders	222 (+40 pending)
Operations	% Pathways where future state agreed between TSD and TC	100%	No Pathways where future state agreed between TSD and TC as part of Liquid Logic implementation	15	No Pathways defined	15
	% Number of ASC Reviews completed	TBC	Number of ASC Reviews completed	TBC	Number of ASC Reviews to be completed	TBC



1.5 Adult Social Care – Proposed KPIs



Workstream	KPI	Value	Numerator	Value	Denominator	Value
Data & Analytics	% Statutory Returns and Reports catalogued	100%	No Statutory Returns and Reports catalogued	75	No Statutory Returns and Reports	75
Data & Analytics	% Staff completed PBI training	Work in Progress	No Staff completed PBI training	Work in Progress	No Staff to receive PBI training	3
	% Priority reports transferred from Tableau to PBI ahead of 01/04/2027	Work in Progress	Priority reports transferred from Tableau to PBI ahead of 01/04/2027	Work in Progress	Priority reports to be transferred from Tableau to PBI ahead of 01/04/2027	7
IT & Infrastructure	% Applications assessed for transition impact	Work in Progress	No applications/systems assessed	Work in Progress	No applications/systems in scope	7
	% Staff with agreed application/system access requirements	Work in Progress	No staff with agreed application and system access requirements	Work in Progress	No staff in scope for transfer	
	% Critical business processes mapped	Work in Progress	No critical business processes mapped and SOPs written	Work in Progress	No critical business processes in scope	21
	% Data migration and archive requirements defined	Work in Progress	No data migration/archive requirements defined	1	No of systems data migration/archive requirements identified	4
	% Key IT transition decisions completed	Work in Progress	No key IT transition decisions completed	Work in Progress	No key IT transition decisions identified	
Communications & Engagement	% Engagement Events completed	93%	No Engagement Events completed	14	No Engagement Events	15
	No of Staff emails released	5				
	% FAQs with responses	100%	No FAQs with responses	40	No FAQs	TBC
	No of ASC Transfer views on ICON	367				
Legal & Governance	% queries requiring internal legal services advice closed	0%	No queries requiring internal legal services advice closed	0	No queries requiring internal legal services advice raised	2

BUILDING A Brighter Future 1.6 Innovation & Evaluation Hub NHS Torbay and South Devon NHS Foundation Trust																																			
Delivered Delivery has focused on progressing key governance, innovation and partnership activities, with stakeholder engagement underway through the Information Systems Group Gateway process and approvals advancing. ✓ ISG Gateway Process: Feedback has been received from two stakeholders. A reminder will be issued on 4 August 2026, with final responses requested by 7 August 2026, after which consolidated feedback will be submitted to the Integrated Care Board (ICB) . ✓ Innovation Pipeline: The Innovation Pipeline has been escalated through the Finance Operations Committee and Oversight Group, with approval anticipated subject to any further feedback. Formal ratification will be sought from Information Systems Group stakeholders in advance of the 13 August 2026 meeting. Following approval, a baseline report will be produced to support ongoing monthly performance monitoring. ✓ Health Innovation Network and NHS Regional Partnership: The Health Innovation Network contract has been completed and is awaiting executive sign-off prior to Trust approval. ✓ The Partnership Agreement with the NHS Region is progressing through legal review and is scheduled for Executive Committee approval on 14 August 2026. ✓ Implementation Lead Recruitment: Organisational structure has been confirmed by the Chief Planning Strategy Officer. Recruitment commenced on 4 August 2026 using a phased approach, prioritising internal candidates before wider Trust and external recruitment. ✓ Evaluation Framework: Health Innovation Network support capacity has been agreed. The draft evaluation framework will now be circulated for stakeholder review and sign-off to enable implementation.					<table><tr><th>Key Performance Indicators</th><th>Baseline</th><th>Target</th><th>Current Position</th><th>Trend</th></tr><tr><td>KPI 1 — % of innovation pipeline actively progressing</td><td> • 39% of pipeline actively progressing (11 of 28 projects). • 61% stalled at prototype stage. </td><td> • Target: 60% or more of pipeline actively progressing by Q4 2026/27. </td><td>Pipeline triage complete (June 2026); all 28 projects classified. Active/stalled split to be formally confirmed at July ISG. 13 of 28 projects progressing.</td><td>↔</td></tr><tr><td>KPI 2 — Number of jointly delivered or co-funded HIN SW projects</td><td> • 0 jointly delivered or co-funded projects. </td><td> • Minimum 1 co-funded or jointly delivered project initiated by Q3 2026/27. </td><td>Not yet initiated. Dependent on partnership agreement completion.</td><td>↔</td></tr><tr><td>KPI 3— Innovation-to-IT pipeline SLA: in place (Y/N)</td><td> • No innovation-to-IT pipeline SLA in place. </td><td> • SLA agreed and operational by Q4 2026/27. </td><td>Not yet established. Dependent on Implementation Lead appointment and IT Services engagement. Options appraisal for structure nearing completion. Conversation being held with Chief Technical Officer & IT Programme Director are starting to progress.</td><td>↔</td></tr><tr><td>KPI 4— Average time from ISG Gateway 3 approval to BAU deployment (days, per project)</td><td> • Not yet established. No formal tracking of Gateway 3-to-BAU time in place. </td><td> • Baseline established and average time tracked monthly from Q3 2026/27 once SLA is operational. </td><td>Not yet trackable. Will be established alongside the innovation-to-IT SLA.</td><td>↔</td></tr></table>						Key Performance Indicators	Baseline	Target	Current Position	Trend	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. 13 of 28 projects progressing.	↔	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.	↔	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. Conversation being held with Chief Technical Officer & IT Programme Director are starting to progress.	↔	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.	↔
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Next Steps • Complete ISG Gateway feedback process, collating stakeholder feedback, and submit consolidated response to ICB. • Secure Innovation Pipeline ratification and produce baseline Innovation Pipeline report to support performance monitoring. • Obtain executive and Trust sign-off for the Health Innovation Network contract. • Progress the NHS Regional Partnership Agreement through legal review and secure Executive Committee approval. • Continue the Implementation Lead recruitment process. • Circulate the Evaluation Framework for stakeholder review and approval, enabling transition to implementation.					<table><tr><th>RAID Group</th><th>Score/Category</th><th colspan="4">Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i></th></tr><tr><td></td><td></td><td colspan="4">No new RAID in this reporting period.</td></tr></table>						RAID Group	Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>						No new RAID in this reporting period.																
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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

Work is progressing with a primary focus on T&O, with the review establishing an improvement methodology that can be replicated across other services. The next phase will focus on translating recommendations into a structured improvement plan, supported by targeted change management. Strong leadership will be essential to creating the conditions for sustainable improvement and driving the cultural and behavioural changes required to support long-term transformation.

- ✓ The Trauma and Orthopaedics (T&O) review undertaken by the external clinical specialist was presented to Finance and Operational Committee (FOC) on 29/07/2026. Development of an improvement plan in response to the recommendations is now commencing, with implementation support requirements to be confirmed.
- ✓ Commissioning Service Unit (CSU) analysis continues against the 21 Lines of Enquiry across Emergency Medicine, Trauma and Orthopaedics, and Oncology to identify opportunities for improvement and inform future recommendations.
- ✓ The Phase 1 Paediatrics and Maternity improvement plan remains on track for presentation to the workstream group in August 2026.
- ✓ The Chief Operations Officer (COO) will lead the identification and securing of external clinical support for Emergency Medicine. Getting it Right First Time (GIRFT) Team support identified and date to be confirmed.
- ✓ Following the departure of co-workstream lead Associate Director of Strategy and Provider Partnerships, arrangements are in place for Business Director of Planning and Productivity to assume responsibility for the Paediatrics and Maternity Clinical Service Reviews.
- ✓ Sickness absence has affected project support availability and change to roles will mean capacity is lost here imminently. Replacement support has been identified and transition now planned.
- ✓ This work is heavily connected to the Clinical Pathway Review workstream and the Productivity workstream. Findings, insights and recommendations will be shared across programmes, with interdependencies actively managed to ensure alignment of outputs, timelines and service improvement objectives..
- ✓ The capacity risk has escalated to an active workstream issue due to resource constraints impacting delivery and resulting in milestone slippage. While longer-term mitigation is dependent on organisational restructuring and workforce changes, short-term recovery options are currently being explored to minimise further delays and maintain progress against key deliverables.

OPFBC Oversight debated the future of clinical services review and the need to refocus the programme, prioritising specialties with the greatest opportunity for impact while pausing or redirecting reviews where benefits are likely to be limited. Trauma and Orthopaedics remains the primary area of focus, with reviews of Paediatrics and Maternity paused and Emergency Medicine incorporated into broader unscheduled care improvement work.

Next Steps

- Develop T&O improvement plan and identify support requirements.
- Progress Emergency Medicine review with CSU support and further engagement with Lead Clinician.
- Conclude paediatrics and maternity reviews.
- Begin review of Oncology.

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

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



Note - delivery impact KPIs to be identified following reviews

RAID Group

Score/ Category

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

Risk

16

Pathway redesign, data validation, modelling and option development will be incomplete or delayed. If clinical, operational, corporate or system partners do not have sufficient capacity. This now being managed as an issue. Mitigating Actions: Resource constraints are impacting the achievement of deliverables on time. Risk has become an issue for workstream to manage

Issue

Critical

I017(NEW) - Pathway redesign, data validation, modelling and option development will be incomplete or delayed. If clinical, operational, corporate or system partners do not have sufficient capacity. Affecting workstream's delivery quality and pace. Action Plan: Mitigation to recover this is linked to restructures which is going to take some time to resolve so short-term options under consideration.

Dependency

D-092 (NEW) -This workstream is dependent on, and closely aligned with, the Clinical Pathway Review and Productivity workstreams. What is Required: Key findings and recommendations will be shared across workstreams to inform decision-making, avoid duplication, and support coordinated service improvement. Interdependencies will be actively managed to ensure alignment of outputs, timelines, and objectives. Impact if not met: Failure to share key findings may result in duplication of effort, conflicting recommendations, misaligned priorities, and missed opportunities for service improvement.

Assurance

Rating

Executive Sponsor Rating

Limited



2.2 Productivity Including Best Practice


Torbay and South Devon
NHS Foundation Trust

Delivered

The workstream continues to make progress; however, delivery remains slower than planned due to limited resource capacity. The SRO has met with subgroup leads to clarify expectations, confirm scope and priorities, and establish a clearer direction for delivery. This has helped strengthen accountability and should support renewed momentum across the programme. Additional resource requirements are being identified and aligned to planned team restructures. It is necessary to reset some milestone dates to reflect the resource constraints.

Key areas of progress include:

- ✓ Ongoing development of productivity analysis capability, although progress has been limited and requires increased pace. The productivity analyser implementation is progressing slowly, but greater pace required. Final (Service Line Reporting) SLR data for 2025/26 awaited.
- ✓ Continued support from Midlands Commissioning Service Unit (CSU), focused primarily on productivity issues with clinical service reviews. Initial hypotheses have been developed and are being tested using national benchmarking and comparative data.
- ✓ Productivity theme Subgroups continue to develop project plans and progress detailed work programmes, with further refinement of deliverables and Key Productivity Indicators (KPIs) underway.
- ✓ Additional work has been completed to define, agree and populate KPIs, as reflected within this report.

OPFBC Oversight discussed a focusing of the workstream, with agreement to move away from centralised productivity initiatives, instead providing specialty teams with data packs and clear expectations to develop productivity improvement plans within defined timescales, and focusing on specialties with the largest RTT and financial challenges.

Next Steps

- Finance Team to progress implementation of productivity analyser tool.
- Finance team to produce final SLR data for 2025/26.
- Complete subgroup plans and KPIs and progress the detailed work on the cross-cutting themes.
- Complete opportunity analysis with the CSU.

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	101,266	0.00	0.00	0.00	0.00	
27-081	Finance – NHSE Variable Contract	1,000,000	500,000	0	500,000	0.00	0.00	0.00	0.00	

Key Performance Indicator	Baseline	Target	Current Position	Trend
Extensive number of KPI's required for this workstream. Please refer to slides 23-24 for the latest KPI performance update and progress against key measures.				

RAID Group	Score/ Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
Risk	16	Insufficient dedicated resource, analytical capacity, or technical expertise. Mitigating Action's: Resource constraints are impacting the achievement of deliverables on time. Risk has become an issue for workstream to manage.
Issue	Concerning	I-019 (NEW) - Insufficient dedicated resource, analytical capacity, or technical expertise cause productivity initiatives to be poorly designed, slow to be progressed, or are not robustly evidenced. Limiting the workstream's ability to identify, deliver, and sustain credible productivity improvements. Action Plan: Mitigation to recover this are being managed by SRO and Workstream Lead.

Assurance	Rating
Executive Sponsor Rating	Limited



2.2 Productivity Including Best Practice – KPIs

Key Performance Indicators	Baseline	Target	Current Position	Trend
OUTPATIENTS				
• % of clinic templates meeting GIRFT UQ	Review underway to source data for KPI. Expect to have something by mid August.			
• % of follow up pathways adhering to GIRFT standards	Not started any work on sourcing the data for this KPI.			
• % patients discharged at first appointment	Should be provided via the ICB Deep Dive Dashboard. Data currently not available for TSD.			
• % DNA (SRO to approve recommendation that this target should be at 4.5% or even 4% for Trust level)	TBC from GIRFT work	Under 5% ICB target	5.3% (May 2026)	
• First to follow up ratios	TBC from GIRFT work	Target TBC by SRO Peer median = 2.0 Provider median =2.0	2.8 (May 2026)	
• Proportion of outpatient attendances that are for first appointments, or follow up appointments attracting a procedure tariff – ERF (SRO to approve addition of KPI as a key finance metric)	TBC from GIRFT work	Target TBC by SRO Peer median = 46.3% Provider median =46.4%	44.5% (March 2025)	
• % activity undertaken as virtual	TBC from GIRFT work	ICB Target = 25% Peer median = 20.9% Provider median =18.8%	19% (May 2026)	
• % activity re-directed through SPOA	This project will start when A&G is available in Epic, which is planned for in November 2026.			
• % room utilisation in c these half sessions we seem to have	Not currently available – plan in place to access this data.			
• % follow up overdue backlog reduction	Performance Team data – Need to agree access to data with Performance Team			
• PIFU (SRO to approve addition of KPI as a key metric. Whilst TSD are performing above RDU and UHP, there are specific services that underperforming.- should these be shown separately)	TBC from GIRFT work	Target TBC by SRO RDU = 7.6% UHP = 5.6%	12.6% (May 2026)	
THEATRE				
• % theatre capacity used (fallow sessions) broken down by specialty	Apr26: 88.2% used (11.8% stood down; 36/306 sessions). By specialty: Urology 92.9%; Colorectal 86.1%; UGI 71.9%; Max Fac 91.4%; ENT 90.9%; O&G 95.8%; Breast 87.5%; Plastics 82.1%; Ophth 85.5%; Ortho 89.3%.	≥85% allocated sessions used; reduce fallow/stood-down lists by specialty.	May26 latest populated SL Trend: 92.7% used (7.3% stood down; 34/468 sessions). By specialty: Urology 96.8%; Colorectal 87.2%; UGI 90.0%; Max Fac 89.7%; ENT 97.7%; O&G 100.0%; Breast 97.1%; Plastics 92.9%; Ophth 89.5%; Ortho 91.2%.	
• Theatre utilisations (knife to skin or needle to skin)	Apr 26 total 66% General 61%; Special 78%; DSU 68%; ESU 59%; Hub 66%; Teignmouth 60%.	Increase utilization; local target TBC once EPIC reporting basis is validated.	Jun 26 total 70% General 63%; Special 82%; DSU 79%; ESU 67%; Hub 76%; Teignmouth 70%.	
• % HVLC lists adhering to GIRFT standards	Apr 26 data not provided in extract.	GIRFT HVLC standard / target TBC.	Jun 26 data not provided in extract.	No quantified trend available.
• % cancellations on the day (non-clinical)	Apr 26: 12% cancelled OTD.	National revised target from Apr: 7% overall; 2% due to clinical reasons.	Jun 26: 13% cancelled OTD. Drivers include humidity issues and trauma / emergency demand; reason code "other" under review.	
• Compliance with 6-4-2 protocol	Apr 26: firm line with 6-4-2; lists closed down at 4 weeks.	Maintain compliance with 6-4-2 protocol; quantify % compliance for future reporting.	Jun 26: compliance narrative maintained; no % compliance value provided in extract.	Maintained narrative; quantified trend not available.



2.2 Productivity Including Best Practice – KPIs



Key Performance Indicators	Baseline	Target	Current Position	Trend
DIAGNOSTICS				
% direct to test pathways in place and used	Email has been sent to BI Team on 16 June 2026 requesting support for all the subgroups.. Response received in week commencing 26/08/2026 confirming the lead for each of the subgroups			
Number of tests per inpatients (radiology and pathology)				
% risk stratified pathways in place				
Reporting turnaround times				

BUILDING A
Brighter
Future

2.3 Pathology

NHS

Torbay and South Devon

NHS Foundation Trust

Delivered
✓ Progress continued across Histopathology, Microbiology and Blood Sciences through joint meetings focused on the Clinical Model, Workforce Model, operational logistics and Full Business Case (FBC) assumptions. ✓ Workforce models have been finalised to support the current FBC position, with validation and caveats continuing through governance and implementation planning. ✓ Histopathology remains a key focus because the portacabin needs to be vacated by August 2027. RIBA 5 completion remains a timing concern, with further work required to understand whether activities can be compressed or run in parallel. ✓ Latest Capital information clarifies the affordability position. The build cost was discussed as around £4.2m, but the total position increases substantially once VAT, optimism bias, contingency and equipping are included. The figure discussed was £8.8m, with an optimistic position potentially just under £8m, subject to further work. ✓ Capital, workforce, transport, digital, equipment and revenue assumptions remain interdependent. Current work is focused on completing the FBC narrative, confirming caveats and identifying areas requiring senior decision or further validation. ✓ The Equality Impact Assessment (EQIA) has been completed and circulated for comment. Further discipline-level review may still be needed where risk scoring differs by discipline, with the worst-case position used where appropriate. ✓ Gadeon House design work has progressed. Architectural layouts are complete, with mechanical and electrical design work still being finalised and further RIBA 4 design required before RIBA 5 construction. ✓ Digital approach has progressed towards RDUH expanding its infrastructure and IT services to the third floor, with Torbay staff using RDUH provision when working from Gadeon House. Epic configuration, support arrangements and any revenue consequences still require confirmation. ✓ Transport modelling has progressed but remains caveated. GP Liaison work provides indicative worst-case costing for separate runs and van lines, but further detail is required on routes, staffing, base location, electric vehicle requirements and charging infrastructure. ✓ Cytology trial activity continued. Externalisation to Exeter is expected to release space for storage/formalin improvements once the service transfer is complete and next steps are confirmed. ✓ Programme governance, stakeholder engagement and communications activities continued. The Save Torbay Hospital group remains active, a solicitor letter is being addressed with executives and legal colleagues, and public-facing Q&A material has been developed to support myth-busting.

Key Performance Indicators	Baseline	Target	Current Position	Trend
No of TSD agreed clinical strategies (Histopathology model)	N/a	4	4 (All 4 elements to be completed by 31/07/2026)	↑
% of enabling milestones completed for workforce changes	N/a	5	1 (Only 1 due to be completed in August)	↑
% of enabling milestones completed for Estates.	N/a	3	0	↔

Next Steps
• Review assumptions and caveats added to the FBC for transport, equipment and digital. • Amend Equality Impact Assessment (EQIA) to reflect feedback, submit and attend Panel meeting. • Progress the FBC approval pathway, securing Steering Group and Programme Board endorsement by 24/08, full programme sign-off by mid September and onward Board approvals from 30/09. • Confirm remedial portacabin works and storage improvements required to maintain safe operation. • Confirm equipment installation, validation and supplier collaboration timelines for Gadeon House to support safe mobilisation and operational readiness. • Finalise the remaining detailed components of the Clinical Model, Workforce Model and logistics planning to support delivery readiness and post-FBC implementation. • Undertake a joint RDUH-TSD review of shared risks. • Finalise RIBA Stage 3 design outputs, including floor plans and associated design documentation, to support delivery readiness and programme progression. • Review of cost implications for both revenue and capital.

RAID Group	Score/Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
See following slide.		

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										



2.3 Pathology



Torbay and South Devon
NHS Foundation Trust

RAID Group	Score/ Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
Risk	16	R083(NEW) - Further joint discussion required around assumptions/caveats used in FBC – risk that joined up plan may not be deliverable. Mitigating Actions: Lead to misaligned objectives, delays in implementation, fragmented decision-making, and reduced stakeholder's confidence , impacting achievement of programme
Assumption		A- 059(NEW) - TSD ASL model and specifications for each discipline developed on the assumption the Gadeon House CSL will operate 08:00 to 20:00, 7 days/week for microbiology and blood sciences .
Assumption		A-064(NEW) - Blood Sciences and Microbiology acute-site areas are assumed to be broadly fit for purpose.
Assumption		A-065(NEW) - Histopathology: Specimen drop-off at Torbay will continue on the same basis as the current set-up, including Poundbury. Frozen sections are planned activity for which staff will travel from the CSL as required. Portacabin demolition does not appear to be included in current business case. RDUH will provide the Gadeon House IT environment for third floor.
Assumption		A-066(NEW) - Current transport costing is based on diesel vans and excludes electric vehicle charging.
Assumption		A-067(NEW) - Utilities, waste, security and wider building revenue costs treated as assumptions until the basis of recharge is confirmed.
All the above new assumptions will need to be approved as part of the joint discussion for FBC.		
Issue	Critical	I-021(NEW) -Total capital position is materially higher than anticipated. May affect affordability, funding route and governance readiness. Action Plan: Escalate senior review of capital affordability and funding options.
Issue	Critical	(I-012) - RIBA 5 completion is currently expected at end of October. This would push vacation of the portacabin beyond the fixed end of August 2027. Action Plan: Identify options to accelerate or run activity in parallel. Escalate through programme governance. See if dependant project dates be delayed
Issue	Concerning	(I-013) - Equipment installation, validation and supplier collaboration timescales currently unknown. could affect operational readiness and compromise portacabin vacation deadline. Action Plan: Confirm supplier lead times and align these to other activities on the critical path.

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
Progress during the reporting period has been limited due to challenges in securing stakeholder alignment and coordinating the availability of key participants required for pathway review activities. ✓ Proposed meeting dates have been circulated to key stakeholders to support pathway review discussions. Responses are awaited, with SRO support required to secure engagement and maintain workstream momentum. OPFBC Oversight discussed the need to strengthen alignment between pathway review activity and wider transformation programmes to avoid duplication and ensure improvement efforts are focused on delivering system-wide benefits. Work on mandated pathways will be progressed through the most appropriate programme, including existing unscheduled care and Same Day Emergency Care (SDEC) initiatives. The discussion recognised that achievement of some best practice pathway standards is dependent on factors beyond the Trust's direct control, including community and commissioning arrangements. Further work will be undertaken to refine reporting and oversight arrangements, providing greater clarity on pathway ownership, delivery routes, and areas requiring ongoing clinical and executive focus.

Next Steps
- Engagement with key stakeholders to support pathway review discussions and inform next steps. - Engagement with Neighbourhood colleagues ensuring strategic alignment and coordinated delivery across workstreams.

Key Performance Indicator	Baseline	Target	Current Position	Trend
% of identified clinical pathways reviewed against GIRFT	N/A	100% (13)	100% (13)	↑
% Current pathways compliant with GIRFT Standard	N/A	100% (13)	8% (1 - Cardiology)	↑
% 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 for % of patients that follow GIRFT pathway		85%		

RAID Group	Score/ Category	Mitigation / Description <i>(Risks, Issues) (Assumptions, Dependencies)</i>
Issue	Critical	I006 - Limit clinical and managerial capacity to engage consistently in pathway review activity'. Limited clinical and managerial capacity to engage consistently in pathway review activity means Pathway redesign milestones are delayed, with slippage in delivery timelines. Action Plan: 1) Secure protected clinical time for pathway review activity, agreed via job planning or SPA allocation. 2) Plan engagement around operational cycles (e.g. avoiding known peak pressure periods).

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



Torbay and South Devon
NHS Foundation Trust

Delivered
✓ AI scoping has been completed and the programme has progressed into the pilot phase, with delivery focused on the preferred One Devon solution and planned integration with Epic to support future implementation. ✓ An internally developed Appointment Intelligence tool is being prepared for pilot deployment, with testing underway to validate accuracy, safety, and system integration requirements ahead of wider implementation. ✓ Discussions with Kate Lissett, Senior Information Risk Owner (SIRO), regarding Phase 2 of the programme, focusing on the safe and controlled rollout of licences to clinical teams. ✓ Following the Phase 1 co-pilot rollout, user feedback identified a requirement for additional training and support. Bespoke internal training materials is therefore being developed to enhance user adoption, capability and benefits realisation. ✓ Engagement has commenced with clinical teams, including the Pain Physiotherapy Management Team, to inform the development of consultation modality choice pathways. Initial scoping has also begun with the People and Education Directorate to explore dashboard requirements.

Next Steps
• Explore opportunities to commercialise the internally developed Digital Future solution through a third-party provider, such as Epic, in exchange for Ambient AI licences and academic publication opportunities and ensure the milestones underpinning this deliverable will be reviewed and refined to align to the revised delivery approach. • Continue development of bespoke internal Copilot training materials to strengthen user capability, support adoption, and maximise benefits realisation across the organisation.

Key Performance Indicators	Baseline	Target	Current Position	Trend
Number of Co-Pilot licences issued	0	1000	475	⬆️
% of clinical staff using digital dictation	TBC - Meeting scheduled for Tuesday, 18 August 2026 with Kate Lissett to source data			
% of staff completing digital skills programme	0	1500	405	⬆️
No of alternative applications in use where Epic is the primary platform	5	0	5	↔️
MyCare adoption rate	0	50,000 (end of year 1)	32,000	⬆️
Average documentation time reduction per consultation from using AI (baseline and follow-up)	TBC – Investigating how this data can be sourced			

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
CIP scheme to be developed in conjunction with PMO										



4.2 Epic Implementation & Benefits including MY CARE

Delivered
Full understanding of steps to deliver our Operational Plan, including recovered activities post Epic Go-Live. ✓ Material reduction in Referral to Treatment (RTT) performance caused by fall in post go-live clock starts have led to challenges to progression of next events and failure to return to full Business As Usual (BAU) activities. ✓ 6 “Turbo Room” sessions supported by Epic and TSD Core Team held twice weekly over 3-week period which began 13th July. Targeted Outpatient (OP) support for high-risk specialties has also been introduced. Support for UHP go-live across Information Officer (IO) and Super User teams needs to be fully formed. ✓ Plans and rotas are in place, and support has been provided since UHP go-live. Full transition to benefits delivery. ✓ Working with Programme Management Office (PMO) team to finalise delivery plans for all Cash releasing benefits (CRBs) over next 2 months. ✓ Status of non-cash releasing benefits needs to be clarified as currently no formal PMO support plan. Plan for adoption of self-booking through the MY CARE app. ✓ Business case drafted and timeline modelled, which has been reviewed by RDUH lead. Currently being reviewed by TSD Finance colleagues. Approval of BAU Governance and Resource plans for One Devon and TSD. ✓ The BAU resourcing plan for the One Devon Programme Analyst Team has been approved by the SRO. ✓ The TSD BAU resource plan has been updated in line with the FBC, and recruitment to Admin IO roles has commenced.

Next Steps
• Continued focus on recovering activity with additional support activities as required. • Recruitment of One Devon and local TSD roles. • Continue development and promotion of Thrive training. • Clarification around how non-cash releasing and societal benefits will be managed.

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
4 schemes	1,650,000	603,808	0	134,400	0	0	0	0	
7 schemes	3,300,000	2,477,057	0	2,005,853	0	31.3	0	10.34	
13 schemes	406,312	2,232,958	1,852,974	2,174,433	18.7	22.85	10.78	18.34	
1 scheme	300,000	0	0	0	0.00	0.00	0.00	0.00	

Key Performance Indicators	Baseline	Target	Current Position	Trend
MyCare adoption rate	N/a	50,000 end Yr1	32,000	↑
Value of Project Outline Documents (POD's) approved vs business case	N/a	£4,916k	£4,988k	↑
Epic CRB Forecast against plan	N/a	£4,916k	£4,315k	↓
Counting/coding metric – data not currently robust enough, aim to report on this in approx. 3 months	Reporting for this KPI will commence in Q3 when sufficient and robust data is available			
KPI Dashboard within Epic	This will be developed once UHP is live and stable, as the required resource is currently focussed on their go-live.			

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

Assurance	Rating
Executive Sponsor Rating	Limited

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



Torbay and South Devon
NHS Foundation Trust

Delivered

- ✓ **The Voluntary Redundancy (VR) scheme** has now concluded. A total of 99 applications were approved, of which 82 colleagues accepted the offer of voluntary redundancy, equating to 61.48 WTE. The associated establishment and budget changes have now been completed, with all approved VR posts removed from the Month 4 budgets. Of the 61.48 WTE reduction, 47.27 WTE contributes to existing Cost Improvement Programme (CIP) schemes, with the remaining 14.21 WTE allocated to the Trust-wide workforce reduction scheme.
- ✓ **The Operational Management Phase 1** consultation is now complete. Planning for Phase 2 is also complete, with consultation materials drafted and ready for launch. Phase 2 will include all remaining colleagues in Band 5 and above roles who were not included within Phase 1. The launch date is currently being finalised and will be communicated to affected staff and stakeholders in due course.
- ✓ **Phase 2 of the People Directorate consultation** has now been launched. Following engagement with the Partnership Forum, formal consultation commenced on 27 August and will run until 11 September. Consultation meetings, engagement activity and opportunities for feedback are now underway in line with the agreed timetable.
- ✓ An independent review of the **One Devon People Digital Programme** is underway and is expected to report in September. In parallel, work continues on the delivery of 19 system enhancements to improve EVA's functionality and user experience, alongside Department of Health-funded technical development to address system issues that currently limit delivery of the target operating model. The first progress report on this technical improvement work is expected in October.

Risk Closure Recommendation: VR Scheme

This risk can now be closed as the Voluntary Redundancy (VR) scheme has concluded. The risk relating to insufficient uptake of the VR scheme has therefore not materialised, and the planned workforce reductions and associated savings have been secured. Any residual risks relating to delivery of financial plans should now be managed through the relevant workforce, financial recovery and CIP governance arrangements.

Next Steps

- Complete the People Directorate Phase 2 consultation period on 11 September 2026, ensuring all collective and individual consultation meetings are concluded and feedback is fully considered.
- Launch Phase 2 of the Operational management consultation.
- Support affected colleagues through the transition process, including individual meetings, wellbeing support and redeployment activity where applicable.
- Continue implementation of Voluntary Redundancy savings and monitor delivery against workforce reduction and CIP targets.
- Further embed governance and partnership working arrangements with the One Devon Payroll & Pensions Service following the TUPE transfer.
- Continue monitoring workforce establishment, vacancy controls and workforce spend to support delivery of the Trust's financial recovery plan and workforce objectives.

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	163,671	295,671	7.95	7.95	4.09	7.95	
27-077	Operational Management Review	0	1,263,000	189,807	978,408	0.00	33.69	4.61	29.58	
27-078	Corporate Management Review	2,340,000	1,077,000	476,185	1,077,185	55.36	16.37	9.21	17.70	
	Reduction in Management Costs	60,000	60,000	0	0	1.00	1.00	0.00	0.00	
	F&C Reduction in Management Costs	0	0	0	60,000	0.00	0.00	0.00	1.00	

Key Performance Indicators	Baseline	Target	Current Position	Trend
CIP Workforce Reductions	N/A	56.36 WTE	27.56 WTE	
People Digital CIP Target	N/A	7.95 WTE	4.09 WTE	
Voluntary Redundancy Uptake	N/A	56.36WTE	61.48 WTE Complete	★
Successful TUPE transfer of Payroll & Pension team	N/A	01/07/2026	Complete	★

RAID Group	Score/Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
Issue	Critical	People Digital programme delivery: Unresolved technical issues with wave 2 and resourcing issues linked to LMS. Delay to programme rollout and inability to realise planned benefits. Action Plan • Independent review of the original People Digital Business Case. • Implement targeted enhancements to the existing systems to address issues with system functionality and capability. • Develop a solution to the system issues identified within EVA's functionality that do not currently support the target operating model. • Address LMS resourcing gaps.

Assurance	Rating
Executive Sponsor Rating	Satisfactory



5.2 Cultural Transformation



Torbay and South Devon
NHS Foundation Trust

Delivered

The Cultural Transformation workstream remains rated **Satisfactory**, with all five key deliverables currently on track and no issues, risks, dependencies, or escalations requiring further escalation this reporting period.

- ✓ Significant progress has been made with approval of the Wellbeing Strategy and business case, enabling phased implementation of the wellbeing programme, and the launch of Phase 2 of the People & Education restructure on 27 July 2026.
- ✓ Progress has also continued on the Restorative Just and Learning Culture (RJLC) programme, with the Attendance Policy progressing towards ratification and policy review activity ongoing. The publication of the National Leadership and Management Framework has removed a key dependency and enabled development of the refreshed leadership offer to progress.
- ✓ There are no material variances against plan at this stage. Some activity within the Learning Academy and leadership development programmes remains dependent on completion of the ongoing People & Education consultation and recruitment to revised structures, which may influence the pace of future delivery but is not currently impacting overall milestones.
- ✓ The previously identified wellbeing investment and national framework dependencies have now been resolved.
- ✓ Key achievements this period include approval of the wellbeing business case, closure of the associated wellbeing investment risk, launch of the formal People & Education consultation, progression of RJLC policy development, and publication of the National Leadership and Management Framework, enabling programme design work to advance.

Next Steps

- Delivery will focus on implementation of the approved Wellbeing Programme, progression of RJLC policy development and Attendance Policy ratification, continuation of the People & Education consultation, and development of the refreshed Leadership and Management Development Programme.
- Planning activity for the Learning Academy will continue, enabling implementation following completion of consultation and recruitment activity.

Key Performance Indicators		Baseline	Target	Current Position	Trend
Workstream Performance					
% policy due for review completed & published		N/A	5	0	Confirmation of framework and business case means start to build system to extract required data to complete these KPIs
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	741 (all supervisors as defined by ESR)	Not yet active	
Organisational Impact					
Reduction in sickness absence		5.17	3.9%	5.30 (May 26)	
Staff engagement: Recommendation as a place to work		57%	62%	57%	
Staff Survey response rate		38%	47%	38%	
Global majority representation (WRES)					
Increase band 6-7		13.3%	9.64%	5.97%	
Increase band 5-6		13.3%	11.3%	10.36	
(WDES) (Data not yet available this month)					
To be agreed with GS FTSU provision		Awaiting Data			
RAID Group	Score/Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)			
		No unresolved RAID escalations 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
27-020	Education & Training - Cost Reduction	174,000	174,000	69,628	94,630	2.73	2.70	2.00	2.70	
27-035	Temporary Staffing	1,400,000	1,400,000	0	1,400,000	4.14	4.14	0.00	4.14	

6.0 Strategic Enablers

Senior Responsible Owner – James Corrigan, CFO

Securing the essential foundations for transformation



6.1 One Devon Shared Services - Finance

Delivered

There are increasing concerns that the project go live date of 1st October may not be achievable. The SBS system is not yet built, testing of the system is not ready, and a number of the Trust's key areas and concerns are yet to be addressed by SBS this poses a risk to key milestones and deliverable dates.

- ✓ Delivery of the Fusion system build has been delayed from July to August 2026. System testing will be undertaken centrally by the One Devon team, supported by a limited number of Trust representatives, resulting in reduced local visibility of system functionality, reporting outputs and access arrangements. In addition, finance training is currently scheduled for 19 October, which presents a risk to first month-end readiness; a request has been made to SBS to bring training forward, with confirmation awaited.
- ✓ Data Collection activity is expected to continue through to go-live, with a series of data uploads, review and feedback cycles, and re-uploads. Delays in feedback from SBS are reducing the opportunity to incorporate changes between cycles, creating a potential risk to data quality and readiness.
- ✓ A detailed exercise is ongoing to map all Unit 4 codes to the new system. Although this has been completed for some parts of the coding structure, the last mapping for Analysis and Project codes is causing some issues as there isn't a comparable code type within the Unit 4 system. A task & finish group has been set up locally to work on this as soon as possible, details of this will become available in the coming weeks, with similar issues reported across Devon Trusts. The alternative option is to not map the first half of the year to the new Project & Analysis codes, but this will lead to increased work each month to produce internal reporting and could also lead to lack of clarity for budget holders.
- ✓ Engagement with SBS continues through regular system demonstrations and review sessions, with TSD providing ongoing feedback to inform system readiness. Pre-recorded 'Get Ready' resources are now available, and end-user training is scheduled for September and October, with invitations being issued by SBS.
- ✓ Confirmation of the future accounting arrangements for the charity is awaited following several revisions to the proposed approach. As the charity cannot be accommodated within the SBS solution, it is implementing an alternative system, which must be operational ahead of SBS go-live to ensure continuity of financial management and reporting.
- ✓ Concerns remain regarding resource capacity and readiness ahead of the 1 October go-live date, particularly given the outstanding code mapping activity, interface development and unresolved system design requirements. Several existing Unit 4 processes, including custom data tables, WTE uploads for NHSP and STAFFflow, and Willow Pharmacy integrations, do not yet have confirmed SBS solutions. While SBS has provided an initial implementation plan, further clarification and development are required to support successful deployment and operational readiness.

Key Performance Indicator	Baseline	Target	Current Position	Trend
Completion of critical path milestone	N/A	13	4 complete, 9 showing as on track/not yet due	↔
Testing status	N/A	88%	84% complete	↑
One Devon Shared Service Programme KPI's	N/A	29	Now reported by exception by SBS. 2 showing as behind target, 2 behind in June.	↔

RAID Group	Score/Category	Mitigation / Description (Risks, Issues) (Assumptions, Dependencies)
Risk	12	R084 (NEW) - System not ready resulting in delay of go live date for 1st October. Mitigating Actions: 1) Carry on with Unit 4 as a financial system until SBS programme ready. 2) If all other Trusts are in agreement to delay, then the financial implication should fall with SBS. 3) SBS are currently working on an action plan to address concerns to ensure no delay.

Next Steps

- Go/No go decision for a transfer to SBS on 1st October is expected at the end of August
- Training reminders will be sent to invite staff to attend training in September/October.
- There will be continuous cycles of data uploads, review/feedback and updating as we move towards go live

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

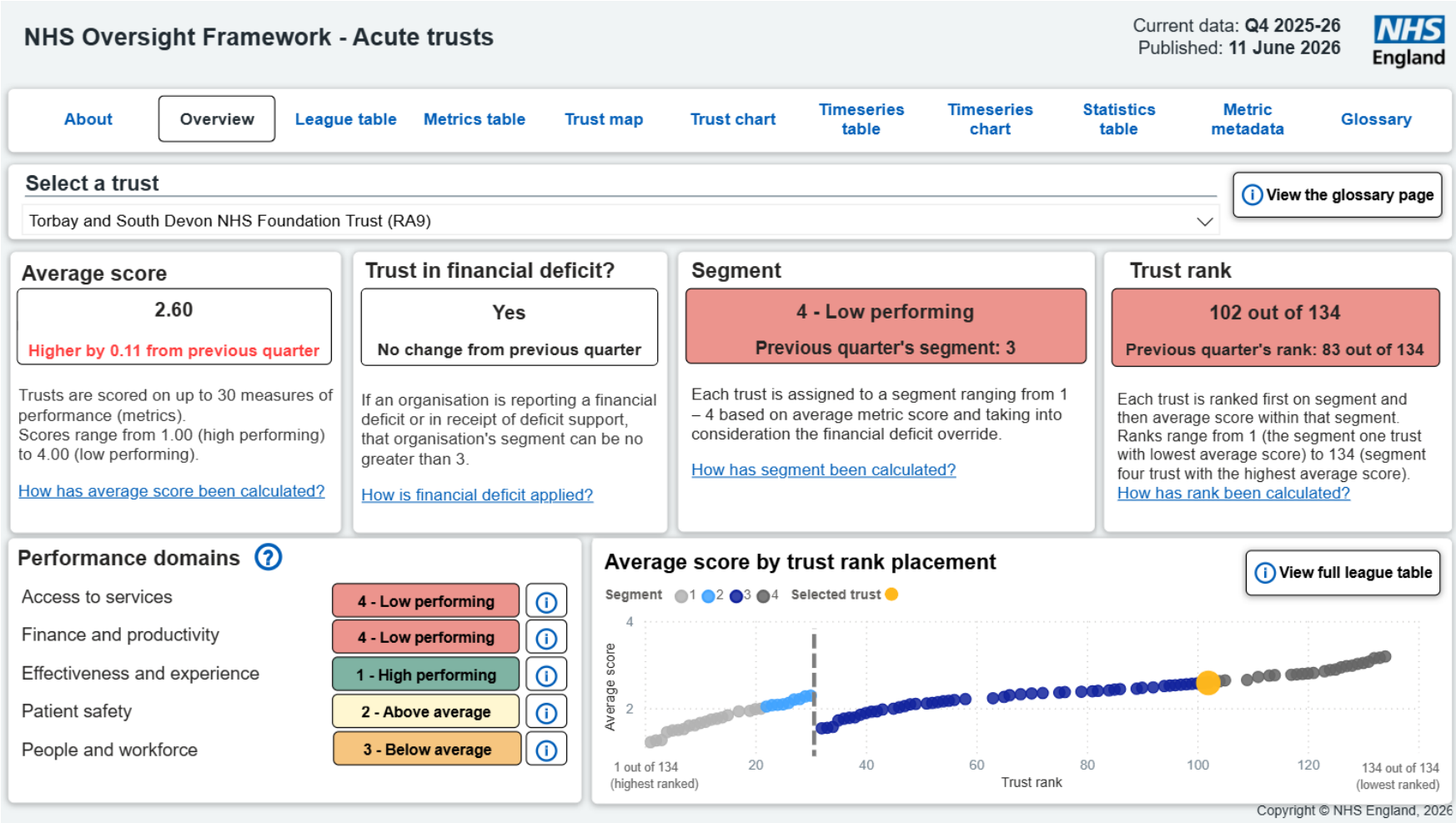
No CIP savings expected to be delivered in 2026/27

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.

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 exception reports have been created reflecting the review and risks discussed through the Governance meetings.



Performance Reporting - Governance

System performance governance and reporting:

New monthly Devon System performance Review Meetings have been set up from July 2026 replacing the weekly performance and Tier meetings. Performance associated Key Lines Of Enquiry across Elective and Urgent and Emergency care, Cancer standards and Diagnostics will be reviewed.

Internal performance oversight:

The Trust continues to oversee its performance through weekly performance oversight structures and monthly through the Care Group Governance meetings and Quality and Performance Assurance Frameworks.

Urgent and Emergency Care Executive Summary

- July performance remains materially behind plan: record ICO demand and constrained flow offset limited improvement in ambulance delays. Four-hour performance was 63.9% against a 75.0% trajectory; August month-to-date is 63.2%.
- Ambulance handovers over 45 minutes reduced from 783 to 729 (–6.9%) and the latest weekly ranking improved from 118th to 114th of 123 trusts.
- ED attendances were 7,357, 1.4% lower than July 2025, although total ICO attendances reached a 13-month high of 11,507 as MIU/UTC demand rose 5.9%.
- Core access performance deteriorated: ED type 1 performance fell to 49.3% and ICO performance to 63.9%.
- Patient flow remains the binding constraint: average ambulance handover was 46m 48s; pre-noon discharges were 13.3% against the 33% target; ED corridor-care waits rose from 940 to 1,092 in July.
- Recovery support is mobilised through the ED Stabilisation Plan, Corridor Care Programme, Getting It Right First Time (GIRFT)-led pathway, capacity, and Same Day Emergency Care (SDEC) work.
- Sustained demand remaining above historical levels, with July attendances 2.9% higher than the same period last year.
- Ongoing ambulance handover delays, number of handovers exceeding 45 minutes remaining high.
- Insufficient bed capacity during periods of escalation, impacting patient flow and ambulance turnaround.
- Continued organisational pressure associated with embedment of Epic and delivery of UEC CIP requirements.
- Corridor care and patient boarding resulting from demand-capacity imbalance across the system.

On-going actions

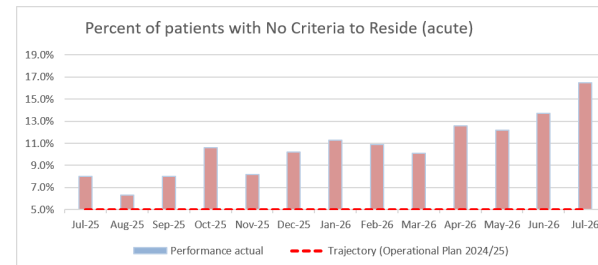
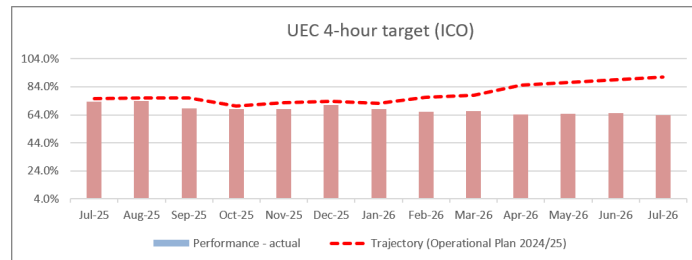
The ED team continue with building upon their Apr-Oct 2026 Stabilisation and Improvement Plan to support the ongoing support of the Timely Handover Process (THP), the new national drive to eradicate Corridor Care and the embedment of Epic.

The National GIRFT teams have attended during the end of July and into August, giving the UEC objectives in how to improve UEC performance and outcomes. This will include a project involving Community Urgent Care (CUC), and Acute Internal Medicine (AIM) changes to bed stock and SDEC pathways, increased capacity and utilisation.

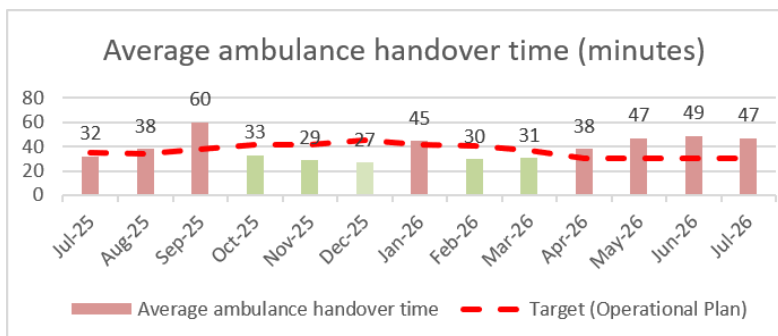
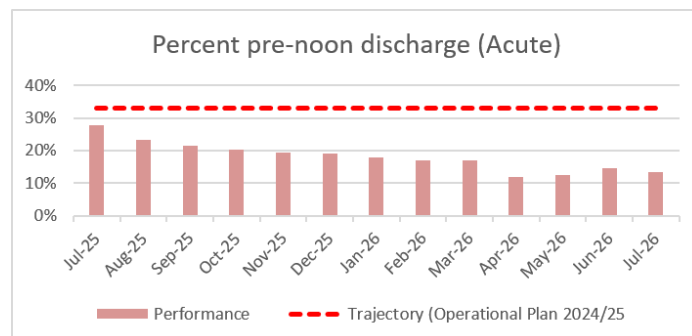
National Oversight Framework– Urgent and Emergency Care Performance Summary

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										Torbay and South Devon 							
Data RAG rated against monthly Operational Plan trajectory Bold number = national data			Target March 2027	13 month trend	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Urgent and Emergency Care																	
Ambulance handovers - time lost over 15 mins - Actual (hours)			725	943	1823	810	624	559	1283	621	755	952	1390	1363	1343		
Ambulance handovers - time lost over 15 mins - Plan												641	676	623	681		
Average handover time (mins) - Actual			32	38	60	33	29	27	45	30	31	38	47	49	47		
Average handover time (mins) - Plan	30 mins		35	34	38	42	42	45	42	41	37	30	30	30	30		
Total average time in ED (hours/minutes) - Actual	Reduction		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		457	426	655	585	549	520	918	740	734	676	839	805	950		
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan												394	655	469	423		
Percentage of patients waiting over 12 hours in ED - Actual			6.5%	6.1%	9.7%	8.5%	8.3%	7.5%	13.6%	12.1%	10.6%	9.8%	11.7%	11.1%	12.9%		
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%		73.5%	74.1%	68.3%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.2%	64.7%	65.3%	63.9%		
UEC 4-hour target (RAG against local trajectory to national target) - Plan	82%		76.0%	76.0%	76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%	75.0%		
% patient discharges pre-noon - Actual			27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	14.6%	13.3%		
% patient discharges pre-noon - Plan	33%		33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%		
Percentage of inpatients with No Criteria to Reside (acute) - Actual			8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	13.7%	16.5%		
Percentage of inpatients with No Criteria to Reside (acute) - Plan	<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 26 July 2026. The Trust did not meet the Operational Plan trajectories for A&E 4-hour performance. Ambulance handover delays over 45 minutes have decreased from last month but remain high at 729; the most recent weekly ranking puts the Trust at 114 out of 123 trusts from rank of 118 last month.



Organisation

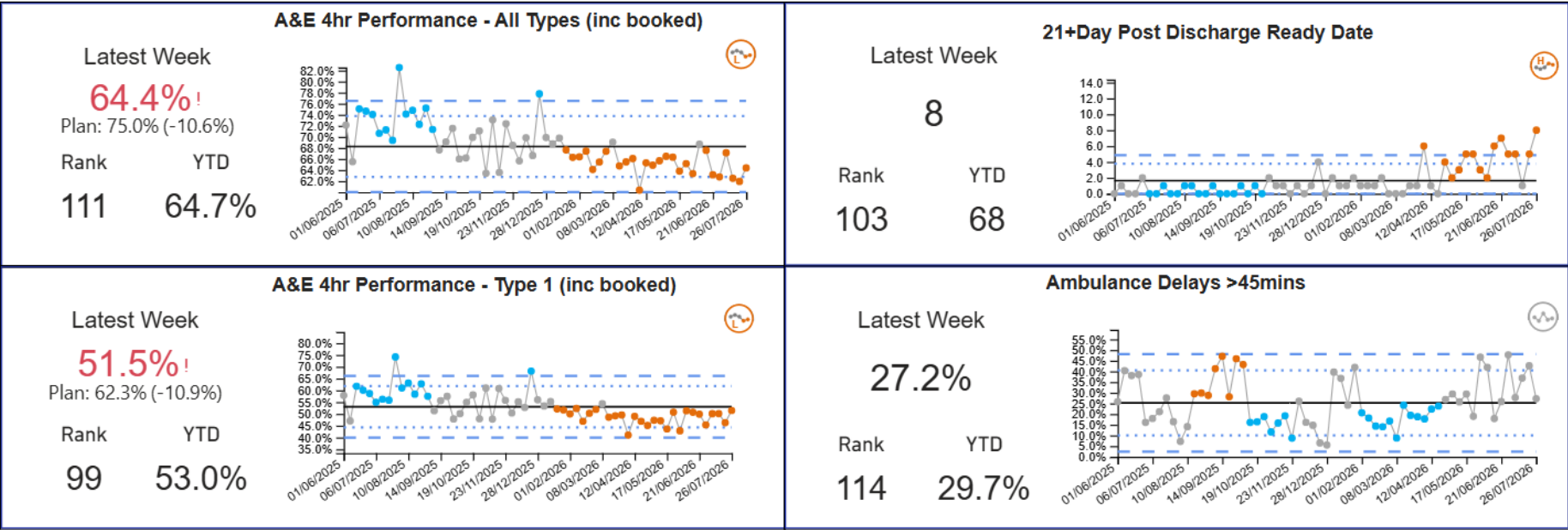
Torbay and South Devon

Metric Focus: UEC

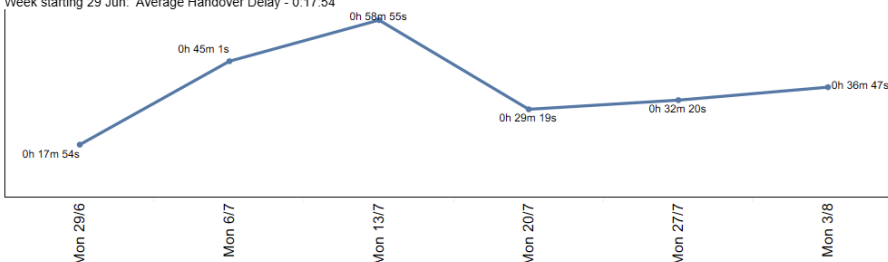
Week Ending:

26 July 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 July was 2,494 (2,357 in June 2026) and is a 2.9% increase on handovers from July 2025. July's average ambulance handover was 46mins 48secs. The number of handovers over 45mins has decreased from 783 in June to 729 in July. Average handover time – rolling 30 day (as 12 August 2026) <table><tr><th>Ambulance Trust</th><th>Site Name</th><th>Handover Time</th></tr><tr><td>South Western</td><td>Derriford Hospital</td><td>1:52:23</td></tr><tr><td>South Western</td><td>Royal Cornwall Hospital (treliske)</td><td>1:26:02</td></tr><tr><td>South Western</td><td>Royal United Hospital</td><td>0:54:15</td></tr><tr><td>South Western</td><td>Torbay Hospital</td><td>0:52:35</td></tr><tr><td>South Western</td><td>The Great Western Hospital</td><td>0:42:51</td></tr><tr><td>South East Coast</td><td>Blt Accident Emergency</td><td>0:40:19</td></tr><tr><td>South Western</td><td>Royal Bournemouth Hospital</td><td>0:38:20</td></tr><tr><td>South Central</td><td>Royal Bournemouth Hospital</td><td>0:34:41</td></tr><tr><td>South East Coast</td><td>Queens Hospital</td><td>0:32:42</td></tr><tr><td>South East Coast</td><td>Great Ormond Street Hospital Cen...</td><td>0:32:24</td></tr><tr><td>South Western</td><td>Salisbury Health Care NHS Trust</td><td>0:31:07</td></tr><tr><td>South Western</td><td>Royal Devon & Exeter Hospital (w...</td><td>0:30:18</td></tr><tr><td>South East Coast</td><td>Croydon University Hospital</td><td>0:28:47</td></tr><tr><td>South Western</td><td>Poole Hospital</td><td>0:28:18</td></tr><tr><td>South Western</td><td>Yeovil District Hospital</td><td>0:26:42</td></tr><tr><td>South East Coast</td><td>St Thomas' Hospital (camhs Ment...</td><td>0:26:31</td></tr><tr><td>South East Coast</td><td>Princess Royal University Hospital</td><td>0:25:41</td></tr></table>	Ambulance Trust	Site Name	Handover Time	South Western	Derriford Hospital	1:52:23	South Western	Royal Cornwall Hospital (treliske)	1:26:02	South Western	Royal United Hospital	0:54:15	South Western	Torbay Hospital	0:52:35	South Western	The Great Western Hospital	0:42:51	South East Coast	Blt Accident Emergency	0:40:19	South Western	Royal Bournemouth Hospital	0:38:20	South Central	Royal Bournemouth Hospital	0:34:41	South East Coast	Queens Hospital	0:32:42	South East Coast	Great Ormond Street Hospital Cen...	0:32:24	South Western	Salisbury Health Care NHS Trust	0:31:07	South Western	Royal Devon & Exeter Hospital (w...	0:30:18	South East Coast	Croydon University Hospital	0:28:47	South Western	Poole Hospital	0:28:18	South Western	Yeovil District Hospital	0:26:42	South East Coast	St Thomas' Hospital (camhs Ment...	0:26:31	South East Coast	Princess Royal University Hospital	0:25:41	July continued to see sustained operational pressure across urgent and emergency care pathways, with ICO attendances reaching a record high of 11,507. Demand was compounded by ongoing patient flow constraints and bed capacity challenges across the system. Length of stay in the Emergency Department has again increased throughout July with 192 patients with a stay greater than 24 hours and 15 patients greater than 48 hours. 11% increase in 45-minute handover delays from this time last year. Average ambulance handover time Wednesday 1 July 2026 - Sunday 9 August 2026 - Weekly data Week starting 29 Jun: Average Handover Delay - 0:17:54  <table><tr><th>Date</th><th>Average Handover Time</th></tr><tr><td>Mon 29/6</td><td>0h 17m 54s</td></tr><tr><td>Mon 6/7</td><td>0h 45m 1s</td></tr><tr><td>Mon 13/7</td><td>0h 58m 55s</td></tr><tr><td>Mon 20/7</td><td>0h 29m 19s</td></tr><tr><td>Mon 27/7</td><td>0h 32m 20s</td></tr><tr><td>Mon 3/8</td><td>0h 36m 47s</td></tr></table>	Date	Average Handover Time	Mon 29/6	0h 17m 54s	Mon 6/7	0h 45m 1s	Mon 13/7	0h 58m 55s	Mon 20/7	0h 29m 19s	Mon 27/7	0h 32m 20s	Mon 3/8	0h 36m 47s
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Actions to complete next month	Risks/issues																																																																				
• 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 National GIRFT teams have attended during the end of July and into August, giving the UEC objectives in how to improve UEC performance and outcomes. This will include a project involving CUC, and AIM changes to bed stock and SDEC pathways, increased capacity and utilisation.	• Sustained demand remaining above historical levels, with July attendances 2.9% higher than the same period last year. • Ongoing ambulance handover delays, number of handovers exceeding 45 minutes remaining high. • Insufficient bed capacity during periods of escalation, impacting patient flow and ambulance turnaround. • Continued organisational pressure associated with embedment of Epic and delivery of UEC CIP requirements. • Corridor care and patient boarding resulting from demand-capacity imbalance across the system.																																																																				

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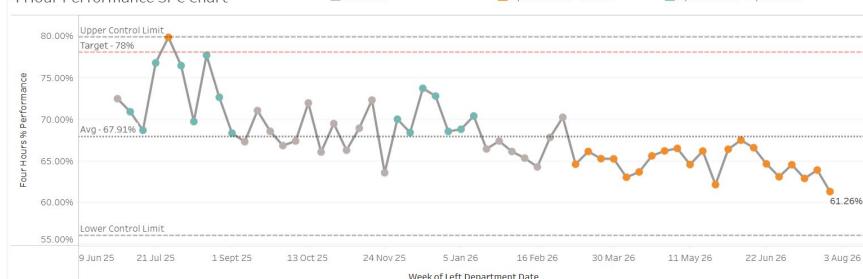
Exception report: 4-hour ED target: - Urgent and Emergency Care**Performance**

	July 25	July 2026	% difference
MIU/UTC attendances	3918	4150	+5.9%
MIU/UTC performance	98.8%	89.7%	- 9.1%
ED (type 1) attendances	7463	7357	-1.4%
ED (type 1) performance	60.3%	49.3%	-11.0%
ICO attendances	11381	11507	+1.1%
ICO performance	73.5%	63.9%	- 9.6%

ED/UTC/MIU ATTENDANCE ANALYSIS | 4HR TARGET



4 Hour Performance SPC Chart

**Operational update**

4-hour performance for the month stands at 63.9% against a trajectory of 75.0%, meaning a deterioration in performance and 11.1% below trajectory. The ICO had 11,507 attendances in July the highest recorded attendance in the last 13 months. The Emergency Department recorded 7,357 attendances.

August's month-to-date is showing a performance of 63.2%. Focus has remained on delivery of the ED Stabilisation and Improvement Plan, progression of the Trust-wide Corridor Care Programme and continued optimisation of Epic workflows, with multidisciplinary teams working to reduce boarding, improve flow and support safer care environments during periods of sustained pressure.

The National GIRFT teams have attended during the end of July and into August, giving the UEC objectives in how to improve UEC performance and outcomes. This will include a project involving Community Urgent Care, and Acute Internal Medicine changes to bed stock and SDEC pathways, increased capacity and utilisation.

Actions to complete next month

- Continue delivery of the ED Stabilisation and Improvement Plan, with particular focus on improving patient flow, reducing ambulance handover delays and minimising patient boarding.
- Progress actions arising from the Trust-wide Corridor Care Programme and launch event, supported by the Improvement & Innovation team, to improve patient experience and safety during periods of escalation.
- The National GIRFT teams have attended during the end of July and into August, giving the UEC objectives in how to improve UEC performance and outcomes. This involves Community Urgent Care, and AIM changes to bed stock and SDEC pathways, increased capacity and utilisation to be led by ADNPP with clinical and operational support.

Risks/issues

- Continued increase in ambulance handovers exceeding 45 minutes, reflecting ongoing pressure across urgent and emergency care pathways.
- Sustained demand remains above historical levels.
- Insufficient bed capacity during periods of escalation continues to affect patient flow, resulting in patient boarding and reduced flexibility within assessment and same-day emergency care areas.
- Delivery of the 7.5% UEC CIP requirement alongside prolonged operational escalation.
- Ongoing operational impact associated with embedding Epic and adapting to revised workflows.

Exception report: Percent of pre-noon discharges: Urgent and Emergency Care

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	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
% patient discharges pre-noon - Actual			27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	14.6%	13.3%
% patient discharges pre-noon - Plan	33%		33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%

Performance

The percent of pre-noon discharge for July is showing at 13.3% and pre-5PM at 69.6%. This is the third lowest performance in the last 13 months.

Operational update

Improving pre-Noon discharges forms part of our Trust 'Eliminating Corridor Care Programme' Programme Senior Responsible Leads and project leads have been identified and programmes of work and actions throughout August and September established.

The Expected Dates of Discharge (EDD) are consistently being applied. Improvement Programme will focus on using this data to forecast bed demand and capacity; improvement in the accuracy of EDDs will be key to this initiative.

Actions to complete next month

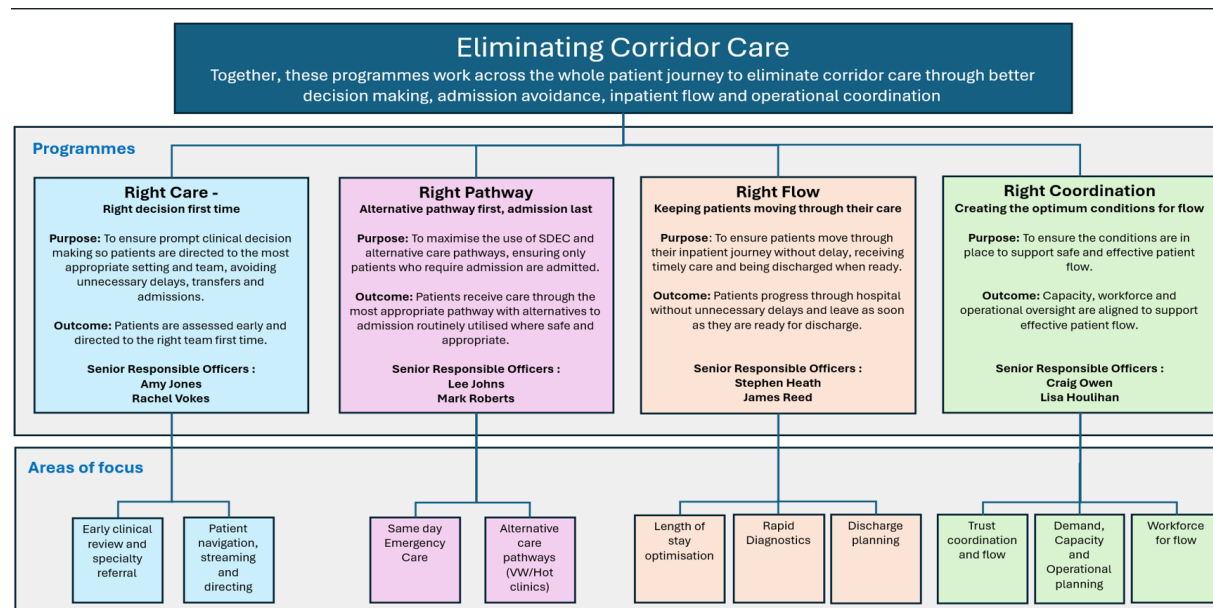
- Understanding of the workstreams that are being scoped up and launched.

Risks/issues

We continue to not meet the 33% pre-noon target for acute wards; this impacts on patient experience, patient flow, 4-hour and 12-hour patient waits.

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.							Outputs from the Corridor Care summit have been reviewed and grouped into five Trust-wide, whole-system themes: Right Care, Right Coordination, Right Pathway and Right Flow. Together, these programmes work across the whole patient journey to eliminate corridor care through better decision-making admission avoidance, inpatient flow and operational coordination. This work will be overseen through the Corridor Care Programme and jointly chaired by the Chief Operating Officer and Chief Nurse.
	Feb 2026	Mar 2026	April 2026	May 2026	June 2026	July 2026	
Corridor Care	1056	1122	933	963	940	1092	
Actions to complete next month							Risks/issues
- Review team project submissions, support needs, and shared-learning opportunities. - Confirm theme leads, establish workgroups, prioritise activity and mobilise implementation.							- Momentum may reduce without clear leads, ownership and workgroup capacity. - Interdependent themes require coordination to avoid duplication, gaps or siloed action. - Delivery depends on colleague engagement and whole-Trust commitment to implementation.



Planned Care Executive Summary

- Planned care remains behind trajectory with one of the seven Month 4 key performance indicators being met. The waiting list is on plan at 34,241 (provisional July data), but Epic-related validation means the reduction cannot yet be treated as sustained recovery.
- 78-and 65-week waits remain a challenge, weekly RTT breach review meetings continue to take place to address long waits.
- RTT first outpatient performance was 62.6% against a 67.4% trajectory. Long waits have worsened: 176 patients exceeded 65 weeks and 1,319 exceeded 52 weeks, concentrated in T&O, Ophthalmology and ENT.
- Cancer remains off track despite improvement: the 62-day forecast is only 58%, and the Datix risk score increased from 12 to 16. Dermatology, Gynaecology and breast pathways face capacity, workforce and pathway-control constraints.
- Epic stabilisation, incomplete restoration of clinic capacity, estate failures, sickness and recruitment delays threaten activity recovery and create uncertainty over waiting-list data.

On-going actions

- Stabilisation of EPIC – activity stabilisation and validation being the primary focus.
- 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

National Oversight Framework 4 Exit Criteria – Elective Recovery Performance Summary

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS

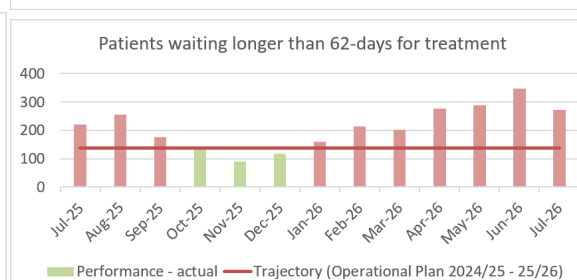
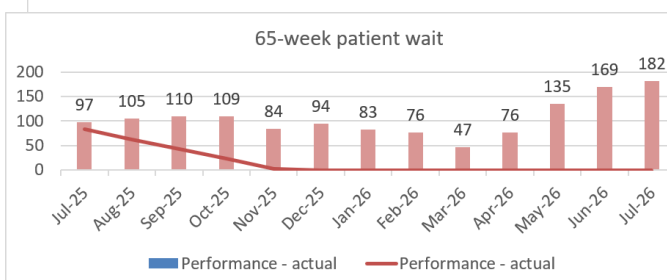
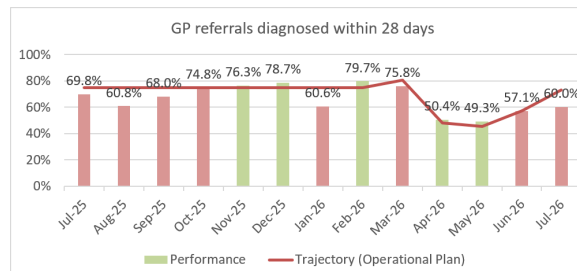
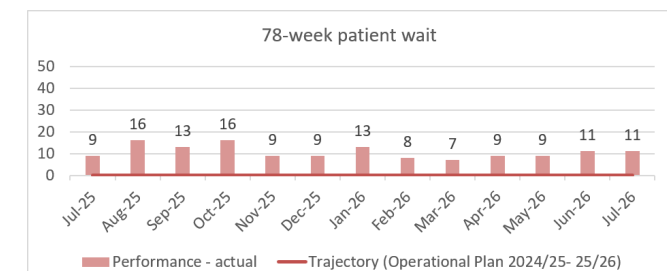
Torbay and South Devon
NHS Foundation Trust

Data RAG rated against monthly Operational Plan trajectory Bold number = national data	Target March 2027	13 month trend	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Elective Care															
RTT 78 week wait incomplete pathway - Actual	0		9	16	13	16	9	9	13	8	7	9	9	11	11
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			97	105	110	109	84	94	83	76	47	76	135	169	182
RTT 65 week wait incomplete pathway - Plan	0		83	63	43	23	3	0	0	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual			615	618	615	647	607	663	604	607	600	799	993	1088	1317
RTT 52 week wait incomplete pathway - Plan	292		780	728	673	586	505	449	383	327	268	805	941	1088	1009
RTT % Incomplete pathways <18 wks - Actual			69.7%	69.5%	70.4%	69.3%	68.7%	67.5%	67.0%	66.8%	66.4%	66.4%	66.4%	59.6%	56.8%
RTT % Incomplete pathways <18 wks - Plan	73.8%		63.5%	63.8%	64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	63.3%	60.8%	57.0%	59.0%
RTT Wait for first appointment <18 weeks - Actual			74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%	66.5%	62.4%	62.6%
RTT Wait for first appointment <18 weeks - Plan	74.0%		66.7%	67.2%	67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%	66.3%	67.4%
Cancer: 28-day FDS - Actual			70.1%	62.3%	67.3%	75.7%	76.2%	78.3%	60.6%	79.7%	75.7%	48.0%	45.5%	57.1%	60.0%
Cancer: 28-day FDS - Revised forecast	80.9%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	48.0%	45.5%	57.4%	73.0%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual			57.8%	64.5%	63.2%	70.4%	71.1%	79.8%	75.2%	67.1%	60.1%	58.5%	48.9%	50.6%	53.9%
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.7%		75.7%	75.2%	75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	78.1%	81.7%	78.8%	79.2%
Cancer: No of patients waiting >62 days to start treatment - Actual			220	257	176	132	91	119	159	214	201	276	288	347	272
Cancer: No of patients waiting >62 days to start treatment - Plan															
Cancer: % of patients > 62 days to start treatment - Actual			7.8%	9.2%	7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%	8.6%	12.0%	8.9%
Cancer: % of patients > 62 days to start treatment - Plan															
Diagnostics - proportion waiting over 6 weeks - Actual			36.7%	37.1%	36.8%	29.4%	28.4%	30.4%	35.8%	30.6%	37.4%	39.4%	34.6%	24.1%	23.7%
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%	25.6%

RAG indicator

Meeting monthly trajectory

Not meeting monthly trajectory

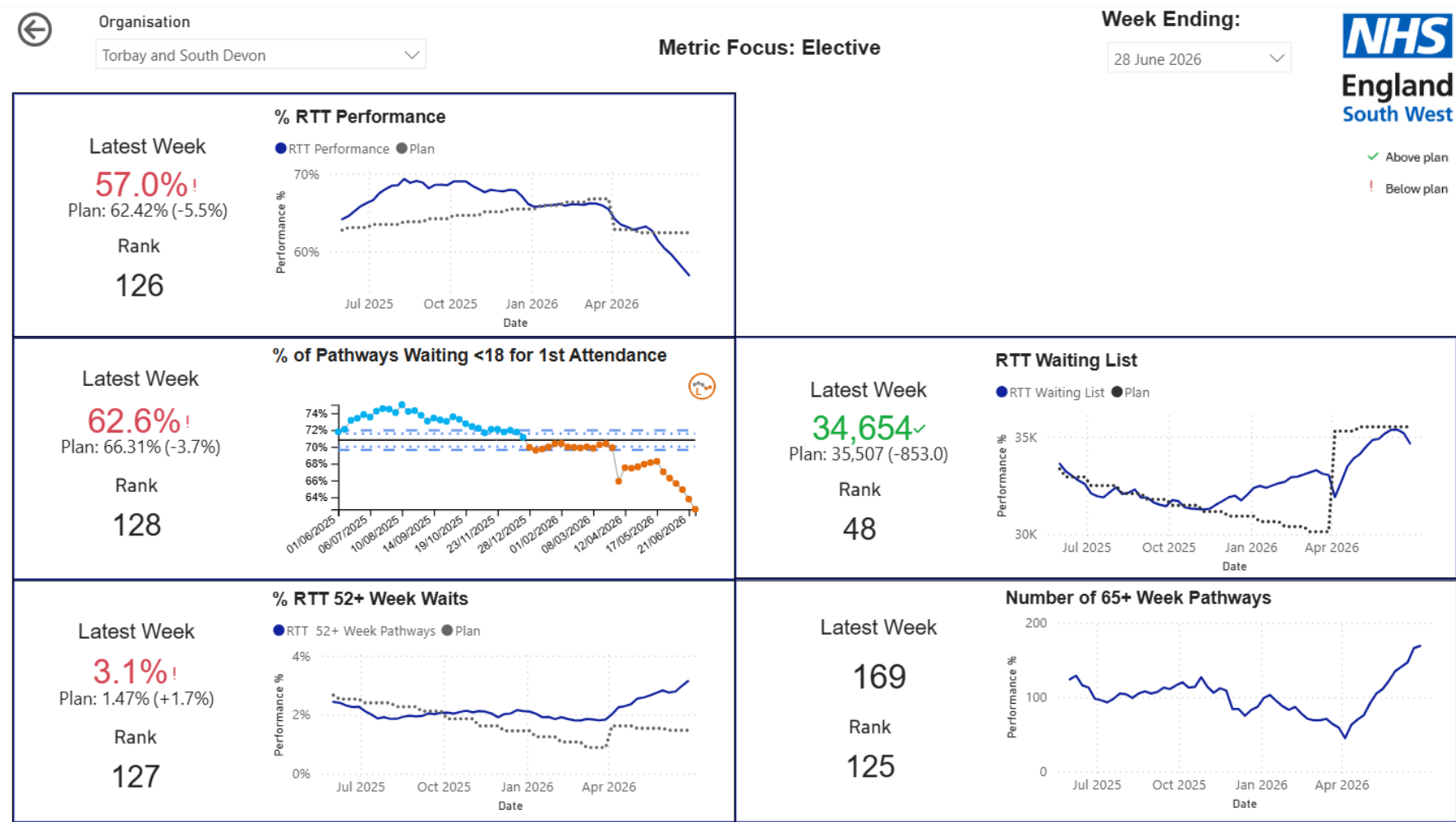


Trajectories have been agreed as part of the 2026/27 Operational Plan submission. The latest month trajectory is shown in the table above. Monthly performance RAG rating for these indicators is based on these trajectories; 1 of the 7 trajectories in Month 4 have been met.

Elective Care Performance Summary - NHS England monitoring report

The report below has been taken from the national NHSE Southwest weekly performance dashboard which monitors performance against key elective care metrics.

The published report shows the latest performance and trust ranking (134 Trusts) against the RTT waiting time metrics. At present on plan for RTT waiting list size, however, challenges continue around 18-week, 52-week, and 65-week position.

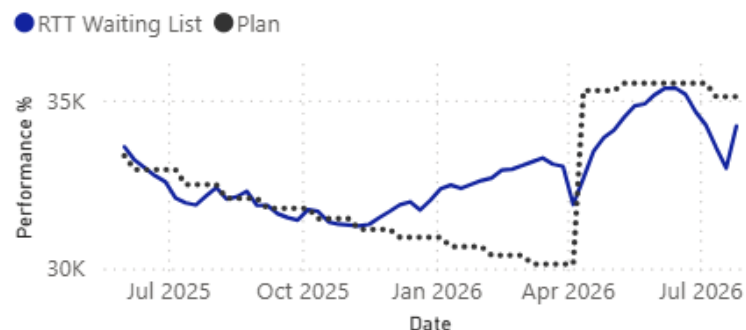


Data source: NHSE SW Weekly Performance Dashboard

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.

	July 2025	July 2026
78 weeks	9	9
65 weeks	95	176
52 weeks	587	1319

RTT Waiting List

[Metric Focus: Elective - NHSE SW Weekly Performance Dashboard - Power BI](#)

Operational update

78 week: At the end of July (provisional figures) there are 8 breaches sitting within T&O and 1 within Ophthalmology

65 week: In July (provisional figures) there were 176 breaches – with the majority sitting within T&O (64), Ophthalmology (53) and ENT (14)

Ongoing weekly cadence of breach review and action planning.

Total waiting list size: The total waiting list has decreased to 34,241 on 31st July (Provisional) following the new Electronic Patient Record go live on 3rd April. This decrease was unexpected and has highlighted potential data quality issues which are being looked into by EPIC. For the first 6 weeks 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 – activity stabilisation and validation being the primary focus
- 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 progress

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.

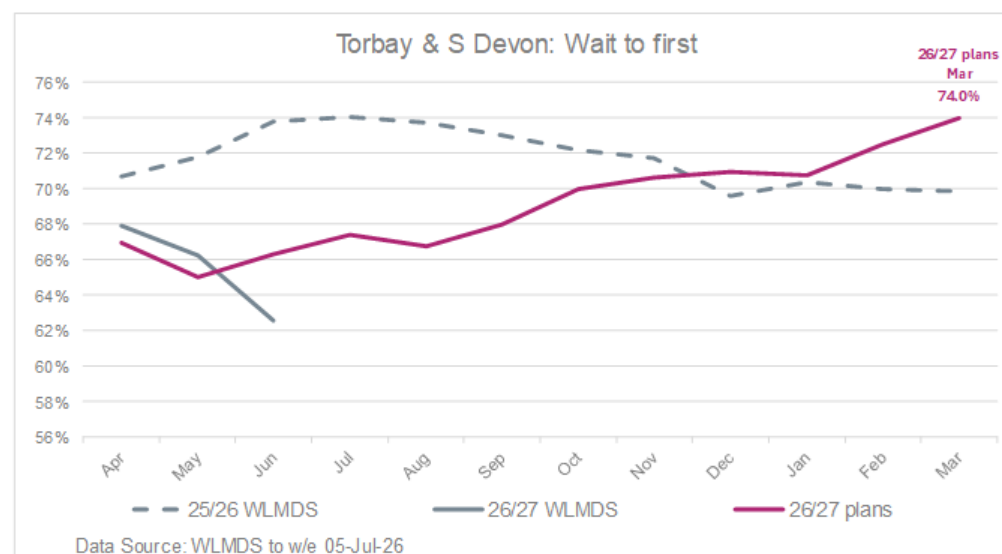
Exception report: RTT First Outpatient – Elective Recovery

The Outpatient Improvement Group 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 62.6% in July against the July trajectory of 67.4% of patients being seen at first outpatient appointment in under 18 weeks from referral.

Some specialties have not restored clinic capacity pre-go-live levels; 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. Activity levels have been improved month on month although are behind the original planning assumptions to restore pre-EPIC levels of activity by end of M3. The loss of activity will be recovered over the remainder of the year.

Improve the percentage of patients waiting no longer than 18 weeks for first activity



**WLMDS
w/e 05-Jul-26
62.5%**

Torbay & S Devon: Wait to first by specialty

Specialty	0-18 weeks	First activity	Wait to first
Rheumatology	275	626	43.9%
ENT	1,261	2,737	46.1%
Oral Surgery	916	1,915	47.8%
Urology	601	1,204	49.9%
Elderly Medicine	110	215	51.2%
Ophthalmology	1,984	3,744	53.0%
Trauma & Orthopaedics	731	1,213	60.3%
Other - Medical Services	922	1,502	61.4%
Neurology	603	976	61.8%
Cardiology	1,009	1,379	73.2%
General Medicine	9	12	75.0%
Dermatology	1,777	2,343	75.8%
Respiratory Medicine	597	722	82.7%
Gynaecology	572	683	83.7%
Other - Surgical Services	1,061	1,252	84.7%
Other - Other Services	220	249	88.4%
Gastroenterology	667	731	91.2%
Plastic Surgery	32	35	91.4%
Other - Paediatric Services	256	258	99.2%
Cardiothoracic Surgery	1	1	100.0%
General Surgery	7	7	100.0%
Other	15	15	100.0%
	-	-	
	-	-	
Total pathways	13,626	21,819	62.5%

Data Source: WLMDS for w/e 05-Jul-26

Exception report: Cancer Waiting Time Standards

Performance				Actions to complete next month
	May 2026	June 2026*	July 2026	- Dermatology: Additional insourcing and locum capacity to support the recovery of waiting times throughout July and into August. - Gynaecology: FDS performance is being constrained by insufficient ultrasound capacity and inconsistent pathway oversight, compounded by administrative vacancies; recovery actions focus on strengthened weekly review and escalation, proactive capacity and workforce management and the transfer of the Booking Team to PAC to reduce diagnostic delays and restore sustainable compliance with the 28-day standard. - Breast pathway performance has been impacted by workforce shortages, increased demand and EPIC implementation challenges. Recovery actions focus on strengthening operational oversight, completing demand and capacity modelling and undertaking pathway redesign with Cancer Alliance support.
28-day Faster Diagnosis Standard	45.5%	57.1%	65% (forecast)	
31-day treatment	92.8%	93%	93% (forecast)	
62-day cancer RTT	48.9%	54%	58% (forecast)	
62-day backlog	288 (8.6%)	347 (12.0%)	300 (8.7%)	
Faster Diagnosis Standard (FDS): FDS performance has improved in July with the current forecast at 65% from 57.1% in June. Additional activity and external insourcing continues, particularly in dermatology. 62-day Cancer Referral to Treatment: July's forecast is 53.9%, 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. - OFF TRACK. CWT risk on Datix raised to 16, from 12, due to increased scrutiny.

Operational Performance Indicators - dashboard of key metrics

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

↔

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	M11		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	M3	↑
Medication incidents resulting in moderate or more severe harm		↓	Fracture Neck Of Femur - Time to Theatre <36 hours (>90%) - one month in arrears	M3	↑
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 12 safety incidents in May associated with corridor care: 9 were no harm and 3 were low harm

Incidents: Discharge/ transfer of care

There has been a slight increase in harms rated as 'death' or 'severe' some of which require validating, but the overall trend of incidents classed as moderate or above is stable. This data will be reviewed next month.

Mortality surveillance

No update since May report: 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

Headline data suggests ongoing inconsistency in performance. Low performance in the provision of swallow assessment is being investigated.

Maternity

In July there was 0 stillbirth and 0 late fetal loss. There was one severe incident related to birth of 29wk baby on labour ward, outside of gestation guidance for level 2 unit, due to abnormal fetal heart rate and maternal pre-eclampsia

MS Services

An individual PSII is being undertaken and broader services are being reviewed, with a Duty of Candour exercise in progress

Mixed sex accommodation breaches

Numbers appear to have increased – linked to escalation of SRU

Areas of stable or improving performance

Infection Control

Rates of MSSA, MRSA, C-Diff and e-coli are largely within expected target thresholds.

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

June data is within the NHSE suggested tolerance of 80-120% and also within the TSDFT tolerance of 90-110% fill rates.

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 completed. There were 39 sub-actions presented to the CQC Assurance Group in April 2025, and the remaining 6 actions were completed following the implementation of EPIC. This finalised plan position will be reported to EROG August 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. Next update due to September 2026 meeting.

Adult Social Care CQC Action Plan

All actions currently on track or not due. Next update due September 2026.

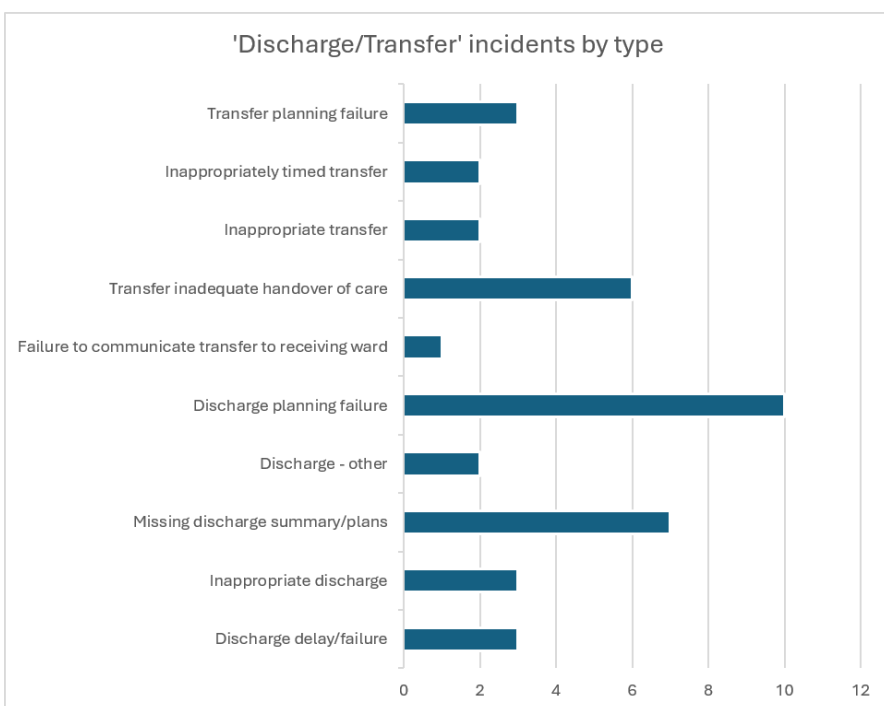
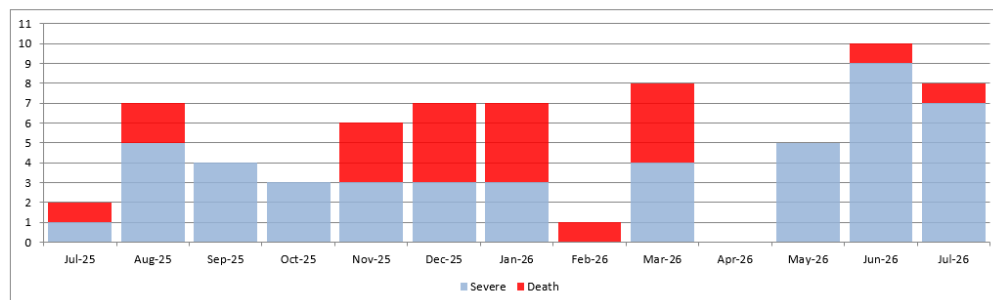
Areas to note and escalate.

- None – no change since last update due to next meeting cycle.

Quality and Safety exception reports – Reported incidents

Reported Incidents - Severe and Death

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Severe	1	5	4	3	3	3	3	0	4	0	5	9	7
Death	1	2	0	0	3	4	4	1	4	0	0	1	1



Areas to note & escalate

- Patient safety incidents associated with Corridor Care are monitored: 9 no-harm and 3 low-harm incidents were reported in July
- 39 Discharge & Transfer incidents were reported during July 2026. None were reported as moderate harm or above. Most were categorised as discharge planning failures [10], followed by missing discharge documentation [7] and inadequate handover of care [6]
- The number of PSIs under review is unchanged at 8 [x5 national priorities & x3 local priorities]

Patient Safety Incidents reported as severe harm or death

There were 7 incidents of severe harm and 1 death related incident in July 2026.

[Death] Management of a deteriorating patient. For SJR/M&M review (may be downgraded)

[Severe] Maternal admission to ITU following 3.7l post-partum haemorrhage (PPH)

[Severe] Birth of 29wk baby on labour ward, outside of gestation guidance for level 2 unit, due to abnormal fetal heart rate and maternal pre-eclampsia (PET)

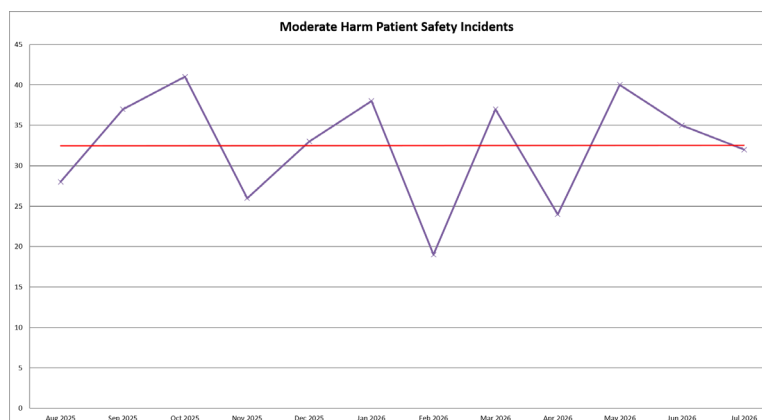
[Severe] Non-fall Osteoporotic fracture to very frail person, at home (may be downgraded)

[Severe x2] Delay to retinal vein occlusion follow-up treatment

[Severe x2] Unwitnessed falls resulting in hip fractures

Moderate Harm: All Patient Safety Incidents

32 incidents were categorised as having moderate harm in July. There were 35 in June and 40 in May. The trend is static. Over the last 12-months the lowest figure was 19, and the highest 41



Quality and Safety exception reports – Hospital Standardised Mortality Ratio HSMR

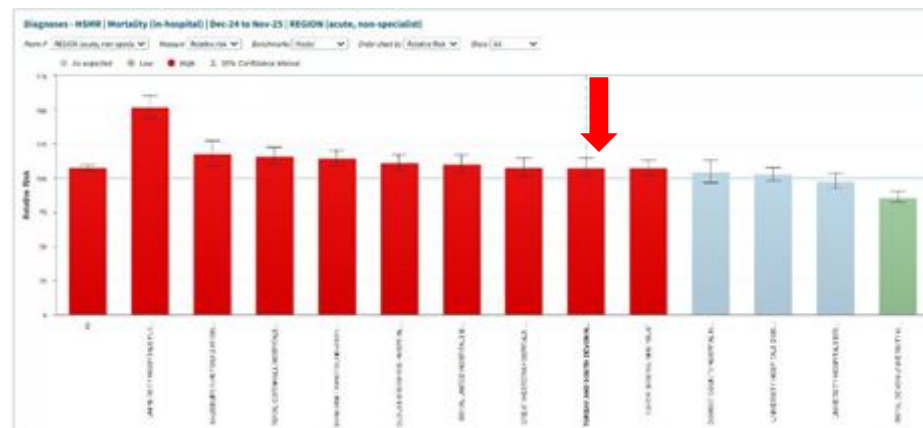
No update since previous report

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 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:

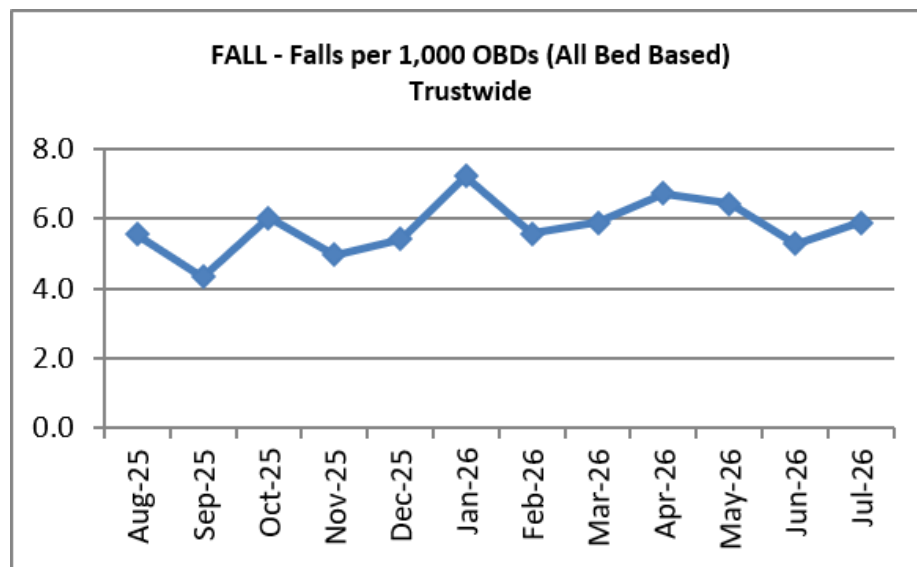
- Congestive heart failure, non-hypertensive – Alert in August 25 (74 observed deaths vs 51.9 expected)
- Diseases of white blood cells – Alert in February 25 (1 observed death vs 0.2 expected)
- Genitourinary symptoms and ill-defined conditions – Alert in January 25 (3 observed deaths vs 1.2 expected)
- 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



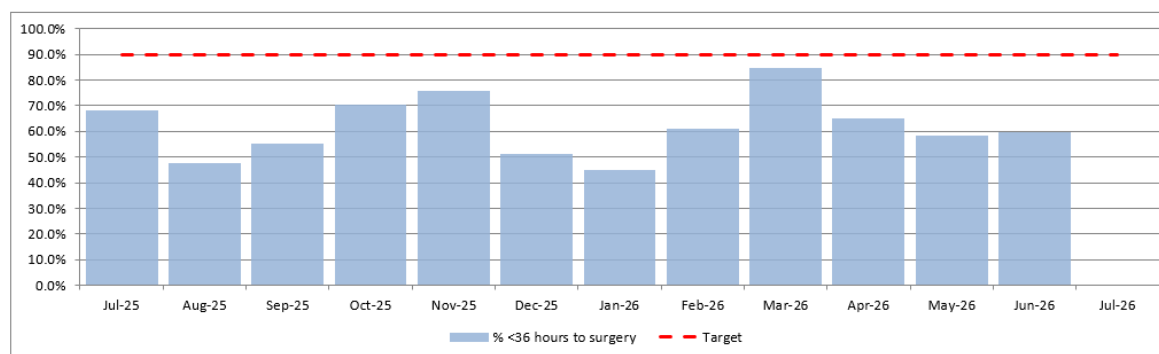
Falls

The Trust has seen an increase in the number of falls sustained within the month of July across all areas; this is particularly in the community services but on review is not related to one specific patient.

Although the number of falls has increased, less have resulted in moderate or above harm in the month.

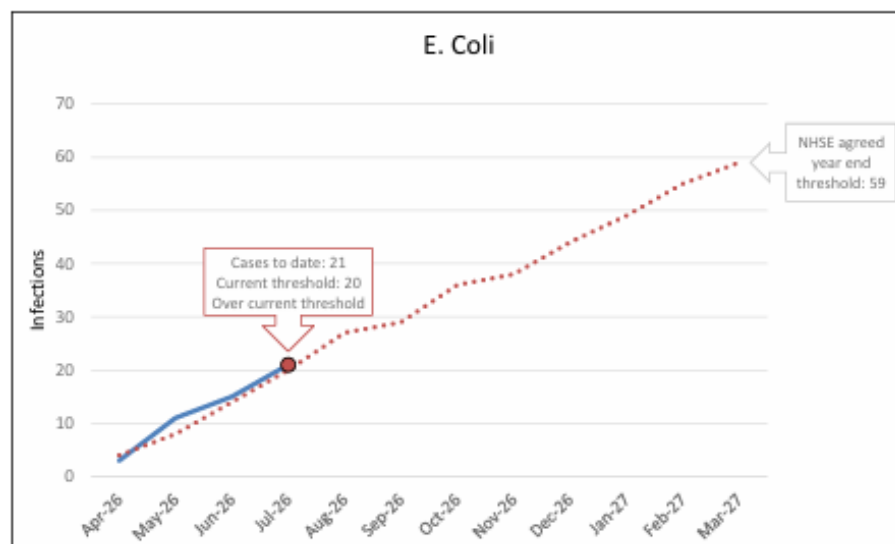
Fractured neck of femur - <36 hours to surgery

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
% <36 hours to surgery	68.1%	47.4%	55.0%	70.3%	75.8%	51.0%	45.0%	60.9%	84.8%	65.0%	58.5%	59.5%	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 4 data not yet available on National Hip Fracture Database).
 July 26 data shows 48 femoral fractures including 9 femoral shaft/periprosthetic fractures admitted. Average time to theatre for the hip fractures was 38 hours. This time to theatre includes 3 long wait patients. These delays were due to requiring specialist kit/surgeon. If we exclude these patient time to theatre is 27 hours.

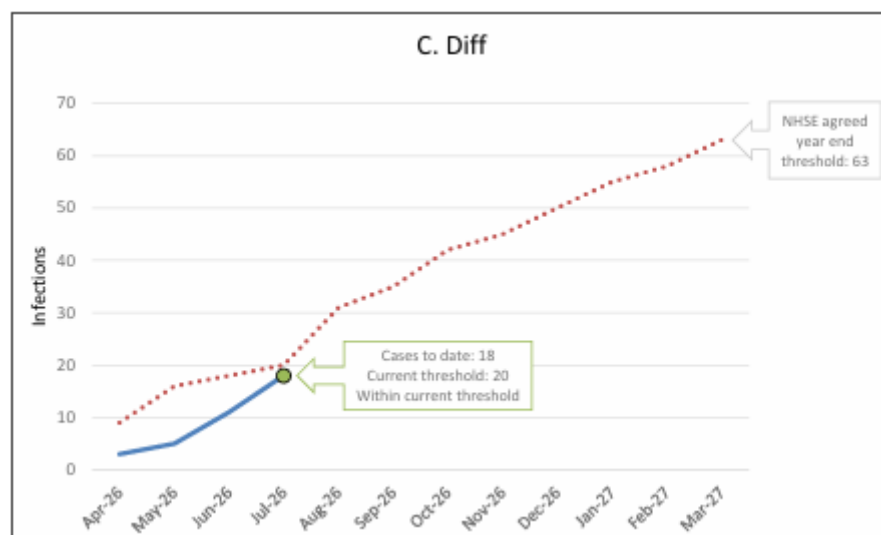
Quality and Safety exception report - Infection control



Escherichia coli (E. coli)

UKHSA historically require a 10% reduction in all blood borne bacteria from the previous year's infections. This has now been confirmed as an end of year threshold of 59 E.coli Bloodborne Bacteraemia's (BBI's). To date there have been 21 E.coli infections detected which is one above the predicted threshold of 20 for July 26.

UKHSA Fingertip rolling data has identified TSDFT as an outlier regarding E.coli bacteraemia's. This is in part due to the demographic of the trust with a high percentage of the infections being Community Onset Community Associated (COCA) which do not reflect in- patient care. The IPC ADNPP has set up monthly meetings to develop and embed an E.coli Improvement plan which will support across in-patient and Community Settings.



Clostridioides difficile (C.diff)

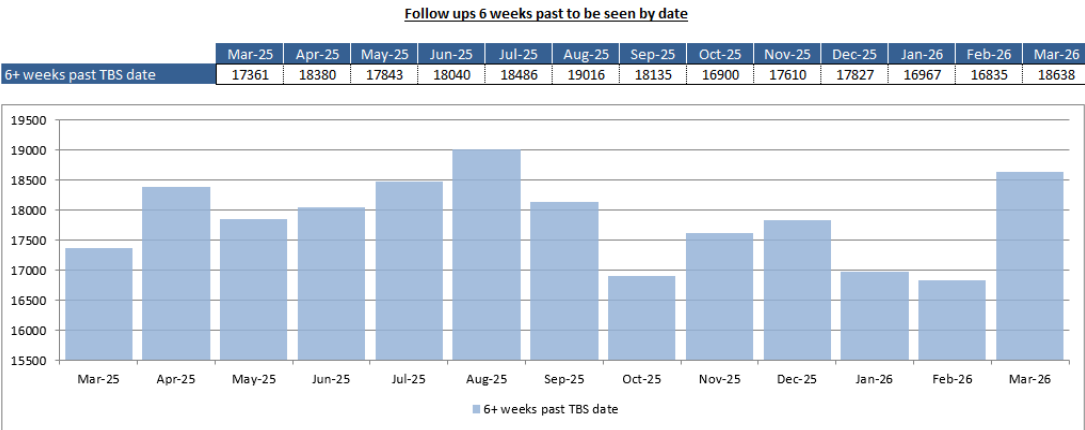
UKHSA historically require a 10% reduction in all blood borne bacteria from the previous year's infections. This has now been confirmed as an end of year threshold of 63 BBI's.

To date there have been 18 C.diff BBI's which is below the agreed threshold of 20 to July 26

UKHSA rolling data identified TSDFT as an outlier regarding C.diff bacteraemia's. This is in part due to the broad-spectrum antibiotic prescribing across the trust which is not being addressed due to the lack of a trust Antimicrobial pharmacist.

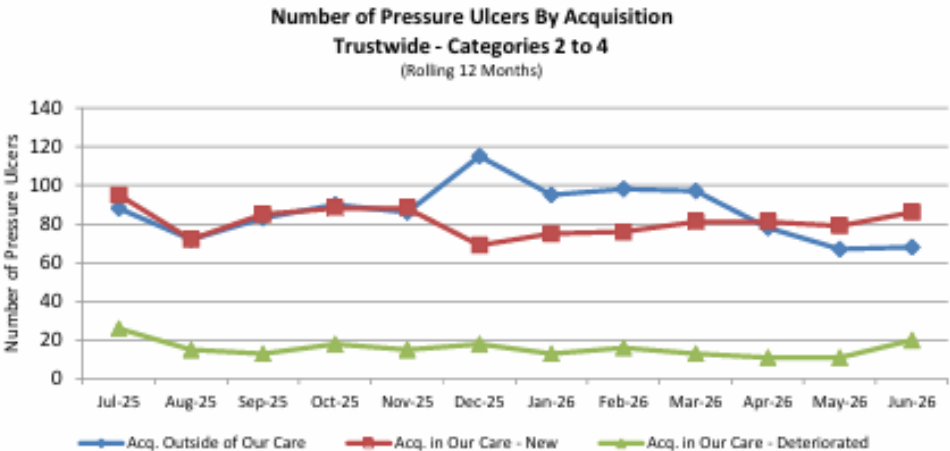
The IPC ADNPP has set up monthly meetings to develop and embed a C.diff Improvement plan which will support across in-patient and Community Settings.

Quality and Safety exception reports – follow-ups past to be seen by date/ pressure ulcer



Follow-ups past 6 weeks to be seen

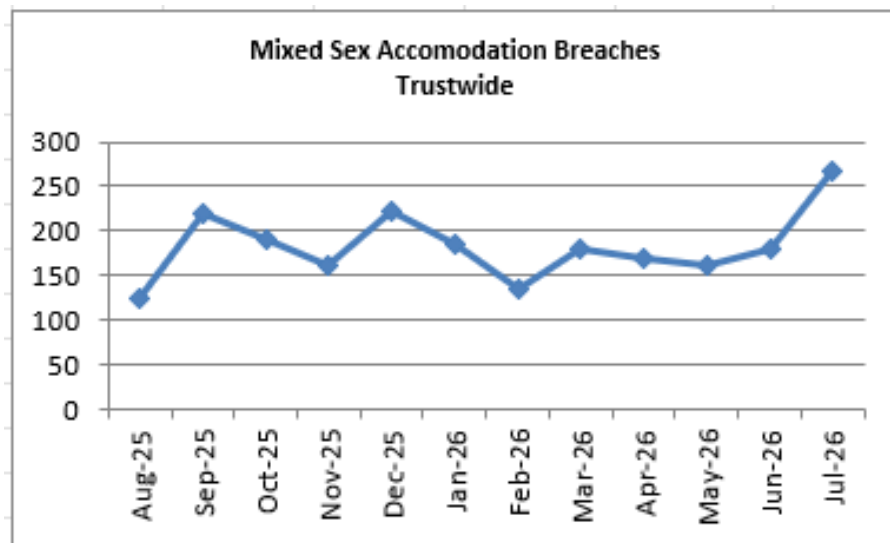
Due to the launch of EPIC no data currently available to report on.



Pressure ulcer

Incidents of pressure ulcers acquired in our care shows a fairly stable picture. The Tissue Viability Service are working trust wide to raise awareness of Pressure Ulcer Prevention. To date patients admitted with pressure damage is slowly decreasing. Patients with cat 2-4 pressure damage acquired in our care presents a stable picture. The slight increase is felt to be related to better reporting with the introduction of an EPR system. The TV Lead is monitoring this ongoing.

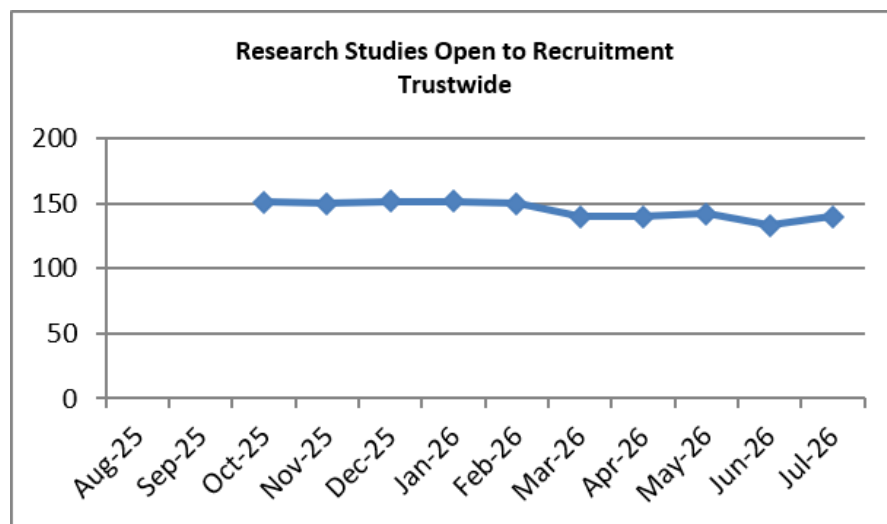
Quality and Safety exception report – Mixed Sex Accommodation



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.

Increasing numbers are likely linked to recent escalation and times when SRU is over capacity



Research studies

The number of research studies open to recruitment remains stable

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: Capture Stroke and DIY tool

Time critical Stroke Standards	Natl. average Jan-Mar 26													
		Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Number of patients (N)		50	58	53	57	44	51	56	40	61	48	49	56	50
% Scanned within 20 minutes updated target	32.70%	24.5%	29.3%	39.6%	27.3%	22.7%	36.5%	37.5%	27.5%	37.70%	31.90%	28.80%	24.60%	34.60%
% Admitted to Stroke Unit within 4 hours	48.90%	28%	46.40%	50%	49.1%	34.1%	52.90%	34%	38%	49.10%	17.80%	20.40%	38.20%	46.00%
Median time to reach the stroke unit (hours:mins)	03:55	06:17	04:18	03:40	03:45	06:55	03:43	05:55	09:09	04:01	08:50	11:16	07:23	04:13
% of patients spending 90% of their time on the Stroke Unit	81.2% (Team)	78.90%	81%	81%	88.9%	65.9%	74.50%	60.70%	71.80%	73.30%	64.30%	50.00%	66.70%	74.00%
% Patients given formal swallow assessment within 24 hours	54.90%	7.5%	5.2%	5.70%	5.50%	40.00%	58.40%	69.60%	71.90%	73.50%	63.60%	21.70%	19.20%	21.70%
% (No.) Patients that received Thrombolysis	13.40%	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)	13.5% (6)	19.7% (11)	1.9% (1)
Median time between clock start and thrombolysis (hours:minutes) New target	00:55mins	01:07	01:17	01:27	00:58	00:57	00:53	01:10	00:48	00:58	00:56	01:00	01:25	03:25

National database now working and DIY tool is available again. A significant amount of work has been completed on data quality and data validation and we are now confident that these are correct; this also highlights our poor performance on certain time-critical standards in Q2 of 2026. **NB: There are still 8 patients to be added to SSNAP for July (they are still inpatients on George Earl); this includes a further 3 that were thrombolysed so data will change.**

- Proportions of patients receiving a swallow assessment within 24 hours continues to be low; this has been reviewed & is not DQ. A review has been requested from SALT colleagues.
- CT scan within 20 minutes has improved and is above national average
- Further improvement in proportion of patients reach stroke unit in 4 hours; slightly below national average.
- Proportion of patients thrombolysed low based on 50 patients; this should rise to circa. 6.8% which is still below national average

Stroke Actions:

- Using Samuel tool (thrombolysis predictor) to review a sample of non-thrombolysed – remains outstanding (Samuel data being updated)
- Progress launch of new hyper-acute pathway SOP; approved via Care Group governance but not supported at present time by Exec. Greater assurance requested re: ward based flow
- Progress project initiation documents for 3 key areas of work; this is ongoing through holiday period.
- **Other work**

Ongoing work to review DIDO (door-in-door-out) pathway for thrombectomy patients – still ongoing but progressing well

Work has started across the region to look at feasibility of an out of hours reperfusion rota; in interim TSDFT likely to join West of England rota

Visit 23rd July from Regional Medical Director & representatives of Southwest Stroke & Cardiovascular Network – report awaited

Risks

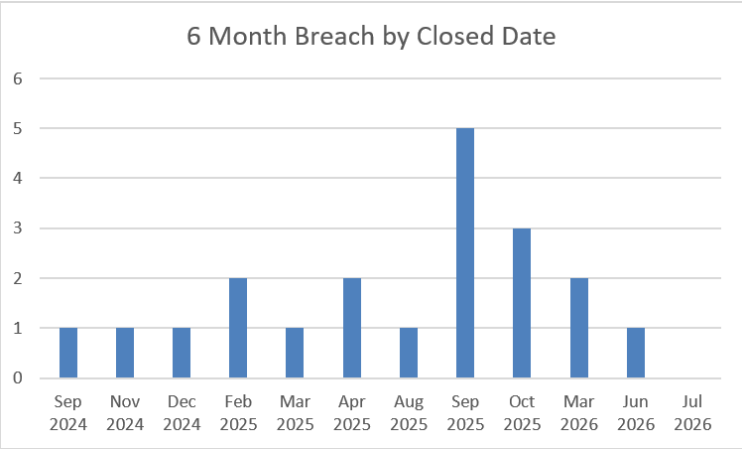
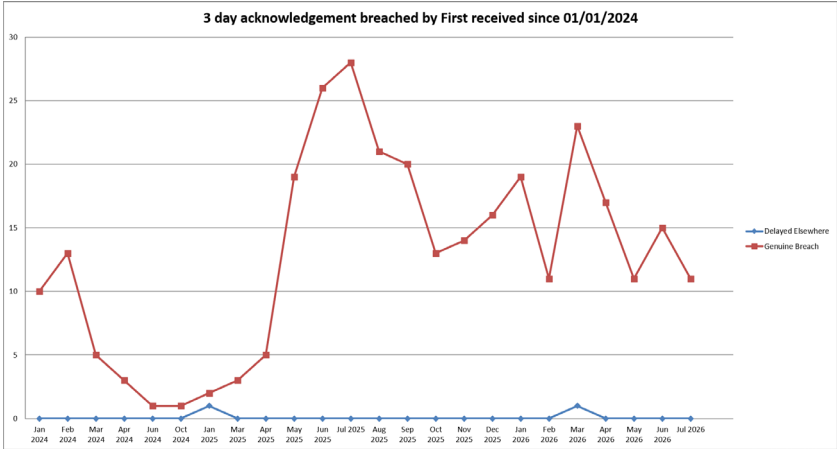
No additional capacity to undertake improvement work

Quality and Safety exception report – Feedback and engagement

Complaint Metrics

The Trust is required to report on two complaint standard metrics; the introduction of Yellow Fin also allows us to track logging details

- Acknowledge complaint within 3 working days
- Formal response within 6 months (internal deadline 12 weeks)
- Time (in days) between first received in inbox time stamp and logged onto DCIQ (team standard)



Average days to raise feedback

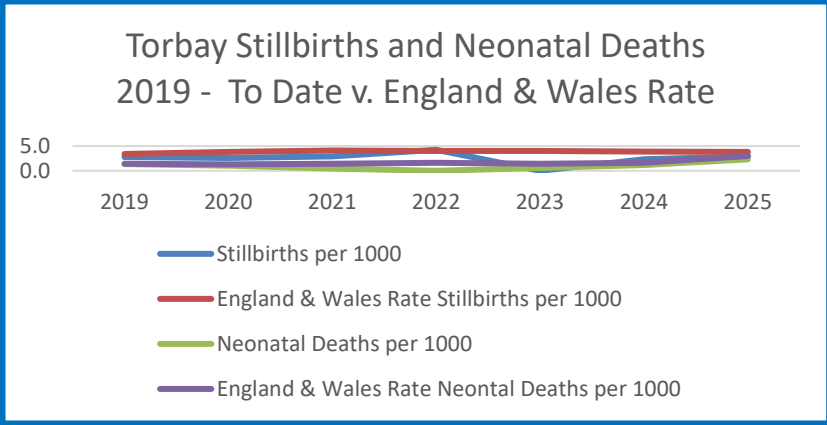
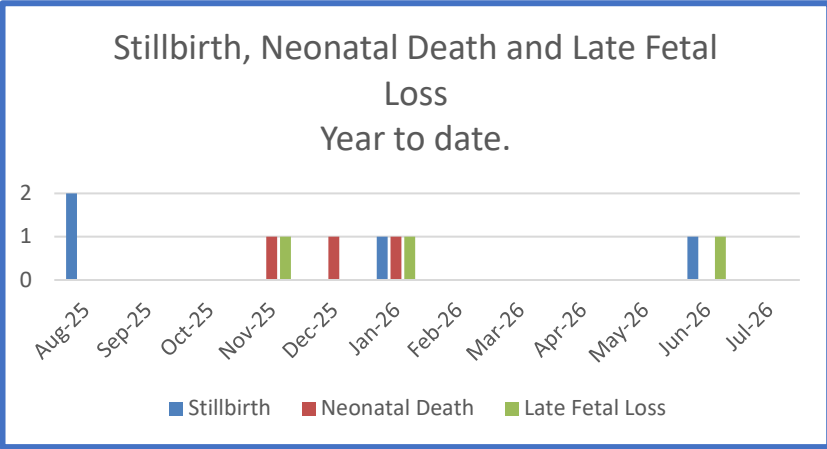


Performance against the 3-day acknowledgement standard remained stable in July, which is consistent with recent months. Average time to raise feedback remained below 8 days, and no 6 month breaches were recorded.

Due to the previous complaint backlog, there will be a number of expected 6 month breaches. This is not recorded until the complaint is closed.

Quality and Safety- Perinatal Clinical Quality Surveillance August 2026 (July 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:

- **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 amnio. Confirmed T21.
- **June 2026** – 1 x Stillbirth at 27/40, woman had HELLP syndrome 1 x Late Fetal Loss at 23+3 weeks gestation.

Incidents moderate and above = 6

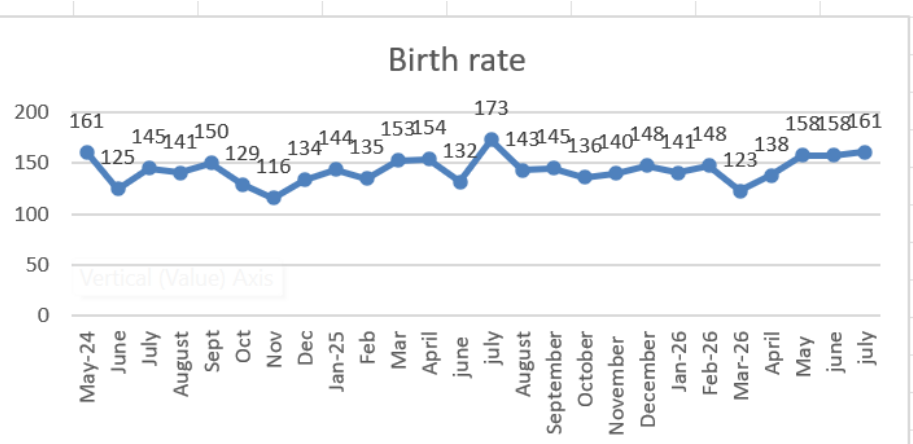
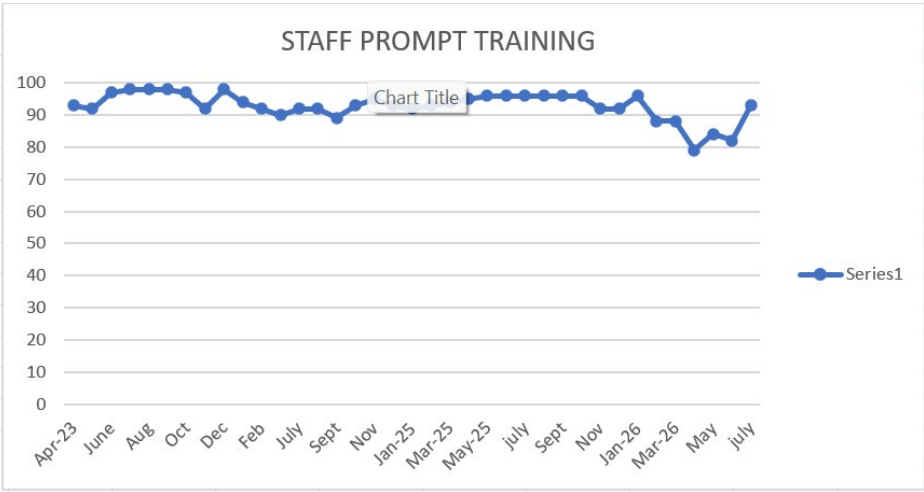
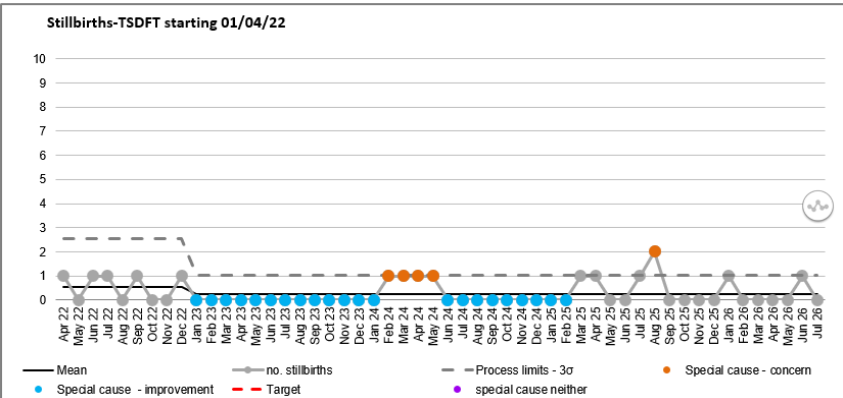
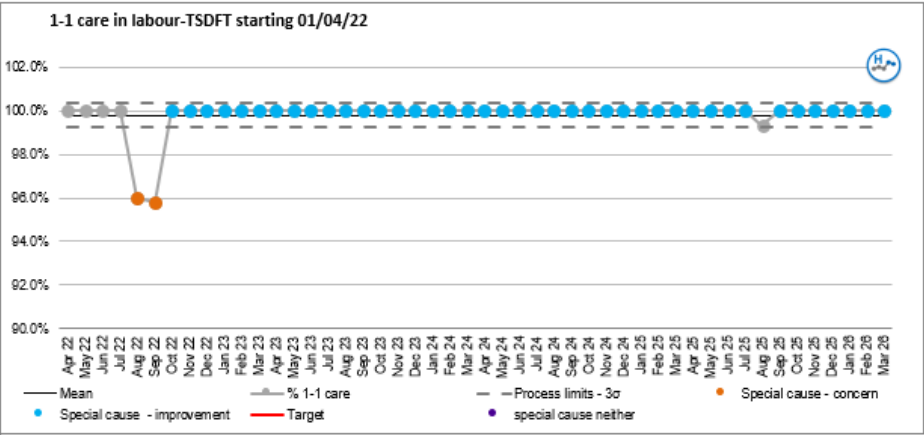
- 40120 - Delivery at 29 weeks due to abnormal antenatal CTG – Delivery below commissioned gestation.
- 40375 - 37+6 admission to SCBU - likely Critical Aortic Stenosis with retrograde flow across the aortic arch.
- 40248 - Baby with nerve palsy following Shoulder Dystocia.
- 40234 - Term admission to SCBU - likely congenital cardiac condition, not detected antenatally.
- 40235 - Admission to SCBU – Transferred to higher level unit for neonatal care due to suspected HIE. Does not meet MNSI criteria as preterm.
- 40201 - Concern regarding care given by independent midwife of a patient in TSDFT area.

MNSI – None

CQC – None

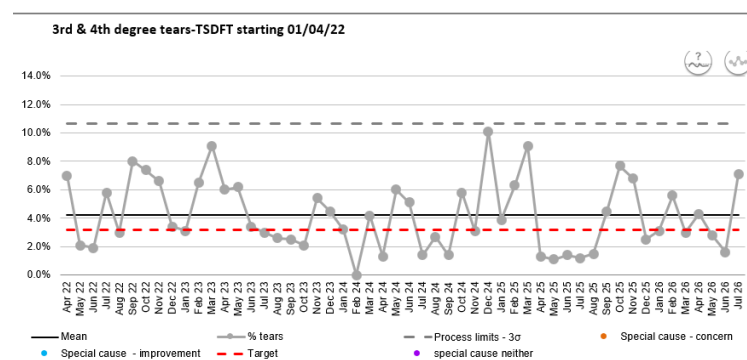
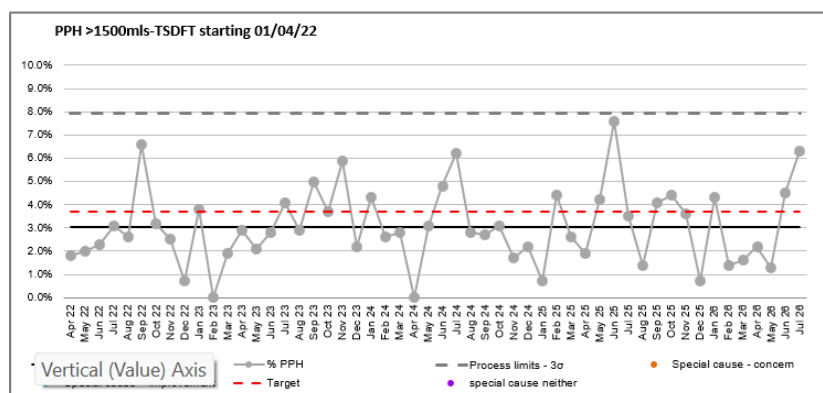
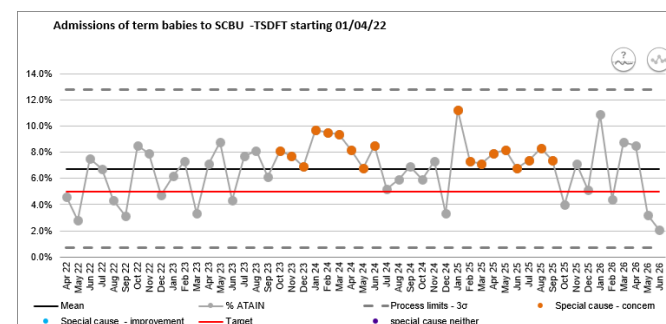
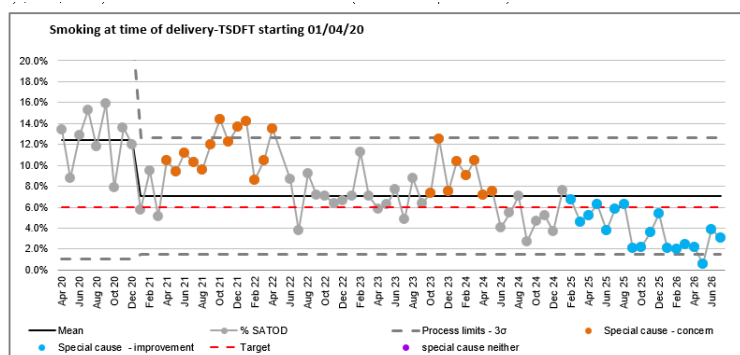
Coroner referral – None

Quality and Safety Metrics relating to the provision of quality maternity care - July 2026



Quality and Safety Metrics relating to the provision of quality maternity care - July 2026

- 161 Births in July 2026 .
- Data this month for smoking at time of delivery is much improved still with some data quality issues due to alterations in reporting due to Epic launch. This is being resolved ready for ongoing reporting. The current reported data for SATOD is 0.6% the truer figure is more likely to be 3.1% after data cleansing completed.
- Increase in the number of 3rd/4th degree from 2.6% in June to 7.1% in July. National target average is 3.2% Detailed explanation and plan submitted within the Trust's quality committee oversight . Ongoing support, education and audit oversight by pelvic health midwife.
- Further increase in the incidence of PPH>1500mls from 4.5% in June to 6.3% in July, above the NMPA target of 3.41% Thematic review being completed to look at these cases and being presented via the Trust Incident review group meeting in September.
- Further reduction in Term baby admissions to SCBU in July. Quarterly rate **3.0%** . National target is 5% or less. Due to the drop in rate , confirmation being sought from team around accuracy of data quality due to interface of Badgernet and Epic.



Quality and Safety – Safer Staffing – Dashboard and CHPPD data- July 2026

Inpatient Wards (All)

Staffing Metrics			
Beds		Establ. Beds	518
		Bed Occ.	93.0%
Staffing Fill Rates	Days	RN / Midwives	90.8%
		Care Staff	95.4%
	Nights	RN / Midwives	93.9%
		Care Staff	110.8%
Actual Staffing Split	Days	% RN / Midwives Hours	54.1%
		% Care Staff Hours	45.9%
	Nights	% RN / Midwives Hours	52.5%
		% Care Staff Hours	47.5%
Care Hours Per Patient Day (CHPPD)	RN / Midwives	Planned	2.5
		Actual	2.2
	Days	Care Staff	Planned 2.0
		Actual	1.9
	Overall Day	Planned	4.5
		Actual	4.2
	RN / Midwives	Planned	1.9
		Actual	1.8
	Nights	Care Staff	Planned 1.5
		Actual	1.6
HR Metrics	Overall Night	Planned	3.4
		Actual	3.4
	Sickness Rate	(May-26)	5.4%
		(Jun-26)	10.3%
Temporary Staffing	Turnover Rate	(Jun-26)	8.9%
		(Jun-26)	6.2%
	Prop. Agency Hours	(Jun-26)	0.1%
Patient Sensitive Indicators			
Safety	Red Flags Raised	ETOC Red Flags	4
		All Red Flags	22
	Mod. Harm Incs and Above		12
			0
	PUs G2+ Acq. in Our Care		44
			49
	Medicine Errors		36
Feedback	% Obs Taken on Time	(Mar-26)	91.5%
			1
	Patient Complaints		-
FFT	% Positive Resp.	(Jul-25)	-
		(Jul-25)	-

Emergency Care (ED Only)

Staffing Metrics				
Number of Attendances				7,357
Staffing Fill Rates	Days	RN / Midwives		89.4%
		Care Staff		77.2%
	Nights	RN / Midwives		97.9%
		Care Staff		73.2%
Actual Staffing Split	Days	% RN / Midwives Hours		65.4%
		% Care Staff Hours		34.6%
	Nights	% RN / Midwives Hours		68.6%
		% Care Staff Hours		31.4%
HR Metrics	Sickness Rate		(May-26)	9.2%
	Turnover Rate		(Jun-26)	12.6%
	Vacancy Rate		(Jun-26)	22.1%
Temporary Staffing	Prop. Bank Hours		(Jun-26)	5.3%
	Prop. Bank Hours		(Jun-26)	0.0%
Patient Sensitive Indicators				
Number of Unplanned Reattendances				(Mar-26) 249
Service Delivery Times	% Waiting > 4 Hrs			50.7%
	% Waiting > 12 Hrs			12.9%
	Avg. Triage Time (mins)			21
	Amb. Handovers < 30 mins			47.8%
Safety	All Red Flags			0
	Mod. Harm Incs and Above			3
	Medicine Errors			6
	PUs G2+ Acquired in Our Care			0
	Falls	No Harm		1
		Harm		3
	Sepsis	% Overall Sepsis 6		73.0%
		% Antibiotics within 1 Hour		100.0%
	Feedback	Patient Complaints		
FFT		% Positive Resp.		(Jul-25)
		Number of Resp.		(Jul-25)

Quality and Safety – Safer Staffing – Dashboard July 2026

July 2026 inpatient staffing fill rates remained within national tolerance overall. Registered nurse/midwife fill rates were 90.8% on days and 93.9% on nights, with care staff fill rates at 95.4% on days and 110.8% on nights. This provides overall assurance, although day registered nurse fill remains close to the lower end of the agreed range and continues to be monitored through twice-daily staffing meetings, SafeCare oversight and senior nursing review.

Bed occupancy was 93.0% in July 2026 and remains amber-rated, reflecting sustained pressure across inpatient areas. Operational focus continues maintaining patient flow, timely discharge planning, appropriate use of escalation capacity and deployment of staffing according to acuity, dependency and risk.

Inpatient CHPPD remains broadly aligned to planned staffing. Actual CHPPD was 4.2 during the day and 3.4 at night, compared with planned CHPPD of 4.5 during the day and 3.4 at night. Actual RN/midwife CHPPD was 2.2 days and 1.8 nights, with care staff CHPPD at 1.9 days and 1.6 nights. The main variance remains within daytime RN/midwife hours.

Workforce indicators show sickness at 5.4%, which remains red-rated against the dashboard threshold. Turnover is 10.3% and vacancy is 8.9%, both green-rated. Temporary staffing use remains controlled, with bank hours at 6.2% and agency hours at 0.1%. Continued weekly review through senior nursing and workforce governance remains in place to maintain control of temporary staffing demand and spend.

Patient-sensitive indicators continue to require triangulation with the staffing position. July reporting shows 22 all-red-flag events and 4 EToC red flags, 12 moderate harm incidents and above, 0 grade 2+ pressure ulcers acquired in care, 44 no-harm falls, 49 falls with harm, 36 medicine errors and observations completed on time at 91.5%. There was 1 patient complaint. FFT positive response data is not available within the July dashboard extract.

Within the Emergency Department, workforce pressure remains more significant. Registered nurse fill was 89.4% during the day and 97.9% at night; care staff fill remained below tolerance at 77.2% during the day and 73.2% at night. ED sickness was 9.2%, turnover 12.6% and vacancy 22.1%. Bank use was 5.3% and agency use was 0.0%, indicating continued agency control but ongoing substantive and care staff workforce pressure.

ED demand remained high, with 7,357 attendances and 249 unplanned reattendances. Flow pressures continued, with 50.7% of attendances waiting over 4 hours, 12.9% waiting over 12 hours, average triage time at 21 minutes and 47.8% of ambulance handovers completed within 30 minutes. ED safety indicators recorded 0 red flags, 3 moderate harm incidents and above, 6 medicine errors, 0 grade 2+ pressure ulcers, 1 no-harm fall and 3 falls with harm. Sepsis 6 compliance was 73.0%, with antibiotics within one hour at 100.0%.

Overall, the July safer staffing position demonstrates continued organisational resilience in maintaining safe staffing oversight across inpatient areas. The key areas requiring continued focus are sustained bed occupancy, sickness, daytime RN/midwife fill, ED care staff fill, high ED vacancy and triangulation of safer staffing data with patient-sensitive indicators through established quality, workforce and safer staffing governance routes.

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 waiting list		↑
Community Hospital - Admissions (non-stroke)		
Community Hospital average Length of Stay (days)		
Community Hospital patient discharges pre-noon		
Urgent Community Response 2 hours		↑
Permanent admissions (18-64) to care homes per 100k population (ASCOF) (14)		
Permanent admissions (65+) to care homes per 100k population (ASCOF) (450)		
Proportion of clients receiving direct payments (ASCOF) (25%)		
% reablement episodes not followed by long term SC support (83%)		

Due to the EPR implementation the above metrics 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. June 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 July, 43 people are reported as waiting over 52 weeks for an appointment (from 64 in June) with 15 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 31st July 2026)

(A) Indicates Adult Service provision; (CYP) indicates Children / Young Person service provision

Specialty	<18 weeks	18-52 weeks	52-104 weeks	>104 weeks	Total	NHS England 78% target < 18 weeks
(A): Community nursing services	350	0	0	0	350	100%
(A): Intermediate care and reablement	44	0	0	0	44	100%
(A): Musculoskeletal service	2,739	197	2	0	2,938	93%
(A): Nursing and Therapy support LTCs: Diabetes	66	7	0	0	73	90%
(A): Nursing and Therapy support LTCs: Falls	184	8	0	0	192	96%
(A): Nursing and Therapy support LTCs: Lymphoedema	56	2	0	0	58	97%
(A): Nursing and Therapy support LTCs: Stroke	201	53	17	0	271	74%
(A): Podiatry and podiatric surgery	149	190	0	0	339	44%
(A): Rehabilitation services	427	38	9	0	474	90%
(A): Therapy interventions: Dietetics	289	17	0	0	306	94%
(A): Therapy interventions: Orthotics	6	3	0	0	9	67%
(A): Therapy interventions: Speech and language	188	43	0	0	231	81%
(A): Urgent Community Response/Rapid Response team	1	0	0	0	1	100%
(A): Weight Management and obesity services	49	144	15	0	208	24%
(CYP): Community paediatric service	231	122	0	0	353	65%
Total	4980				5847	85%

When comparing to previous months, these waiting lists figures are still impacted by the transition over to Epic:

- (A): Musculoskeletal service (using the last "pre-EPIC" figures)
- (A): Nursing and Therapy support LTCs: Stroke (using the last "pre-EPIC" figures)
- A few other services have imported referrals where the 1st RTT appt was recorded in the original IT system (but not migrated to EPIC) giving the impression that these patients are still waiting to start their treatment

Adult Social Care – Executive headlines – Month 34

The number of people receiving long term care has stabilised following the reductions seen through Q1, increasing slightly from 2,747 to 2,755 during M04. Despite this increase, overall volume remains below the peak recorded in M01. The decreasing volume through Q1 mirrors the trend between April and June of last year, albeit with a slightly greater net reduction. It should be noted the end of Q1 in 2025 marked the start of a sustained 6 month increase in volume. Should this be repeated at a similar rate across the next 2 quarters, volume would likely be in excess of 2,830 by the end of 2026.

Total weekly expenditure has reduced through M04 from £2.070m to £2.048m per week (a reduction of approx. £21k per week), driven primarily by lower placement costs, particularly within Supported Living. This contrasts with the cost growth seen through Q1 and brings expenditure back close to the level recorded at the start of April.

The average number of weekly contract starts rose slightly in M04 (22) compared to the Q1 average of 20, but remains lower than the other previous 6 quarter averages. There was also a slight reduction in the average number of weekly contract ends in M04 (20) compared to each of the previous 7 quarter averages. Combined, this reflects the slight increase in client volume through M04.

Waiting list performance improved across several teams through M04. The HSCC waiting list reduced by 85 (18%), CCT reduced by 8 (10%), OPMH reduced by 23 (34%) and IHF reduced by 10 (15%). Although the Front End waiting list increased slightly from 151 to 168, it remains significantly below the M02 peak of 250 and number waiting over 60 days remains at its lowest level since December 2025. Occupational Therapy waiting lists continue to show growth across both teams. Both OT teams recorded significant increases during M04, with Torquay rising to 71 and P&B to 101, continuing sustained growth trends that emerged since early 2026.

Inbound referral demand remains mixed. Customer Services referrals remain below the 12-month average, while referrals into Front End, CCT and Mental Health teams all reduced during M04. However, HSCC referrals increased substantially during the month, reaching 3,036 referrals compared with a 12-month average of 2,052. This will require further validation and monitoring.

Review performance has stabilised following a prolonged period of increasing numbers of overdue reviews. This is likely driven by increased review activity, supported by activity by an external resource. The overall number of overdue reviews remained broadly unchanged 1,578, while the proportion of reviews in date improved slightly to 51.2%. Performance for Out of Area placements continued to improve, with only 17 reviews overdue and 81.5% in date, the best position recorded in the reporting period.

Direct Payments remain broadly stable at 367 active contracts, however the ASCOF 3D2A measure increased from 18.3% to 18.5%, matching the 2024-25 outcome and moving closer towards the March 2027 target position.

Adult Social Care – Principle KPIs

KPI	M03 end	M04 end	Direction	12M Ave	M02 Comment
DOMAIN 1: Working With People					
Waiting Lists					
HSCC Outstanding Enquiries	483	398	▼	362	UCL Breach
Front End Waiting List	151	168	▲	162	UCL Breach
Complex Care Waiting List	80	72	▼	77	UCL Breach
AMHSC Waiting List	18	20	▲	21	
OPMH Waiting List	67	44	▼	49	
Torquay OT Waiting List	53	71	▲	44	UCL Breach
P&B OT Waiting List	82	101	▲	69	
FAB Waiting List	135	143	▲	147	
Transitions Waiting List	41	36	▼	39	UCL Breach
IHF Waiting List	66	56	▼	63	
Dols					
Dols applications received	73	62	▼	-	
Dols applications allocated	45	30	▼	-	
Dols applications authorised	5	18	▲	-	
Support Plans					
Proportion of Support Plans sent	54.1%	53.0%	▼	-	M01 switch to rolling 12M
Direct Payments					
Direct Payment Users	368	367	▼	369	Below Target
ASCOF Measure 3D2A (%)	18.3	18.5	▲	18.2	Below Target
ASCOF Measures					
ASCOF Measure 2A	95.1%	94.8%	▼	91.4%	
ASCOF Measure 2B	19.5	22.1	▲	23.5	Above Target
ASCOF Measure 2C	693.1	680.0	▼	720.6	Above Target
Reviews					
Overdue Reviews (All)	1,576	1,578	▲	1,344	UCL Breach
Proportion Not Overdue (All)	50.8%	51.2%	▲	59.1%	Below Target
Overdue Reviews (OOA Placements)	19	17	▼	26	
Proportion Not Overdue (OOA Placements)	79.6%	81.5%	▲	70.6%	
Ethnicity					
% ethnicity recorded	87.1%	87.6%	▲	86.4%	

Adult Social Care – Principle KPIs continued

DOMAIN 2: Providing Support					
Cost & Volume	M03 end	M04 end	Direction	12M Ave	
Person Count (All)	2,747	2,755	▲		
Gross Weekly Cost (All)	£2,069,733	2,048,467	▼		
Person Count (PD)	1,364	1,360	▼		
Gross Weekly Cost (PD)	£846,309	£817,898	▼		
Person Count (M&C)	216	220	▲		
Gross Weekly Cost (M&C)	£218,173	£220,837	▲		
Person Count (LD)	601	609	▲		
Gross Weekly Cost (LD)	£632,118	£638,490	▲		
Person Count (MH)	506	505	▼		
Gross Weekly Cost (MH)	£350,208	£348,584	▼		
Referrals (In-month)					
Customer Service Referrals	2,350	2,221	▼	2,803	
HSCC Referrals	1,696	3,036	▲	2,052	
Front End Referrals	219	200	▼	187	
Complex Care Referrals	25	22	▼	34	
Mental Health Referrals	64	45	▼	55	
Hospital Discharge					
Total Complex Discharge (P1-P3)					Currently unavailable due to EPIC implementation
P1 Discharges					Currently unavailable due to EPIC implementation
P2 Discharges					Currently unavailable due to EPIC implementation
P3 Discharges					Currently unavailable due to EPIC implementation
Rehab / Recov Utilisation					
Jack Sears	77%	64%	▼		
Hill House	39%	87%	▲		
DOMAIN 3: Ensuring Safety In The System					
Safeguarding					
Safeguarding Referrals Open (SPOC)	20	40	▲	31	
Safeguarding Referrals Open (Non SPOC)	98	90	▼	100	
S.42 over 90 days	41	31	▼	-	

Workforce – Executive Summary – Month 4

Month 4 demonstrates continued stabilisation of the workforce position, with total workforce utilisation of 6,382.57 WTE against a planned workforce of 6,454.32 WTE, representing a variance of 71.75 WTE below plan. This is an improvement on the Month 3 position and reflects the continued impact of workforce controls, vacancy management and recruitment scrutiny. However, substantive workforce remains significantly below plan at 5,975.22 WTE, and the Trust continues to rely on Bank and Agency staffing to maintain safe staffing levels and support service delivery. As approved workforce developments progress and recruitment to funded posts is completed, substantive WTE is expected to increase, reducing both the variance to plan and dependency on temporary staffing.

The financial position has deteriorated during Month 4, with workforce expenditure £510k above budget in-month and a year-to-date overspend of £321k. Whilst substantive pay remains £996k below budget year-to-date, this has been more than offset by increased temporary staffing expenditure. Bank expenditure remains the most significant pressure, with a £357k in-month overspend and a £1.097m year-to-date overspend. Agency expenditure has also increased, with a £56k in-month overspend and a £220k year-to-date overspend. Both Bank and Agency utilisation increased compared to Month 3, reflecting ongoing operational pressures and workforce shortages in key services. A review of overtime and other pay cost drivers is underway to better understand the disconnect between reducing substantive WTE and increasing workforce expenditure.

Workforce performance indicators continue to present a mixed picture. Sickness absence increased marginally to 5.33%, remaining above the Trust target, with sickness costs increasing to £13.5m. Long-term sickness absence remains a growing concern, increasing by 19.3% between May and June, with all Care Groups reporting an increase in cases. A detailed sickness absence deep-dive is underway to understand the key drivers of absence and develop targeted improvement actions. Turnover reduced from 17.85% to 16.90%, providing some early indication of workforce stabilisation, although performance remains significantly above target.

Appraisal compliance remains below target. AfC appraisal compliance reduced slightly to 75.30%, whilst Medical appraisal compliance increased marginally to 72.84%, with both measures remaining significantly below the Trust target of >90%. Mandatory training compliance remains above target at 86.79%; however, Information Governance (80.21%), Infection Control (83.22%) and Manual Handling (65.80%) continue to require focused recovery action.

Employee Relations (ER) performance remains challenging. Whilst formal case volumes reduced from 29 to 24 open cases, average case completion times increased further to 173 days, significantly above the 60-day KPI. Number of delayed cases increased from 12 to 20, with manager-related delays accounting for 60% of all delays. Demand for HR advice and support remains high, with EVA continuing to be the primary route for helpdesk enquiries, accounting for 54 of 65 requests (83%). This demonstrates strong adoption of the digital platform and provides evidence that the People Digital Programme is delivering its intended benefits.

Overall, Month 4 reflects a workforce position that remains below establishment and heavily reliant on temporary staffing. Whilst there are encouraging signs of improvement in workforce utilisation and turnover, increasing Bank and Agency expenditure, elevated sickness absence, declining appraisal performance and continued employee relations pressures present ongoing challenges.

Workforce Performance Summary - Month 4

	Last Month (Jun 26)	Current Month (Jul 26)	Target	Change from last month	Performance against target	Local Benchmark comparisons
Sickness	5.30%	5.33%	<4.90%	↑		5.66%
Sickness Cost	£13.4m	£13.4m	£12.5m	→		NA
Turnover (12-month rolling)	17.85%	16.90%	<12%	↓		11.90%
AfC Appraisal	75.63%	75.30%	>90%	↓		70.30%
Medical Staff Appraisal	72.59%	72.84%	>90%	↑		NA
Combined Mandatory Training	86.79%	86.79%	>85%	→		84.60%
Infection Control	84.09%	83.22%	>85%	↓		NA
Information Governance	81.15%	80.21%	>85%	↓		NA
Manual Handling	65.49%	65.80%	>85%	↑		NA
Safeguarding Children	85.84%	85.77%	>85%	→		NA
Safeguarding Adults	95.07%	95.26%	>85%	↑		NA
Agency % of Budgeted Pay Bill	0.74%	1.24%	<1.10%	↑		NA
Bank % of Budgeted Pay Bill	5.26%	5.67%	<4.54%	↑		NA
Total Workforce Plan WTE	6374.37	6382.57	<6454.32	↑		NA
Substantive Workforce Plan WTE	6006.64	5975.22	<6160.70	↓		NA

Please note: WTE Targets are against Month 4 Plan

Workforce Position to Date

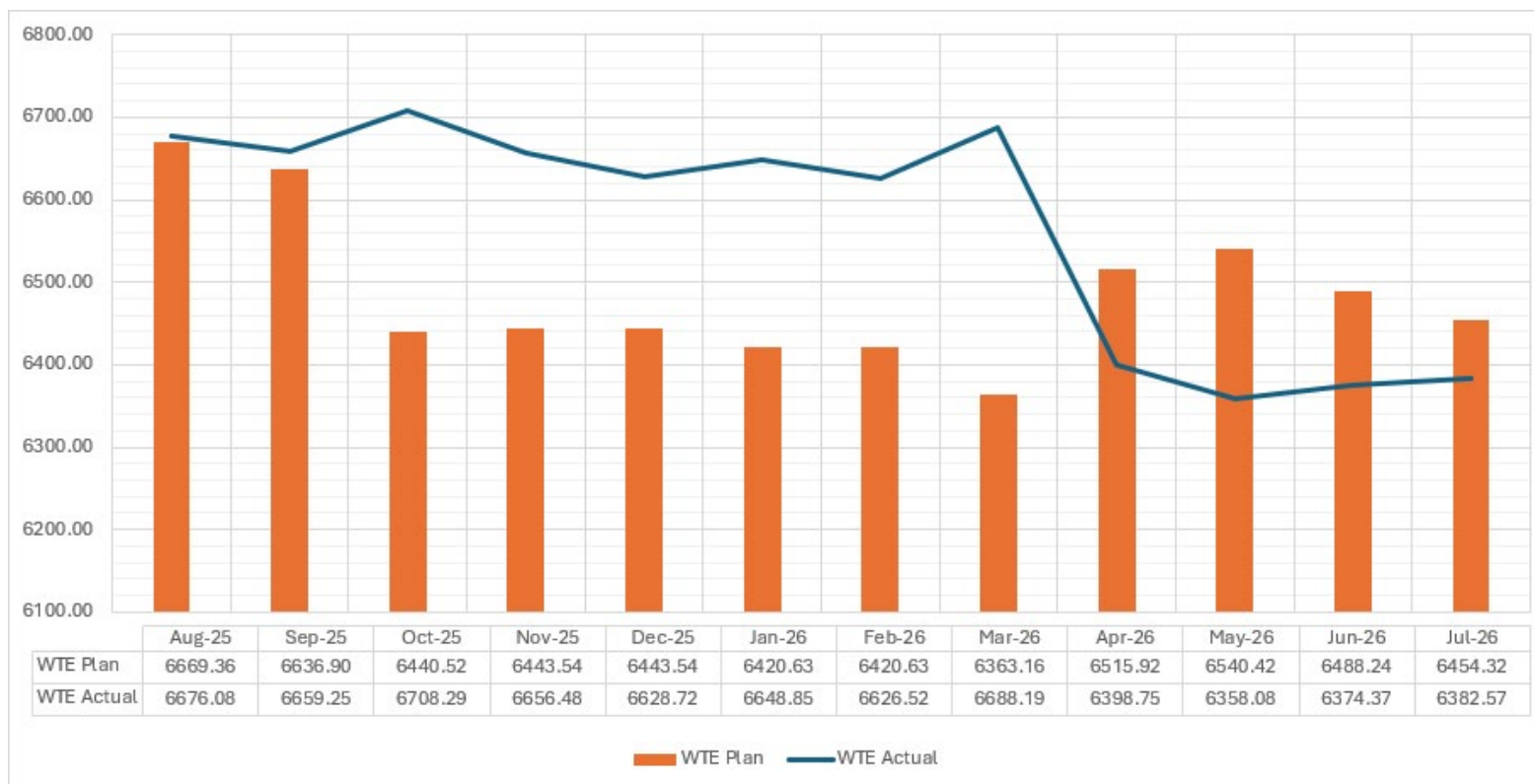
WTE						£					
Month 4	M4 2026/27 Bud WTE	M4 2026/27 Cont. WTE	M4 2026/27 Work. WTE	M4 2026/27 Contracted + Bank + Agency	WTE Variance to Budget	M4 2026/27 Budget £	M4 2026/27 Spend £	£ Difference to Budget	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Agency	35.74	0.00	55.64	55.64	19.90	£343,565	£399,425	£55,860	£1,379,647	£1,599,899	£220,252
Bank	257.88	0.00	351.71	351.71	93.83	£1,461,852	£1,818,974	£357,122	£5,829,756	£6,926,523	£1,096,767
Substantive	6160.70	5975.22	5922.94	5975.22	-185.48	£30,279,907	£30,377,349	£97,442	£120,718,995	£119,723,273	£-995,722
Grand Total	6454.32	5975.22	6330.29	6382.57	-71.75	£32,085,324	£32,595,748	£510,424	£127,928,398	£128,249,694	£321,296

Workforce expenditure remains under close scrutiny at Month 4, with spend £510k above budget for the month and a year-to-date overspend of £321k. The Trust continues to operate below its funded workforce establishment, with contracted workforce at 5,975.22 WTE against a budgeted establishment of 6,454.32 WTE. Total workforce utilisation, including bank and agency staffing, was 6,382.57 WTE, representing 71.75 WTE below budget.

The Trust remains significantly below its funded substantive establishment and continues to rely on temporary staffing to maintain safe service delivery and address workforce shortages in key areas. Whilst overall workforce utilisation remains below budgeted levels, both bank and agency utilisation have increased compared to Month 3, reflecting ongoing operational pressures and the need to maintain staffing levels in priority services. This increased reliance on temporary staffing, alongside service demand pressures, has contributed to workforce expenditure exceeding plan during the month and year to date.

Looking forward, the focus will remain on reducing reliance on temporary staffing through targeted recruitment, retention and workforce redesign initiatives. Organisational change programmes, workforce controls and vacancy management arrangements continue to support delivery of the Trust's financial recovery plans, whilst ensuring workforce capacity remains aligned to service demand, quality standards and patient safety requirements. Continued monitoring through the Workforce Controls Framework and enhanced workforce planning activity will be essential to improving workforce affordability and achieving the required efficiencies during 2026/27.

Total Workforce Plan



In Month 4, actual workforce utilisation increased slightly to 6,382.57 WTE compared to 6,374.37 WTE in Month 3. However, planned workforce levels reduced to 6,454.32 WTE, resulting in a variance of 71.75 WTE below plan, an improvement on the Month 3 variance of 113.87 WTE. This indicates that the Trust continues to operate below its planned workforce establishment, whilst moving closer to the planned workforce position.

The continued reduction in the variance reflects the impact of workforce controls, vacancy management and ongoing scrutiny of recruitment activity. However, it should be recognised that part of the current gap reflects planned workforce growth that has not yet been fully realised. As recruitment to approved posts progresses and workforce developments are implemented, substantive workforce levels are expected to increase, supporting alignment with workforce plans whilst reducing reliance on temporary staffing.

Continued focus on recruitment, retention, productivity and workforce redesign will be required to ensure future workforce growth remains affordable, sustainable and aligned to service demand, quality requirements and the Trust's financial recovery objectives.

Bank WTE & Spend Analysis by staff group

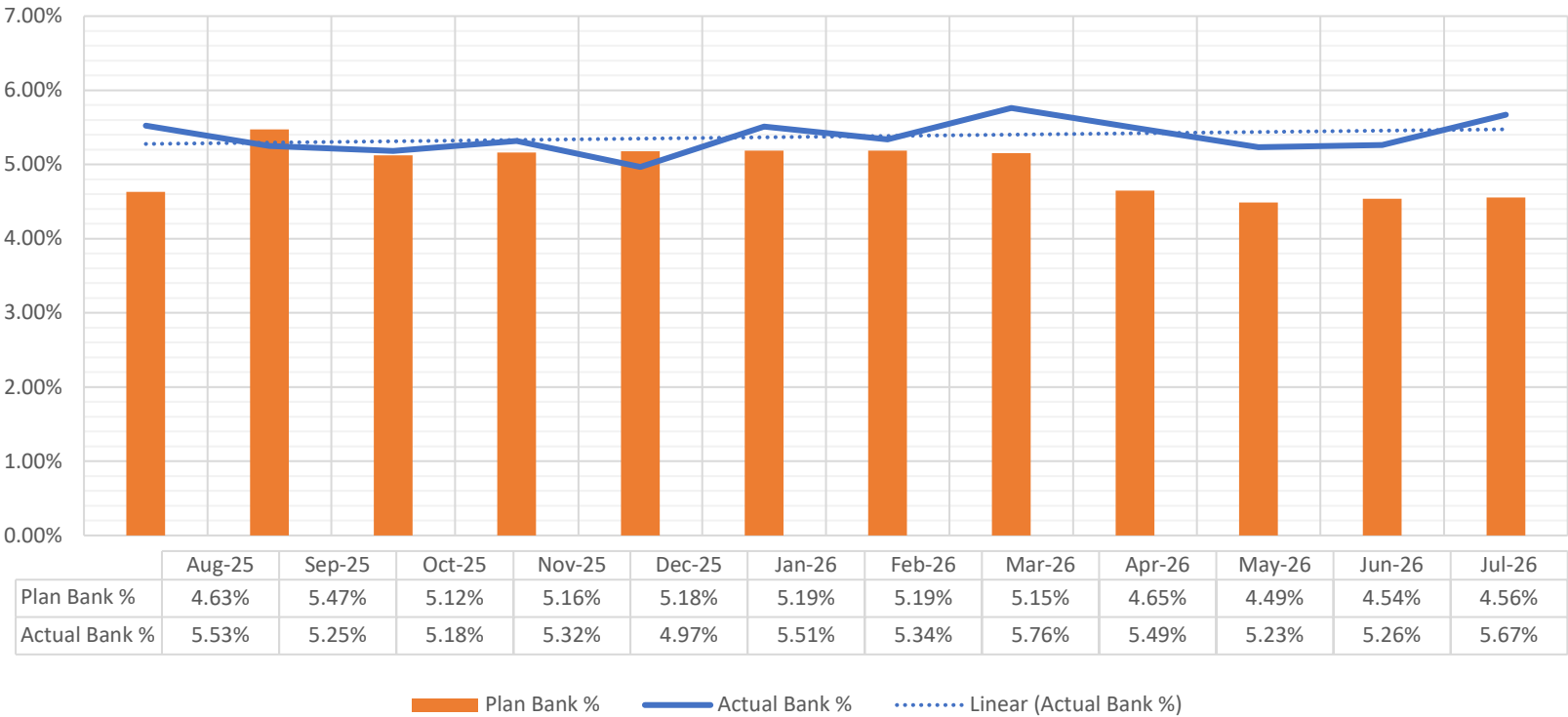
Month 4	M4 Budget WTE	M4 Worked WTE	Variance of worked to budget	M4 Budget £	M4 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Any other Staff (Board Members)	0.00	-0.14	-0.14	£14,966	-£385	-£15,351	£53,868	-£2,254	-£56,122
Medical and Dental	45.70	34.14	-11.56	£513,730	£504,904	-£8,826	£2,004,918	£1,982,668	-£22,250
NHS Infrastructure support	43.04	40.65	-2.39	£136,992	£105,151	-£31,841	£553,964	£510,147	-£43,817
Registered Nursing, Midwifery and Health Visiting Staff	73.73	85.63	11.90	£398,906	£487,361	£88,455	£1,627,973	£1,845,914	£217,941
Registered Scientific, Therapeutic and Technical	2.53	13.56	11.03	£30,099	£69,800	£39,701	£120,397	£207,994	£87,597
Support to clinical staff	92.88	177.87	84.99	£367,159	£652,143	£284,984	£1,468,636	£2,382,053	£913,417
Grand Total	257.88	351.71	93.83	£1,461,852	£1,818,974	£357,122	£5,829,756	£6,926,523	£1,096,767

Bank utilisation increased further in Month 4 to 351.71 WTE, representing 93.83 WTE above the budgeted level of 257.88 WTE. This reflects an increase from Month 3 and demonstrates the continued reliance on bank staffing to support service delivery, maintain safe staffing levels and mitigate workforce shortages across a number of services.

Bank expenditure was £357k above budget in-month, resulting in a cumulative year-to-date overspend of £1.097m. The increase in both utilisation and expenditure compared to Month 3 reflects ongoing operational pressures and the challenges associated with recruiting and retaining substantive staff in key workforce groups.

Whilst bank staffing remains a significant cost pressure, it continues to provide a more flexible and cost-effective solution than agency staffing in many areas. The Trust will continue to focus on substantive recruitment, retention, workforce redesign and vacancy management initiatives to reduce reliance on temporary staffing over time, whilst ensuring safe and effective service delivery. Continued scrutiny of bank usage through the Workforce Controls Framework remains a key priority.

Bank Spend vs Budget



Across the year, Actual Bank % has remained consistently above plan, with utilisation ranging between 4.97% and 5.76%. Following a reduction in April and May, bank usage has increased steadily over recent months, rising from 5.23% in May to 5.26% in June and 5.67% in July, representing the highest level since the March peak of 5.76%.

The increasing trend seen since May indicates a growing reliance on bank staffing to support service delivery and maintain safe staffing levels in the context of ongoing workforce shortages and recruitment challenges. Whilst bank staffing remains the Trust's preferred temporary staffing solution when compared to agency usage, utilisation is continuing to exceed planned levels and remains a significant cost pressure.

Reducing reliance on bank staffing remains a key workforce priority. Continued focus on substantive recruitment, retention, sickness absence reduction, workforce redesign and effective vacancy management will be required to address underlying workforce gaps and support a more sustainable workforce position over the remainder of 2026/27

Agency WTE and Spend Analysis by staff group

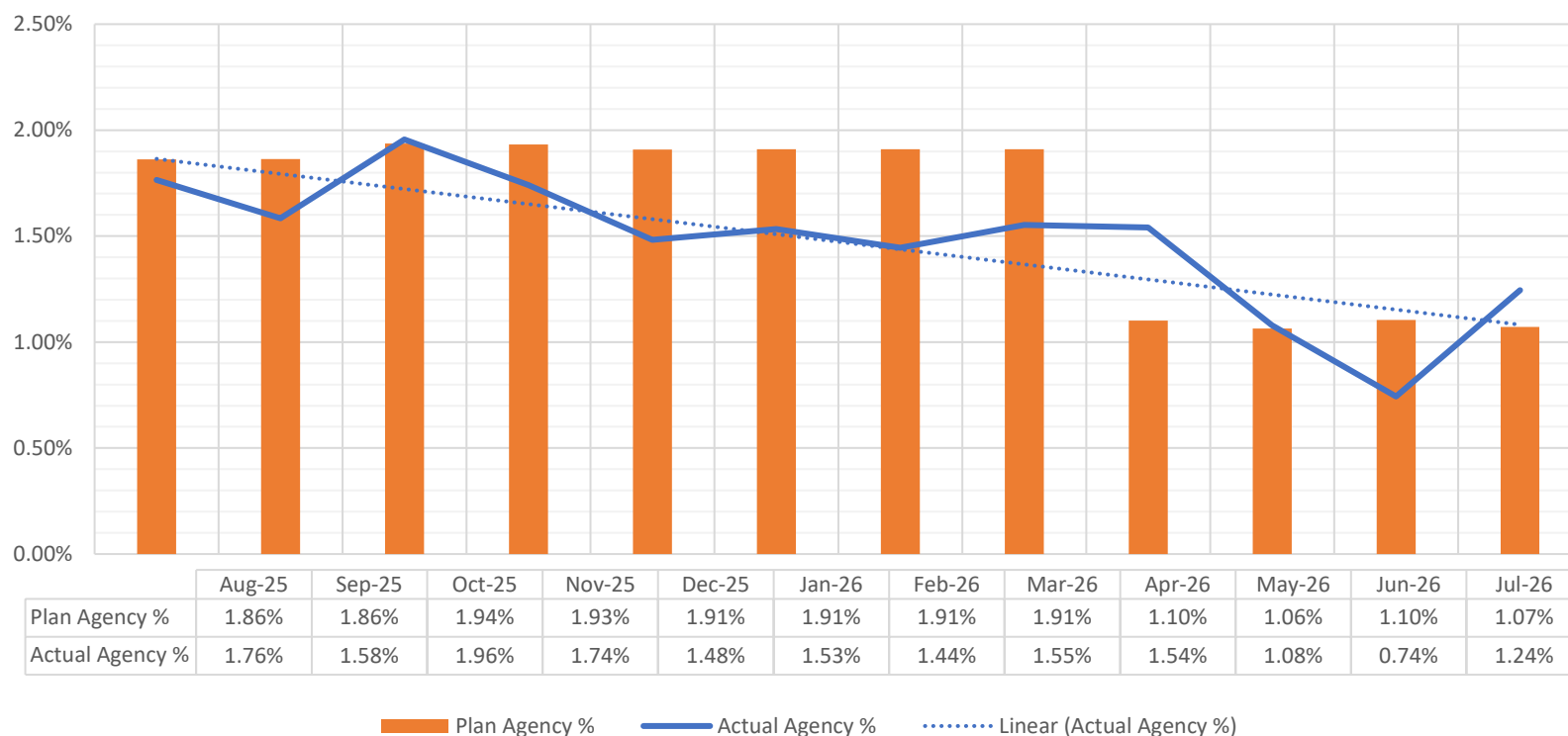
Month 4	M4 Budget WTE	M4 Worked WTE	Variance of worked to budget	M4 Budget £	M4 Actual £	Variance £ (In Month)	Year To Date Budget £	Year To Date Actual £	Year To Date Variance £
Medical and Dental	8.60	9.12	0.52	£164,815	£161,958	-£2,857	£664,647	£575,074	-£89,573
NHS Infrastructure support	0.00	4.03	4.03	£541	£20,159	£19,618	£2,164	£42,846	£40,682
Registered Nursing, Midwifery and Health Visiting Staff	11.36	37.87	26.51	£42,138	£185,292	£143,154	£168,552	£854,760	£686,208
Registered Scientific, Therapeutic and Technical staff	14.36	4.62	-9.74	£130,797	£32,016	-£98,781	£523,188	£118,167	-£405,021
Support to clinical staff	1.42	0.00	-1.42	£5,274	£0	-£5,274	£21,096	£9,050	-£12,046
Grand Total	35.74	55.64	19.90	£343,565	£399,425	£55,860	£1,379,647	£1,599,899	£220,252

Agency utilisation increased in Month 4 to 55.64 WTE, compared to a budgeted level of 35.74 WTE, representing a variance of 19.90 WTE above plan. This reflects an increase from Month 3 and demonstrates continued reliance on agency staffing in a small number of areas where substantive recruitment and retention challenges persist.

Agency expenditure was £55.9k above budget in-month, resulting in a cumulative year-to-date overspend of £220k. Although agency usage remains significantly lower than bank utilisation, it continues to represent a financial pressure and highlights ongoing workforce gaps that cannot yet be fully filled through substantive or bank staffing.

Agency deployment continues to be closely monitored through the Workforce Controls Framework, with approval processes in place to ensure usage is restricted to essential requirements that support safe service delivery. Focus will remain on substantive recruitment, retention, workforce planning and workforce redesign initiatives to reduce agency reliance, improve affordability and support a more sustainable workforce position over the remainder of 2026/27.

Agency Spend vs Budget



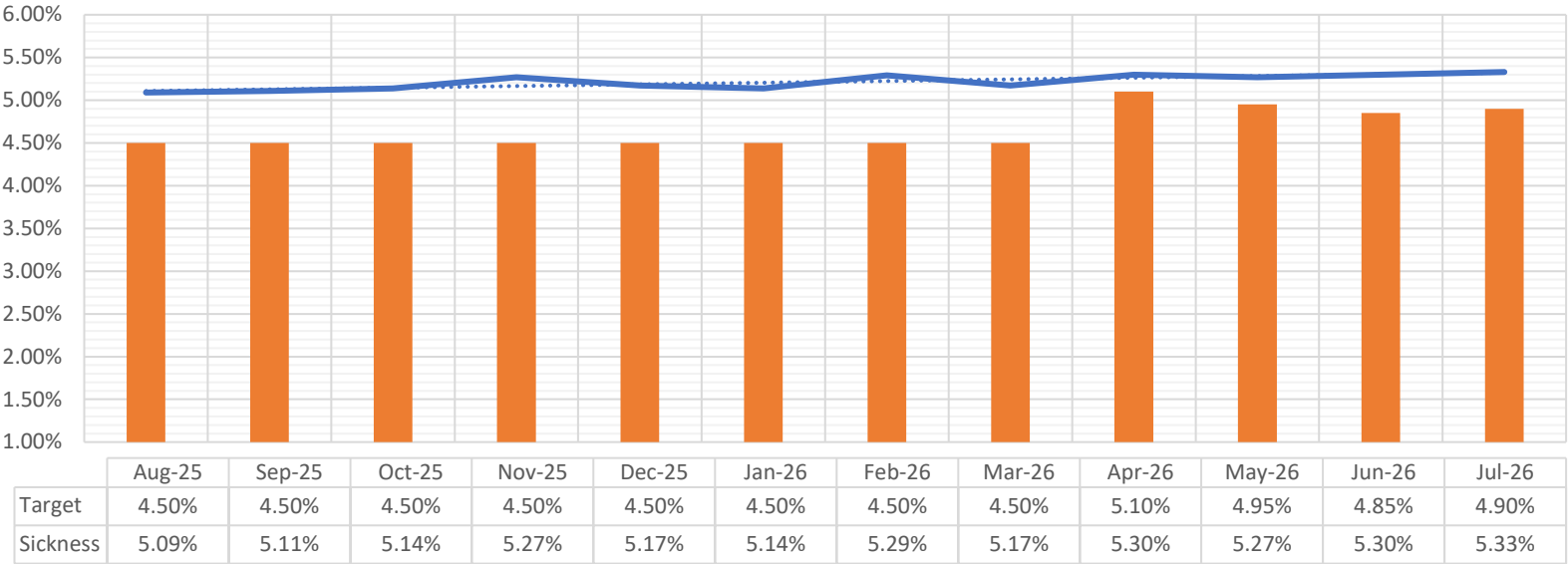
Actual Agency % remained below plan for much of the year, demonstrating generally effective control of agency usage. Following a relatively stable period between January and April, usage reduced significantly to 0.74% in June, the lowest level recorded during the period, before increasing to 1.24% in July.

The increase in July means Actual Agency % is now above the planned level of 1.07%, reversing the improvement seen in the previous month and reflecting the increased agency utilisation reported in Month 4. Whilst agency usage remains considerably lower than bank utilisation, the recent increase suggests continued workforce pressures in a small number of services where substantive recruitment and bank staffing solutions are not yet sufficient to meet demand.

Overall, agency reliance remains lower than earlier in the year and the longer-term trend continues to demonstrate improved control when compared to historical levels. However, the recent increase highlights the need for continued focus on substantive recruitment, retention, workforce planning and workforce redesign initiatives to reduce reliance on agency staffing and support delivery of the Trust's workforce and financial objectives.

Sickness

Last Month (Jun 26)	Current Month (Jul 26)	Target	Change from last month	Performance against target
5.30%	5.33%	<4.90%	↑	



Target Sickness Linear (Sickness)

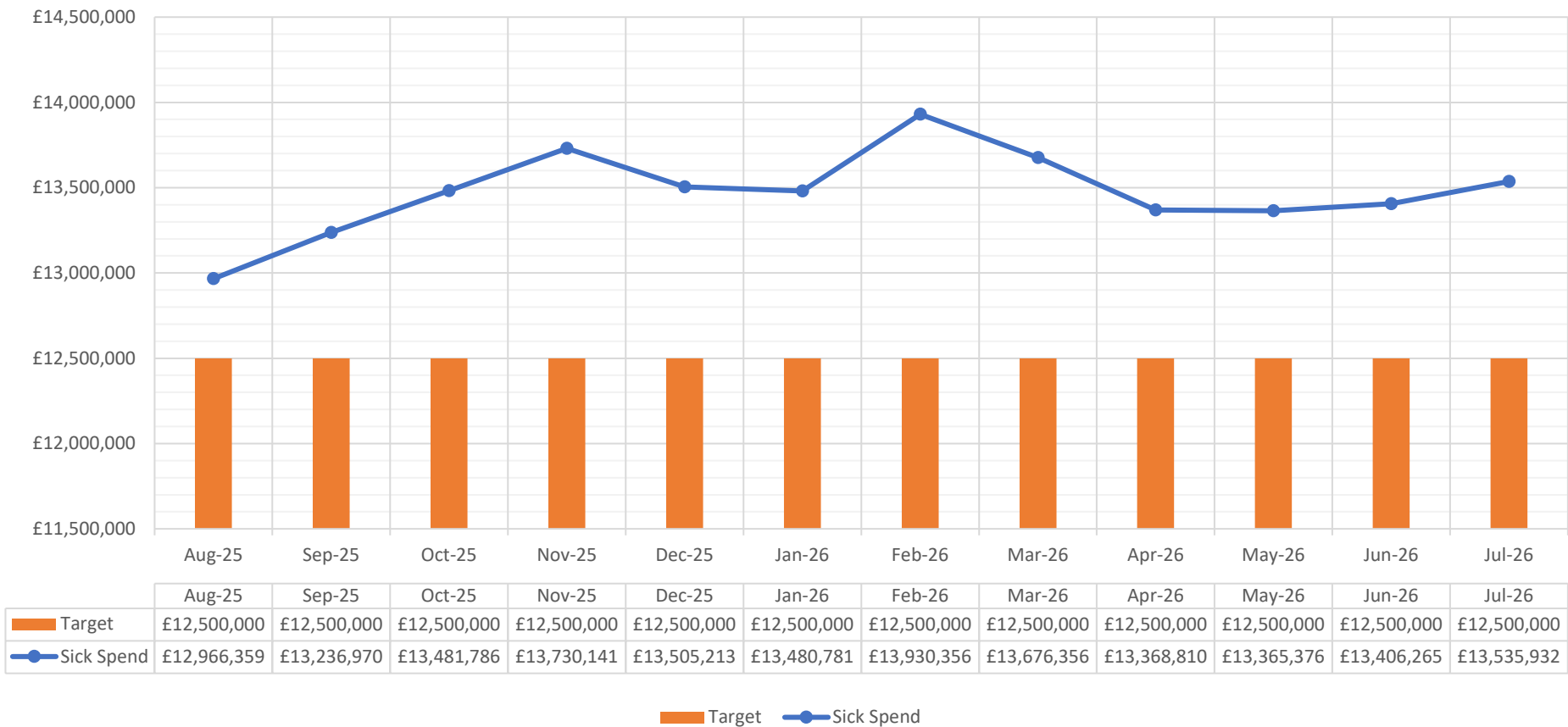
In July 2026, sickness absence increased marginally to 5.33%, compared to 5.30% in June, and remains above the Trust target of 4.90%. This continues the pattern of consistently elevated absence levels seen throughout 2026/27 and reflects ongoing pressure on workforce availability and service capacity.

Whilst monthly fluctuations have been relatively small, there has been no sustained improvement in performance. Following a reduction in absence levels in May (5.27%), sickness absence has increased for the second consecutive month and remains significantly above target.

Overall, sickness absence continues to represent one of the Trust's most significant workforce challenges, impacting productivity, workforce capacity and demand for temporary staffing. The longer-term trend remains relatively static at around 5.3%, indicating that current interventions have yet to deliver a sustained reduction in absence levels.

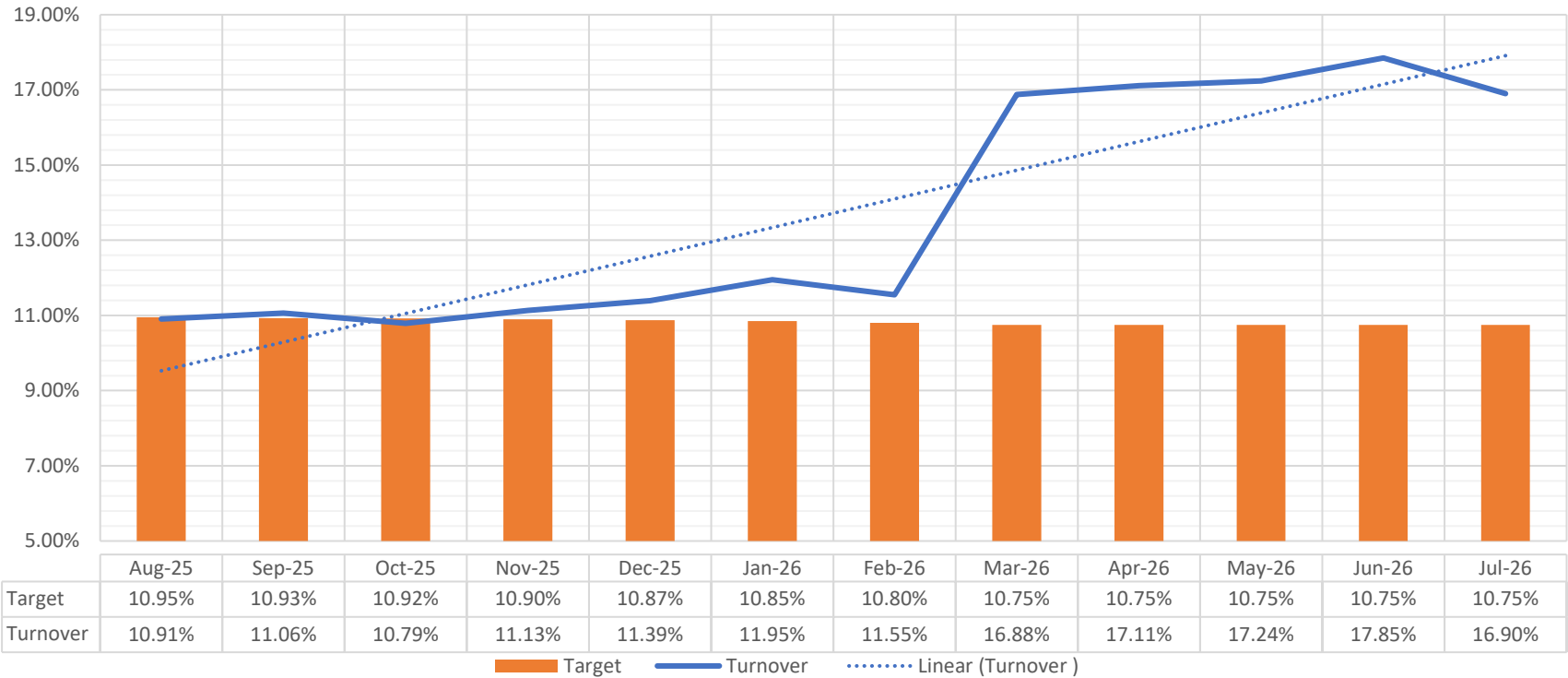
A detailed review of sickness absence is therefore being undertaken to better understand the underlying causes and key drivers of absence across the organisation. This will inform a targeted improvement plan focused on reducing absence, improving staff wellbeing, strengthening management capability and supporting delivery of the Trust's workforce and financial objectives.

Sickness Cost



Turnover

Last Month (Jun 26)	Current Month (Jul 26)	Target	Change from last month	Performance against target
17.85%	16.90%	<12%	↓	



Turnover reduced to 16.90% in July 2026, down from 17.85% in June, although it remains significantly above the Trust target of 10.75%. This is the first notable reduction since the sharp increase observed in March, when turnover rose to 16.88%, and may indicate early signs of workforce stabilisation.

It is important to note that turnover is reported as a rolling 12-month measure and therefore continues to reflect significant workforce movement that occurred over the previous year, including organisational change activity and one-off workforce events. As a result, improvements in current retention rates may take several months to be fully reflected within the reported metric.

Whilst performance remains above target, the reduction from June is encouraging and suggests that turnover may be beginning to normalise. Continued focus on retention, employee experience, recruitment and workforce stability will be required to sustain this improvement and support a gradual return towards target levels over the remainder of 2026/27.

Appraisal

	Last Month (Jun 26)	Current Month (Jul 26)	Target	Change from last month	Performance against target
AfC Appraisal	75.63%	75.30%	>90%	↓	
Medical Staff Appraisal	72.59%	72.84%	>90%	↑	

	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
AfC Appraisal	81.21%	80.51%	81.17%	79.10%	79.53%	79.04%	78.52%	77.65%	75.68%	72.64%	75.63%	75.30%
Medical Appraisal	68.85%	70.89%	69.51%	73.86%	71.48%	71.90%	68.98%	72.00%	72.08%	73.35%	72.59%	72.84%
Families & Community	81.58%	83.04%	81.80%	87.97%	84.96%	79.91%	77.87%	78.15%	78.16%	75.21%	79.80%	77.89%
Medicine & Urgent Care	79.62%	80.02%	79.63%	78.24%	75.46%	77.10%	75.59%	76.55%	77.21%	73.35%	69.18%	73.71%
Planned Care and Surgery	83.28%	82.11%	83.46%	83.24%	82.50%	84.83%	85.16%	83.22%	79.62%	76.82%	80.12%	81.61%
Shared Corporate Services	76.58%	77.27%	78.69%	75.60%	73.40%	74.62%	71.64%	69.10%	69.66%	67.98%	67.55%	67.05%
ASCT	66.22%	65.77%	64.73%	62.50%	64.89%	62.56%	66.67%	66.52%	65.49%	65.02%	60.00%	58.18%

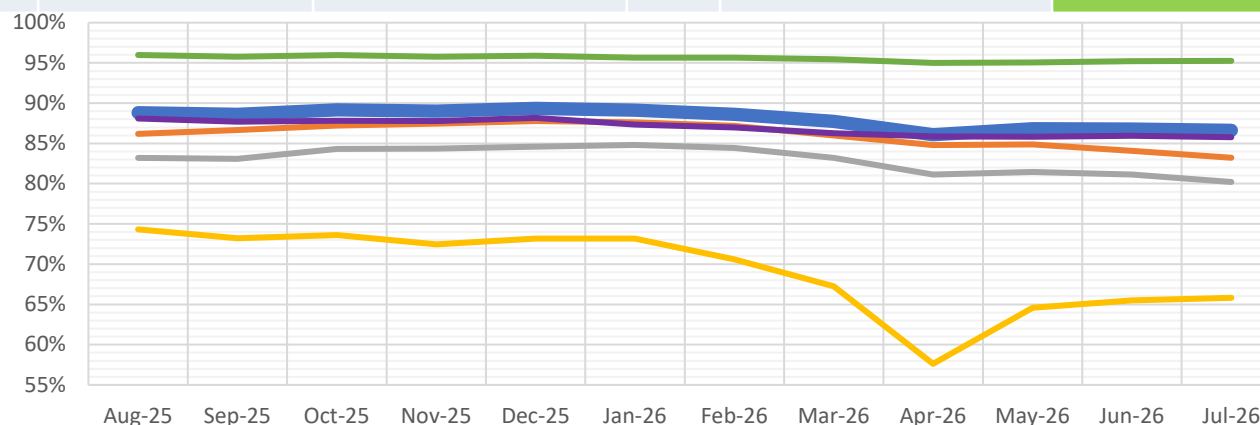
By July 2026, appraisal compliance presents a mixed picture. AfC appraisal compliance has reduced slightly to 75.30%, compared with 75.63% in June, reversing the modest improvement reported last month. Medical appraisal compliance has increased marginally to 72.84%, up from 72.59% in June. Whilst this is a positive movement, both measures remain significantly below the Trust target of >90%.

At Care Group level, performance continues to vary. Planned Care & Surgery has improved further to 81.61%, remaining the highest-performing area and the only Care Group above the 80% threshold. Medicine & Urgent Care has recovered to 73.71%, following a significant decline in June. Families & Communities has reduced slightly to 77.89%, whilst Shared Corporate Services remains low at 67.05%. ASCT has deteriorated further to 58.18%, continuing to report the lowest level of compliance across the organisation.

Overall, appraisal compliance remains significantly below target across both AfC and Medical staff groups. Whilst there are encouraging improvements within some Care Groups, progress remains inconsistent and there has been no sustained improvement at an organisational level. Continued focus from leaders and managers will be required to improve completion rates, strengthen management oversight and implement targeted recovery plans in areas with persistently low compliance.

Mandatory Training

	Last Month (Jun 26)	Current Month (Jul 26)	Target	Change from last month	Performance against target
Mandatory Training	86.79%	86.79%	>85%	→	



	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Overall Training %	89%	89%	89%	89%	89%	89%	89%	88%	86%	87%	87%	87%
Infection Control	86%	87%	87%	87%	88%	88%	87%	86%	85%	85%	84%	83%
Information Governance	83%	83%	84%	84%	85%	85%	84%	83%	81%	81%	81%	80%
Manual Handling	74%	73%	74%	72%	73%	73%	71%	67%	58%	65%	65%	66%
Safeguarding Children	88%	88%	88%	88%	88%	87%	87%	86%	86%	86%	86%	86%
Safeguarding Adults	96%	96%	96%	96%	96%	96%	96%	95%	95%	95%	95%	95%

Overall mandatory training compliance remained stable at 86.79% in July 2026, unchanged from 86.79% in June, and continues to exceed the Trust target of 85%. This demonstrates that compliance levels have been maintained despite the operational pressures and organisational change activity currently underway across the Trust.

Whilst overall performance remains positive, there is variation across individual training subjects. Safeguarding Adults continues to perform strongly at 95%, while Safeguarding Children remains stable at 86%. Manual Handling, whilst still the lowest-performing subject area, has shown a gradual recovery, increasing to 66% from 65% in June, following the significant decline seen earlier in the year. There have, however, been some areas of deterioration. Information Governance compliance has reduced to 80% from 81%, and Infection Control compliance has fallen to 83% from 84%, both remaining below the Trust target. Overall, the Trust continues to maintain mandatory training compliance above target. However, the plateau in performance and ongoing variation between training topics highlights the need for continued focus on targeted recovery actions, particularly in Manual Handling, Information Governance and Infection Control.

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 July 2026 and forecast outturn (FOT) for the year ending 31st March 2027.

Year to date revenue position on plan, with key variances noted:

- Industrial Action Strike costs and income loss (£0.4m adverse)
- NR release of balance sheet flex (£0.4m favourable)
- Income Provision for activity lost due to EPR (£2.9m adverse)
- ASC and CHC overspends on packages of care (£0.6m adverse)
- Underspends on corporate budgets (£0.6m favourable)
- Other underspends mainly relating to undrawn reserves for inflation and growth (£2.9m favourable)

Forecast revenue position on plan, with key risks noted:

- Forecasting breakeven outturn but with base case delivery risks of £11.6m relating to low maturity CIP and impact of EPR on contract activity
- Base case forecast suggests risk of £7.2m against planned ULP

Year to Date CIP position £0.0m variance to plan:

- CIP delivery YTD of £9.6m against a £9.6m target
- The percentage of schemes assessed as fully developed has increased to 90% (£49.2m)
- Forecast CIP is on plan at £54.4m, but with lower recurrent delivery than planned (£4.9m adverse) and with indicators of delivery risk emerging.

Workforce Update

- The Trust is reporting worked WTEs 124 below plan.
- Bank and agency spend is below 2025-26 run rate, but above plan and national cap limits.

Plan	YTD / Forecast	Measure	Month 04 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	(11.2)
Revenue Plan	Forecast	Recurrent Risk to Underlying Position	(7.2)
CIP Plan	YTD	Variance to Target (Adverse) / Favourable	(0.0)
CIP Plan	Forecast	Variance to Recurrent Target (Adverse) / Favourable	(4.9)
Capital Plan	YTD	Variance to Plan (Overspend) / Underspend	0.8
Cash Plan	YTD	Unplanned Cash Support	0.0
Cash Plan	Forecast	Unplanned Cash Support	0.0

Capital programme update:

Year to date capital plan £0.8m underspend

Forecast to deliver full programme, including additional allocation of £2.3m National PDC

Cash Update:

The Trust closing cash balance for Month 4 was (£7.7m) below plan due to late payment from Torbay Council (cash has now been received).

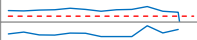
The Trust is not forecasting a need for cash support however risks have been identified that if not mitigated, may require PDC revenue support in M09-M12.

The Finance Committee is requested to agree the overall assurance level relating to the financial position of the Trust as **MODERATE** assurance on financial performance and **LIMITED** assurance on CIP, financial risks and workforce.

Tab 3.1 Integrated Performance and Quality Report (item 5.1.1)

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	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Urgent and Emergency Care															
Ambulance handovers - time lost over 15 mins - Actual (hours)			725	943	1823	810	624	559	1283	621	755	952	1390	1363	1343
Ambulance handovers - time lost over 15 mins - Plan												641	676	623	681
Average handover time (mins) - Actual			32	38	60	33	29	27	45	30	31	38	47	49	47
Average handover time (mins) - Plan	30 mins		35	34	38	42	42	45	42	41	37	30	30	30	30
Total average time in ED (hours/minutes) - Actual			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	Reduction														
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Actual	0		457	426	655	585	549	520	918	740	734	676	839	805	950
ED attendances visit time over 12 hours (minor/major/spec/paeds) - Plan												394	655	469	423
Percentage of patients waiting over 12 hours in ED - Actual			6.5%	6.1%	9.7%	8.5%	8.3%	7.5%	13.6%	12.1%	10.6%	9.8%	11.7%	11.1%	12.9%
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%		73.5%	74.1%	68.3%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.2%	64.7%	65.3%	63.9%
UEC 4-hour target (RAG against local trajectory to national target) - Plan	82%		76.0%	76.0%	76.0%	70.3%	72.6%	73.6%	72.3%	76.4%	78.0%	71.0%	72.0%	73.0%	75.0%
% patient discharges pre-noon - Actual			27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	11.9%	12.5%	14.6%	13.3%
% patient discharges pre-noon - Plan	33%		33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%	33%
Percentage of inpatients with No Criteria to Reside (acute) - Actual			8.0%	6.3%	8.5%	10.6%	8.2%	10.2%	11.1%	10.9%	10.1%	12.6%	12.2%	13.7%	16.5%
Percentage of inpatients with No Criteria to Reside (acute) - Plan	<5%		5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Elective Care															
RTT 78 week wait incomplete pathway - Actual			9	16	13	16	9	9	13	8	7	9	9	11	11
RTT 78 week wait incomplete pathway - Plan	0		0	0	0	0	0	0	0	0	0	0	0	0	0
RTT 65 week wait incomplete pathway - Actual			97	105	110	109	84	94	83	76	47	76	135	169	182
RTT 65 week wait incomplete pathway - Plan	0		83	63	43	23	3	0	0	0	0	0	0	0	0
RTT 52 week wait incomplete pathway - Actual			615	618	615	647	607	663	604	607	600	799	993	1088	1317
RTT 52 week wait incomplete pathway - Plan	292		780	728	673	586	505	449	383	327	268	805	941	1088	1009
RTT % Incomplete pathways <18 wks - Actual			69.7%	69.5%	70.4%	69.3%	68.7%	67.5%	67.0%	66.8%	66.4%	66.4%	66.4%	59.6%	56.8%
RTT % Incomplete pathways <18 wks - Plan	73.8%		63.5%	63.8%	64.2%	64.7%	65.1%	65.5%	65.9%	66.3%	66.8%	63.3%	60.8%	57.0%	59.0%
RTT Wait for first appointment <18 weeks - Actual			74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	70.4%	68.1%	66.5%	62.4%	62.6%
RTT Wait for first appointment <18 weeks - Plan	74.0%		66.7%	67.2%	67.7%	68.2%	68.8%	69.3%	69.9%	70.4%	70.9%	67.0%	65.0%	66.3%	67.4%
Cancer: 28-day FDS - Actual			70.1%	62.3%	67.3%	75.7%	76.2%	78.3%	60.6%	79.7%	75.7%	48.0%	45.5%	57.1%	60.0%
Cancer: 28-day FDS - Revised forecast	80.9%		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	48.0%	45.5%	57.4%	73.0%
Cancer: 62-day wait for treatment (25/26 target 75%) - Actual			57.8%	64.5%	63.2%	70.4%	71.1%	79.8%	75.2%	67.1%	60.1%	58.5%	48.9%	50.6%	53.9%
Cancer: 62-day wait for treatment (25/26 target 75%) - Revised forecast	80.7%		75.7%	75.2%	75.5%	74.9%	76.7%	78.1%	75.8%	74.1%	75.1%	78.1%	81.7%	78.8%	79.2%
Cancer: No of patients waiting >62 days to start treatment - Actual			220	257	176	132	91	119	159	214	201	276	288	347	272
Cancer: No of patients waiting >62 days to start treatment - Plan															
Cancer: % of patients > 62 days to start treatment - Actual			7.8%	9.2%	7.9%	6.5%	4.5%	5.9%	7.6%	9.3%	7.7%	8.3%	8.6%	12.0%	8.9%
Cancer: % of patients > 62 days to start treatment - Plan															
Diagnostics - proportion waiting over 6 weeks - Actual			36.7%	37.1%	36.8%	29.4%	28.4%	30.4%	35.8%	30.6%	37.4%	39.4%	34.6%	24.1%	23.7%
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%	25.6%
RAG indicator															
Meeting monthly trajectory															
Not meeting monthly trajectory															

Tab 3.1 Integrated Performance and Quality Report (item 5.1.1)

Torbay and South Devon NHS Foundation Trust			INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS														Performance Report - July 2026					
RAG rated against year-end position			Setting	Target 2025_26	13 month trend				Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Year to date
QUALITY LOCAL FRAMEWORK																						
Reported Incidents - Moderate	Trustwide	Trend																				
Reported Incidents - Severe	Trustwide	<6		1	5	4	3	3	3	3	0	4	0	5	9	7						21
Reported Incidents - Death	Trustwide	<1		1	2	0	0	3	4	4	1	4	0	0	1	1						2
Medication errors resulting in moderate or more severe harm	Trustwide	<1		0	0	0	1	2	3	0	1	2	0	1	1	2						4
Grade 3 and 4 pressure ulcers acquired in our care (new and deteriorated)	Trustwide	Trend																				
Never Events	Trustwide	<1		0	0	0	0	0	0	1	0	0	0	0	0	0						0
Number of Patient Safety Incident Investigations (PSII)	Trustwide	Trend		0	1	3	1	0	0	1	0	2	1	0	0	0						
Formal complaints - Number received	Trustwide	<20		45	31	25	27	17	22	20	18	28	20	13	23	16						72
Formal complaints - not acknowledged in 3 days	Trustwide	Trend		30	21	20	13	15	17	19	11	24	17	11	14	8						
Formal complaints - closed in 6 months	Trustwide	Trend		10	10	18	13	13	16	15	7	11	9	9	22	12						
Hospital standardised mortality rate (HSMR) (4 months in arrears)	Trustwide	<100		103.6	104.6	105.1	105.4	108	106.9													
Standardised Hospital Mortality Rate (SHMI)	Trustwide	100		0.95	0.95	0.96	0.96	0.97	0.96	0.94	0.94											
Safer staffing fill rate - ICO - Day time	Trustwide	90% - 110%		93.0%	90.9%	91.2%	90.2%	92.1%	92.0%	91.5%	90.4%	90.6%	94.3%	91.3%	91.6%	0.0%						
Safer staffing rate - ICO - Night time	Trustwide	90% - 110%		94.6%	94.4%	95.1%	95.3%	96.6%	95.6%	94.1%	95.4%	95.6%	98.0%	94.1%	93.3%	0.0%						
Care Hours Per Patient Per Day: Day	Trustwide	Trend		4.2	4.2	4.1	4.1	4.2	4.2	4.1	4.1	4.1	4.4	4.2	4.3							
Care Hours Per Patient Per Day: Night	Trustwide	Trend		3.4	3.4	3.3	3.3	3.3	3.3	3.3	3.3	3.3	3.5	3.4	3.4							
Number of Healthcare Associated Infection: MRSA	Trustwide	Trend			0	0	0	0	0	0	0	0	0	0	0							
Number of Healthcare Associated Infection: E-Coli	Trustwide	Trend			10	2	9	3	8	6	8	6	3	8	4	6						
Number of Healthcare Associated Infection: MSSA	Trustwide	Trend			5	2	3	5	5	2	3	1	3	1	3	2						
Nutrition risk assessment within 24 hours	Trustwide	>95%		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		5.7	5.6	4.3	6.0	4.9	5.4	7.2	5.6	5.9	6.7	6.7	5.3	5.2						
Fracture Neck Of Femur - Time to Theatre <36 hours	Trustwide	>90%		68.1%	47.4%	55.0%	70.3%	75.8%	51.0%	45.0%	60.9%	84.8%	65.0%	58.5%	59.5%							
Stroke - % patients admitted to stroke unit within 4 hours	Trustwide	>50%		28.0%	46.4%	50.0%	49.1%	34.1%	52.9%	34.0%	38.0%	49.1%	17.8%	24.4%	38.0%							
30-day readmission rate	Trustwide	Trend			13.1%	13.1%	13.5%	13.8%	13.1%	12.4%	11.9%	13.0%	12.6%	12.3%	12.7%	11.0%						
Mixed Sex Accommodation breaches	Trustwide	Trend		200	124	220	190	160	222	186	134	180	169	160	181	268						778
Follow ups 6 weeks past to be seen date	Trustwide	6400		18486	19016	18135	16900	17610	17827	16967	16835	18638										

Tab 3.1 Integrated Performance and Quality Report (item 5.1.1)

Torbay and South Devon NHS Foundation Trust		INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															Performance Report - July 2026	
RAG rated against year-end position		Setting	Target 2025_26	13 month trend	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Year to date
Maternity 1:1 care in labour (%)		Trustwide	Trend				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%	4.0%	7.8%	5.1%	10.9%	4.4%	8.8%	8.5%	3.4%	2.1%		
Maternity Stillbirths and perinatal deaths		Trustwide	Trend				0	0	0	0	1	0	0	0				
Maternity Smoking at time of delivery		Trustwide	Trend				3	3	5	8	3	3	3	3	1	5	1	
Maternity 3rd and 4th degree tears - total (%)		Trustwide	Trend				4.5%	7.7%	6.8%	2.5%	3.1%	5.6%	3.0%	2.3%	1.3%	1.3%	3.2%	
Maternity PPH>1500mls (%)		Trustwide	Trend				4.1%	4.4%	3.6%	0.7%	4.3%	1.4%	1.6%	4.3%	2.8%	2.6%		
Maternity Birth rate		Trustwide	Trend						140	148	141	148	123	0				

Tab 3.1 Integrated Performance and Quality Report (item 5.1.1)

Torbay and South Devon NHS Foundation Trust			INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS															Performance Report - July 2026	
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Year to date		
WORKFORCE MANAGEMENT FRAMEWORK																			
Staff sickness / Absence Rolling 12 months (1 month in arrears)	Trustwide	<4.00%		5.1%	5.1%	5.1%	5.2%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%				
Appraisal Completeness	Trustwide	>90%		80.2%	80.5%	80.5%	80.5%	78.8%	78.9%	78.7%	78.1%	77.3%	75.5%	72.7%	75.4%	75.1%			
Mandatory Training Compliance	Trustwide	>85%		85.0%	85.4%	85.5%	86.2%	86.2%	87.9%	85.9%	85.0%	84.1%	85.3%	83.3%	83.5%				
Turnover (exc Jnr Docs) Rolling 12 months	Trustwide	10%-14%		10.9%	10.9%	10.8%	10.8%	11.1%	12.8%	12.9%	10.6%	15.0%	15.4%	10.2%	10.1%	10.2%			
COMMUNITY & SOCIAL CARE FRAMEWORK																			
Carers Assessments Completed year to date	Trustwide	40% (Year end)		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%				6.9%			6.7%										
DOLS (Domestic) - Open applications at snapshot	Trustwide	NONE SET							506	472	492	436							
Intermediate Care - No. urgent referrals	Trustwide	NONE SET		235	199	215	264	229	207	243	191	204					2688		
Community waiting list	Trustwide					7812	7863	7688	7004	7236	8040	7058	6465	5349	0				
Community Hospital - Admissions (non-stroke)	Trustwide	NONE SET		211	166	190	241	208	211	242	195	204	#N/A				2478		
Community Hospital Length of Stay (days) - (general)	Community Hospital	NONE SET		14.4	15.7	15.6	13.9	12.8	14.0	14.2	12.9	15.2	0.0				14.2		
Community Hospital % patient discharges pre-noon	Community Hospital	33%		49.0%	50.0%	48.0%	45.0%	47.0%	44.0%	45.0%	48.0%	49.0%	0.0%						
Urgent Community Reponse (2-hour) - Target achievement	Trustwide	80% ICB target		89.9%	85.8%	90.4%	91.3%	94.5%	91.8%	92.6%	93.8%	91.0%	77.0%	83.6%	69.7%	83.6%	77.1%		
Urgent Community Reponse (2 hour) - Number of referrals	Trustwide	157		227	232	251	299	220	243	230	194	211	57	123	114	122	315		
ADULT SOCIAL CARE TORBAY KPIs																			
Permanent admissions (18-64) to care homes per 100k population	Trustwide	14		31.1	24.6	24.6	24.6	24.6	22.1	23.4	24.6	25.9	0.0				25.9		
Permanent admissions (65+) to care homes per 100k population	Trustwide	450		750.6	721.9	687.9	737.6	742.8	729.7	753.3	734.9	745.4	729.7	n/a			729.7		
Proportion of clients receiving direct payments	Trustwide	25%		18.8%	18.5%	17.8%	18.2%	18.2%	18.0%	18.1%	18.4%	18.1%	17.8%	n/a			17.8%		
% reablement episodes not followed by long term SC support	Trustwide	83%		89.1%	88.8%	88.9%	88.6%	88.9%	89.1%	89.1%	88.9%	94.2%	95.7%	n/a			95.7%		
PERFORMANCE FRAMEWORK																			
Cancer - Two week wait from referral to date 1st seen - regional reporting	Trustwide	>93%		31.7%	24.9%	30.9%	38.0%	38.9%	37.0%	37.9%	41.0%	33.6%	29.9%	23.8%	29.1%	40.6%			
Cancer - 31-day wait from decision to treat to treatment - national reporting	Trustwide	>96%		91.4%	88.9%	91.4%	91.1%	93.1%	92.9%	92.7%	95.8%	93.4%	83.0%	83.1%	87.7%	89.6%			
Cancer - 62-day wait for treatment - national reporting (2024/25 target 70%) (2025/26 target 75%)	Trustwide	75%		62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	75.2%	67.1%	66.2%	57.4%	50.4%	50.6%	53.9%			
Cancer - Patient waiting longer than 104 days from 2ww - regional reporting	Trustwide	20		24	28	29	21	21	20	27	44	44	56	70	61	66			
Referral to treatment - % Incomplete pathways <18 wks	Trustwide	>92%		68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	67.0%	66.8%	66.4%	62.8%	60.4%	59.6%	56.8%			
On the day cancellations for elective operations	Trustwide	<0.8%		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		21	11	11	17	17	14	11	11	11							
Theatre Utilisation	Trustwide	85%		76.7%	82.3%	82.7%	83.2%	81.8%	80.3%	82.8%	81.5%	81.3%	66.0%	73.4%	68.0%	73.4%			
Virtual outpatient appointments (non-face-to-face)	Trustwide	25%		15.9%	16.7%	15.9%	14.6%	15.6%	15.5%	16.9%	16.3%	16.1%	23.1%	22.9%	22.7%	22.2%			
Bed Occupancy	Acute	90%		96.0%	95.3%	96.8%	96.7%	96.5%	95.2%	97.5%	97.2%	97.2%	93.9%	95.1%	93.2%	95.7%			
% patient discharges pre-5pm	Acute	75%		75.3%	71.4%	68.3%	66.0%	68.8%	69.5%	68.9%	68.1%	66.8%	55.3%	60.6%	64.1%	69.6%			

Tab 3.1 Integrated Performance and Quality Report (item 5.1.1)

Torbay and South Devon NHS Foundation Trust		INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS														Performance Report - July 2026	
RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Year to date
Percentage of inpatients with No Criteria to Reside (Torbay GP registered patients)	Acute	<5%		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%		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	6.1	5.9	5.6	6.3	7.0	6.9	6.8					
Number of patients >7 days LoS (daily average)	Acute	153		149.2	149.2	159.6	158.3	161.9	169.6	178.2	168.0	169.5	149.7	154.7	163.5	168.8	
Number of extended stay patients >21 days (daily average)	Acute	35		28.4	38.8	42.5	39.3	43.7	47.7	48.9	38.4	41.2	39.8	47.2	46.8	52.5	
Ambulance handover delays > 30 minutes	Acute			716	804	1250	933	957	813	1277	965	1170	1228	1384	1363	1303	5278
Ambulance handover delays > 60 minutes	Acute	0		302	390	764	203	121	103	450	135	167	303	478	493	462	1736
UEC - patients seen within 4 hours (2025/26 plan target 78%)	Trustwide	78%		73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	64.1%	64.7%	65.2%	63.9%	64.6%
Time to Initial Assessment % seen within 15 mins - Emergency Department	Acute			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			22.0%	19.7%	25.6%	21.8%	21.3%	22.5%	25.5%	19.8%	18.1%	23.8%				
Non-admitted minutes mean time in Emergency Department (hh:mm)	Acute			03:48	03:50	04:07	04:10	04:03	03:59	04:14	04:24	04:37	05:34	05:41	05:31	05:49	
Admitted minutes mean time in Emergency Department (hh:mm)	Acute			07:08	07:05	08:58	08:15	08:05	08:16	11:37	10:16	09:36	10:10	11:25	12:00	11:53	
Corridor Care - Emergency Department	Acute	0										1122	933	963	940	1092	
Diagnostic tests longer than the 6 week standard	Trustwide	5%		37.0%	37.0%	37.0%	29.0%	28.0%	30.0%	36.0%	31.0%	37.0%	41.6%	34.2%	24.1%	23.7%	
Dementia - Find - monthly report	Trustwide	>90%		93.6%	97.7%	95.1%	94.9%	96.9%	94.6%	97.2%							95.8%
Care Planning Summaries % completed within 24 hours of discharge - Weekday	Trustwide	>77%		80.0%	77.5%	77.8%	77.5%	71.4%	73.8%	75.6%	71.5%	72.0%					80.3%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	Trustwide	>60%		62.5%	60.8%	58.0%	60.6%	67.2%	63.5%	59.8%	52.5%	61.3%					63.7%
Clinic letters timeliness - % specialties within 4 working days	Trustwide	>80%		76.0%	79.3%	72.2%	72.1%	74.4%	63.2%	50.3%	63.2%	77.1%					
ERF activity 202/27 vs 2019/20 baseline																	
Day cases										104%	106%	99%	99%	91%	112%		109%
Elective inpatient admissions										87%	87%	81%	66%	66%	64%		84%
Admitted Patient Care Total										103%	103%	97%	95%	89%	107%		106%
Outpatient - first appointment										103%	105%	109%	74%	72%	103%		105%
Outpatient - first appointment with procedure										146%	133%	135%	77%	81%	127%		145%
Outpatient - follow-up with procedure										124%	124%	112%	64%	73%	82%		133%
Outpatient Appointment Total										116%	115%	113%	70%	72%	95%		119%
ERF Income Grand Total (% above 2019/20)		114%								111%	109%	104%	70%	78%	88%		114%
Non-ERF activity 2026/27 vs 2025/26																	
Non-elective admissions											102%	104%	0%	0%	0%		105%
UEC attendances (Type 1 and 3)											113%	105%	101%	98%	103%		105%

RAG rated against year-end position	Setting	Target 2025_26	13 month trend	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-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%		

ECSO Activity Summary - July 2026

Source	User-provided ECSO
Total ECSO shifts	435
Reporting note	Whole-shift allocation
Overall RAG	Red
Overall assurance narrative	ECSO activity is concentrated across a small number of areas, with EAU4, New Forest, Simpson and Cheetham Hill accounting for 274 of 435 shifts, equivalent to 63.0% of total activity. Overall rating is Red due to this concentration of demand and the need for continued senior nursing oversight, daily staffing review, redeployment decisions and triangulation with acuity, dependency, incidents and quality indicators.

Applied RAG Criteria for ECSO Activity

Red	15% or above of total ECSO activity
Amber	10% to 14.9% of total ECSO activity
Green	Below 10% of total ECSO activity

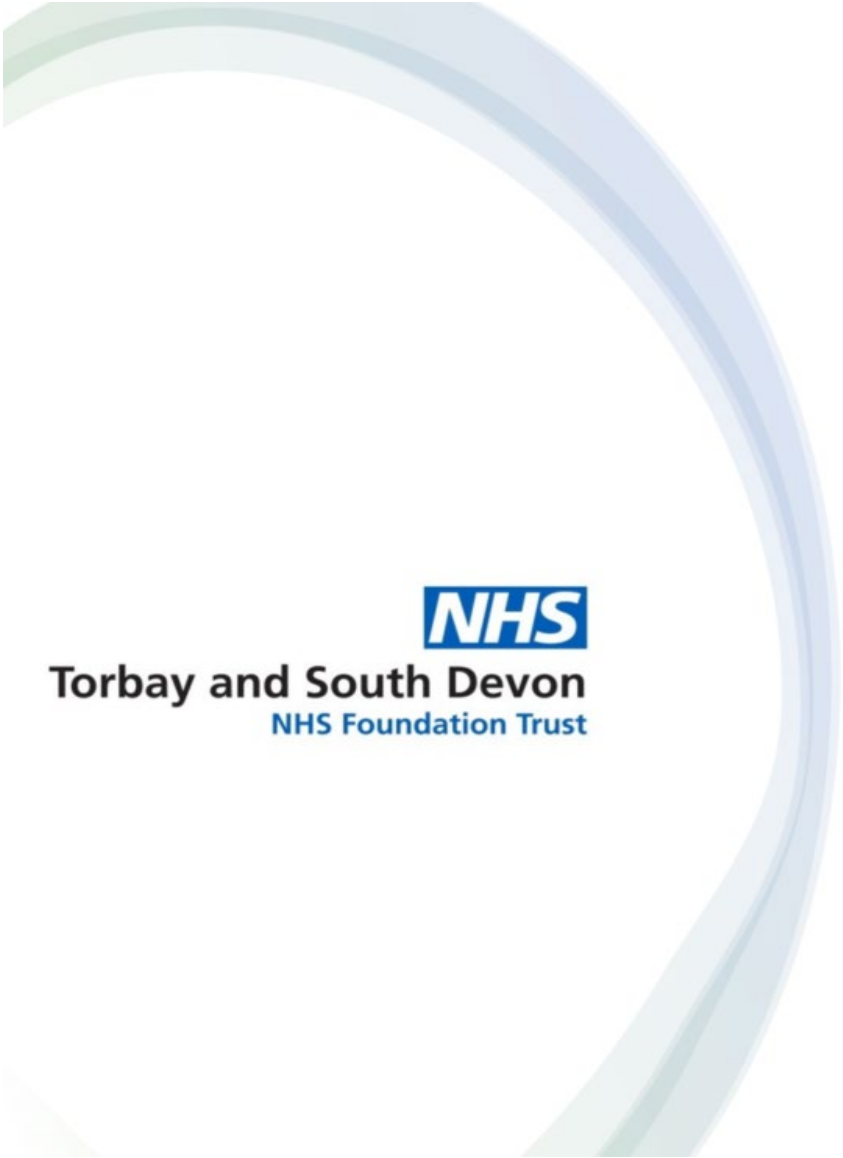
Area	% of ECSO Activity	Calculated Shifts	Whole-Shift Allocation	RAG	Narrative / Interpretation
EAU4	18%	78.3	78	Red	Highest ECSO utilisation; rated Red and should remain a priority area for oversight.
New Forest	16%	69.6	70	Red	High ECSO utilisation; rated Red and requires continued review through staffing governance.
Simpson	15%	65.3	65	Red	High ECSO utilisation; rated Red and should continue to be triangulated with acuity and safety indicators.
Cheetham Hill	14%	60.9	61	Amber	Notable ECSO utilisation; rated Amber and remains a key contributor to total activity.
Allerton	12%	52.2	52	Amber	Moderate ECSO utilisation; rated Amber and should continue to be monitored.
ED	9%	39.2	39	Green	Lower relative ECSO utilisation; rated Green within the applied activity threshold.
AMU	6%	26.1	26	Green	Lower relative ECSO utilisation; rated Green within the applied activity threshold.
George Earle	4%	17.4	18	Green	Lower relative ECSO utilisation; rated Green. Whole-shift allocation includes rounding adjustment to reconcile total shifts.
Cromie	4%	17.4	17	Green	Lower relative ECSO utilisation; rated Green within the applied activity threshold.
Community	2%	8.7	9	Green	Lowest ECSO utilisation; rated Green within the applied activity threshold.
Total	100%	435.0	435		Total reconciles to 435 whole shifts.

Key Concentration Summary

Top four areas	EAU4, New Forest, Simpson and Cheetham Hill
Top four whole-shift total	274
Top four percentage of total	63.0%
Narrative for report	EAU4, New Forest, Simpson and Cheetham Hill account for 274 of 435 ECSO shifts, equating to 63.0% of total activity. The concentration of demand supports a Red overall RAG rating and requires continued senior nursing oversight through daily staffing review, targeted redeployment and triangulation with quality and safety indicators.

Suggested Mitigation / Actions

- 1 Maintain twice-daily staffing review and senior nursing oversight for wards with Red or Amber ECSO activity.
- 2 Review ECSO deployment themes by area and shift to confirm support is targeted to patient acuity and dependency.
- 3 Triangulate ECSO use with staffing fill rates, incidents, complaints, falls, medicine errors and other patient-sensitive indicators.
- 4 Use the findings to inform enhanced care governance, temporary staffing controls and targeted workforce improvement actions.



Safer Staffing Dashboard - July-2026

Report Version: 1
Published: 11/08/2026 10:10

Safer Staffing Dashboard - Inpatient Wards - July-2026

Our priorities for 2025-2026: Triangulation of our workforce metrics and Patient Sensitive Indicators

Report Version: 1 (Published: 11/08/2026 10:10)

Ward	Beds		Staffing Fill Rates				Actual Staffing Split					Care Hours Per Patient Day (CHPPD)												HR Metrics			Temporary Staffing		Ward Accred.1	PATIENT SENSITIVE INDICATORS																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
												RN v Care Staff Splits						Days		Nights		Day v Night Split								RN / Midwives		Care Staff		Overall Day		RN / Midwives		Care Staff		Overall Night		Safety				Feedback																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
	Days		Nights		% 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	Sickness Rate	Turnover Rate		Vacancy Rate	Prop. Bank Hours	Prop. Agency Hours	Red Flags Raised	EToC Red Flags	All Red Flags	Mod. Harm Incs and Above	PUs G2+ Acq. in Our Care	Falls	No Harm	Harm	Medicine Errors	% Obs Taken on Time	Patient Complaints	% Positive Resp.	Number of Resp.																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																						
	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	(Jul-24)	(Jun-25)		(Jun-25)	(Jun-25)	(Jun-25)																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			

Below each RAG'd 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 - July-2026 - Assurance

Measure	Assurance	Narrative	Mitigation	Actions

Tab 3.1 Integrated Performance and Quality Report (item 5.1.1)

Measure		Summary1	Narrative	Mitigation	Actions
STAFFING METRICS					
Bed Occupancy			Bed occupancy is 93.0% for July 2026 and is amber-rated. This indicates sustained pressure across inpatient areas, with a number of wards operating at, or close to, full capacity. Continued focus remains required on patient flow, timely discharge and appropriate use of escalation capacity.	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	July 2026 staffing fill rates remain within national tolerance overall. Registered nurse/midwife fill rates were 90.8% on days and 93.9% on nights. Care staff fill rates were 95.4% on days and 110.8% on nights. The position provides overall assurance, although day RN fill remains close to the lower end of the agreed range and should continue to be monitored through twice-daily staffing meetings.	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	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	For July 2026, actual CHPPD was 4.2 during the day and 3.4 at night. Planned CHPPD was 4.5 during the day and 3.4 at night. Actual RN/midwife CHPPD was 2.2 days and 1.8 nights; actual care staff CHPPD was 1.9 days and 1.6 nights. Overall CHPPD remains broadly aligned to plan, with the largest variance seen in daytime RN/midwife hours.	Review of CHPPD on a monthly basis. This data is shared nationally and inputted on Model hospital for transparency. Where the fill rate is less then 90% and greater than 110% our senior nurse leaders are asked for narrative to account for the clinical need. To seek weekly narrative and assurance from senior nursing leaders where compliance falls outside of these target ranges.	To continue to report data to Model Hospital. Compare CHPPD data with our peer hospitals. To continue to work with NHS P to meet our shift fill rate targets. To continue to ask our senior leaders for narrative to support reasons for non compliance. To use the data to report trends and themes where compliance is outside of these metrics.
		Care Staff			
		Overall			
	Nights	RN / Midwives			
		Care Staff			
		Overall			
HR Metrics	Sickness Rate		Organisational sickness is 5.4% for July 2026 and remains red-rated against the dashboard threshold. Turnover is 10.3% and vacancy is 8.9%, both green-rated. Continued focus is required on sickness management, retention and targeted recruitment to support sustainable staffing.	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		Temporary workforce use for July 2026 shows bank hours at 6.2% and agency hours at 0.1%. Bank use remains amber-rated and agency use is green-rated, indicating that agency reliance remains low. Continued weekly review through senior nursing and workforce governance should support ongoing control of temporary staffing demand and spend.	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					
Safety	Red Flags	EToC Red Flags	Red flag reporting in July 2026 shows 22 all-red-flag events and 4 EToC red flags. Reporting continues to provide assurance that staffing risks are being raised through SafeCare and reviewed through daily staffing meetings. EToC red flag use remains an area for continued focus and senior nursing oversight.	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 and above were 12 in July 2026. Continued triangulation with workforce metrics remains important, particularly in areas with higher acuity, EToC pressures, sickness, vacancy or temporary staffing use.	Review daily high risk areas at twice daily staffing meeting, ensuring that they have appropriate skill mix and substantive staff on shift.	All incidents follow a robust process where duty of candour is completed. Learning is shared embedding a 'just culture'. Report of trends to indicate where patient demand is needed to reduce risks.
	Pressure Ulcers G2+ Acq. in Our Care		There were 0 grade 2+ pressure ulcers acquired in our care in July 2026. This maintains a positive position and indicates continued focus on skin assessment, preventative care and professional accountability.	Review daily high risk areas at twice daily staffing meeting, redeploy staff in accordance to risk and patient dependency. To work with clinical governance to ensure learning is shared around incidents raised about pressure ulcers.	For senior leaders to follow the escalation process within the One Devon safer staffing SOP. Robust governance process and timely review of Datix and responses. Where harm has been caused AARs are completed. Trends across the directorate are reported to the Quality
	Falls	No Harm	Falls remain a key patient-sensitive indicator for July 2026, with 44 no-harm falls and 49 falls with harm recorded. Higher-risk areas should continue to be reviewed through twice-daily staffing meetings, with staff redeployed according to patient dependency and risk.	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			
	Medicine Errors		Medicine errors were 36 in July 2026. Continued review of themes, skill mix and temporary staffing support is required through daily staffing meetings and trust-wide safety and quality governance.	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		Observations completed on time were 91.5% for July 2026. Compliance remains above the 85% threshold and should continue to be monitored, with follow-up through clinical leads where local compliance falls below expected levels.	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			There was 1 patient complaint in July 2026. Complaints continue to be managed within care groups, with themes and trends shared through care group meetings and escalated where required.	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.

Tab 3.1 Integrated Performance and Quality Report (item 5.1.1)

Feedback	FFT	% Pos. Resp.		FFT positive response data is not available within the July 2026 dashboard extract. Patient feedback response volumes should continue to be reviewed locally, with QR codes and ward-level processes used to support feedback capture.	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) - July-2026

Torbay and South Devon 
NHS Foundation Trust

STAFFING METRICS			Emerg. Dept
Number of Attendances			7,357
Staffing Fill Rates	Days	RN / Midwives	89.4%
		Care Staff	77.2%
	Nights	RN / Midwives	97.9%
		Care Staff	73.2%
Actual Staffing Split	Days	% RN / Midwives Hours	65.4%
		% Care Staff Hours	34.6%
	Nights	% RN / Midwives Hours	68.6%
		% Care Staff Hours	31.4%
	Day / Night Split	% Day	48.9%
		% Night	51.1%
HR Metrics	Sickness Rate	(Jul-26)	9.2%
	Turnover Rate	(Jun-26)	12.6%
	Vacancy Rate	(Jun-26)	22.1%
Temporary Staffing	Prop. Bank Hours	(Jun-26)	5.3%
	Prop. Bank Hours	(Jun-26)	0.0%
Accreditation			#VALUE!

PATIENT SENSITIVE INDICATORS			Emerg. Dept
Number of Unplanned Reattendances (Mar-26)			249
Service Delivery Times	% Waiting > 4 Hrs		50.7%
	% Waiting > 12 Hrs		12.9%
	Avg. Triage Time (mins)		21
	Ambulance Handovers < 30 mins		47.8%
	All Red Flags		0
Safety	Mod. Harm Incs and Above		3
	Medicine Errors		6
	PUs G2+ Acquired in Our Care		0
	Falls	No Harm	1
		Harm	3
	Sepsis	% Overall Sepsis 6 Compliance	73%
		% Antibiotics within 1 Hour	100%
	Patient Complaints		8
Feedback	FFT	% Positive Resp. (Jul-25)	
		Number of Resp. (Jul-25)	

Safer Staffing Dashboard - Emergency Care (ED Only) - July-2026 - Assurance

Torbay and South Devon 
NHS Foundation Trust

Measure	Assurance Summary1	Narrative	Mitigation	Actions

STAFFING METRICS						
Staffing Fill Rates	Days	RN / Midwives		July 2026 staffing fill rates show registered nurse fill at 89.4% for days and 97.9% for nights. Care staff fill remains below the 90% tolerance, at 77.2% for days and 73.2% for nights. This indicates continued care staff workforce pressure in the department and supports ongoing recruitment, retention, redeployment and escalation actions.	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			The latest HR metrics show sickness at 9.2%, turnover at 12.6% and vacancy at 22.1%. Sickness and vacancy remain elevated and continue to present a risk to sustainable staffing, particularly alongside the need to reduce temporary workforce reliance and maintain safe staffing during periods of high demand.	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			Temporary staffing for July 2026 shows bank hours at 5.3% and agency use at 0.0%. Agency use remains well controlled, with continued focus required on safe bank utilisation, booking controls and alignment of temporary staffing to acuity and demand.	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					
Accreditation						
PATIENT SENSITIVE INDICATORS						
Number of Unplanned Reattendances				Unplanned reattendances were 249 in July 2026. Attendances were 7,357, so continued demand management, streaming and signposting to alternative services remain important to manage pressure through the	Strengthen Demand Management Implement streaming and triage models to redirect non-urgent attendances Promote use of alternative services (GP, UICs, NHS 111)Improve	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
Service Delivery Times	% Waiting > 4 Hrs			In July 2026, 50.7% of attendances waited over 4 hours and 12.9% waited over 12 hours. Average triage time was 21 minutes, and 47.8% of ambulance handovers were completed within 30 minutes. Performance remains pressured and requires continued use of escalation and surge arrangements to support flow and timely care.	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					
Safety	Mod. Harm Incs and Above			3 moderate harm incidents and above, 6 medicine errors, 0 grade 2+ pressure ulcers acquired in care, 1 no-harm fall and 3 falls with harm. Sepsis 6 compliance was 73.0% and antibiotics within one hour was 100.0%. Safety metrics should continue to be triangulated with staffing, acuity and demand pressures.	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 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-	Early Risk Identification: Consistent triage screening (sepsis, falls, skin integrity) Standardisation: Use checklists, protocols, and care bundles (Sepsis 6, medication safety) Timely Care: 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
	Medicine Errors					
	PUs G2+ Acquired in Our Care					
	Falls	Falls - No Harm				
		Falls - Harm				
	Sepsis	% Overall Sepsis 6 Compliance				
		% Antibiotics within 1 Hour				
	Feedback	Patient Complaints				
FFT		% Positive Resp.				
		Number of Resp.				

1 Definitions for the Assurance Summary categories are given in the 'Notes and Definitions' section of this document.

Safer Staffing Dashboard - July-2026 - Notes and Definitions

STAFFING METRICS

Measure	Applicability	RAG Criteria			Notes and Definitions
		Red	Amber	Green	
Beds	Established Beds	N/A	N/A	N/A	Figures represent the established Bed Stock along with the percentage of available beds that were occupied throughout the month.
	Bed Occupancy	>=93% or <77%	(>=77% and <80%) or (>90% and <93%)	>=80% and <=90%	Please note that the Bed Occupancy RAG status is not applied to John Macpherson, Louisa Cary, SCBU or ICU due to the specialty of the areas.
Number of Attendances	Emergency Only	N/A	N/A	N/A	The total number of ED attendances.
Staffing Fill Rates	Days RN/Midwives	<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.
	Care Staff				
	Nights RN/Midwives				
	Care Staff				
Actual Staffing Split	Days % RN / Midw.	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.
	% Care Staff Hours				
	Nights % RN / Midw.				
	% Care Staff Hours				
Care Hours Per Patient Day (CHPPD)	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.
	Day				
	Night				
	Overall				
Care Hours Per Patient Day (CHPPD)	Days RN / Midwives	Actual CHPPD is <80% of the Planned CHPPD	Actual CHPPD is (>=80% and <90%) of the Planned CHPPD	Actual CHPPD is >=90% of the Planned CHPPD	Figures indicate the number of Care Hours per Patient resident on the ward at 23:59 each day. Figures for each staff category (and 'Overall') are split between the CHPPD provided by the Planned staffing level and the CHPPD provided by the Actual staffing level. The bracketed figures in the Actual column represent the difference between the Planned and the Actual figures with a positive difference indicating that the Actual CHPPD exceeds the Planned CHPPD. The RAG status is only applied to the Actual CHPPD column and is based on the relative difference between the Actual CHPPD and the Planned CHPPD. A Green RAG status is assigned where there was no Planned staffing but Actual staffing was present.
	Care Staff				
	Overall Day				
	Nights RN / Midwives				
	Care Staff				
	Overall Night				
HR Metrics	Sickness Rate	>4%	>=3.65% and <=4%	<3.65%	Please note that the Vacancy Rate represents the difference between the Staff in Post FTE and the Establishment FTE - this means that if the Staff in Post FTE exceeds the Establishment FTE for a ward then a negative 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	<5%	>=5 and <=10%	>10%	Figures represent the Bank and Agency FTE as a proportion of the Establishment FTE based on weekly averages within the month.
	Prop. Agency Hours	<3%	>=3% and <=10%	>10%	
Accreditation		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 not the accreditation statuses for the months prior to the current reporting month.

Safer Staffing Dashboard - July-2026 - Notes and Definitions (cont.)

PATIENT SENSITIVE INDICATORS

(Measures that are potentially impacted by staffing issues)

Measure		Applicability	RAG Criteria			Notes and Definitions
			Red	Amber	Green	
Number of Unplanned Reattendances		Emergency Only	N/A	N/A	N/A	
Service Delivery Times	% Waiting > 4 Hrs	Emergency Only	>5%	N/A	<=5%	The percentage of ED attendances that exceeded 4 hours.
	% Waiting > 12 Hrs		>0%	N/A	0%	The percentage of ED attendances that exceeded 12 hours.
	Avg. Triage Time (mins)		>=15	N/A	<15	The average time to triage (minutes).
	Amb. Handovers < 30 mins		<95%	N/A	>=95%	The percentage of Ambulance handovers completed within 30 minutes.
Safety	Red Flags Raised	Inpatient and Emergency (EToC Red Flags: Inpatient Only)	>=2	1	0	A Red Flag is a concern raised by a member of staff regarding staffing levels.
	All Red Flags		>=5	>=3 and <5	<3	The collection of data for 'Lack of EToC Provision' Red Flags begun in March 2025. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	Moderate Harm Incidents and Above	Inpatient and Emergency	>=3	>=1 and <3	0	The number of incidents resulting in Moderate Harm where the ward / area was recorded as the location of the incident. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	Grade 2+ Pressure Ulcers Acquired in Our Care	Inpatient and Emergency	>=4	>=2 and <4	<2	A Pressure Ulcer 'Acquired in Our Care' is a Pressure Ulcer that has developed subsequent to the Patient coming under our care. (This includes both those that are newly acquired and those that have resulted from a deterioration) The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	Falls	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
			>=4	>=2 and <4	<2	The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	% Overall Sepsis 6 Compliance	Emergency Only	<70%	>=70% and <90%	>=90%	The percentage of Patients meeting all six of the Sepsis 6 criteria. (They are: Sepsis proforma, Senior Review within an hour, Oxygen appropriately administered, IV access and bloods taken, Antibiotics administered appropriately, IV Fluids administered appropriately and Ongoing monitoring)
	% Antibiotics within 1 Hour		<70%	>=70% and <90%	>=90%	The percentage of appropriate Patients receiving antibiotics within one hour.
	Medicine Errors	Inpatient and Emergency	>=2	1	0	Figures represent the number of Patient medicine-related incidents where the location was recorded as the relevant ward. Figures are grouped by the month the incidents was recorded on Datix. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
	% Obs Taken on Time	Inpatient Only	<80%	>=80% and <85%	>=85%	Figures represent observations taken on time as a percentage of those expected.

All measures sourced from Datix CloudIQ are grouped by the month that they were reported on the system which may not necessarily be the month that the incident occurred

Safer Staffing Dashboard - July-2026 - Notes and Definitions (cont.)

PATIENT SENSITIVE INDICATORS (cont.)

Measure	Applicability	RAG Criteria			Notes and Definitions
		Red	Amber	Green	
Patient Complaints	Inpatient and Emergency	>0	N/A	0	The number of formal complaints received by the Trust where the primary area of complaint is the relevant ward location. The RAG status applied to the 'All Wards' figures is based on a ward average (mean).
Feedback	% Positive Responses	<90%	>=90% and <95%	>=95%	The Friends and Family Test is a nationally mandated Patient feedback opportunity given to inpatients upon discharge. A 'Positive Response' is a response of either 'Very Good' or 'Good' to the core question of 'Thinking about the service we provide, overall, how was your experience of our service?'. Please note that figures for the maternity and neo-natal wards are taken from the Maternity Friends and Family Test and not the Inpatient Friends and Family Test. Please also note that responses may relate to Hospital Stays in earlier months due to the time it takes to receive and process them. All figures exclude 'Don't Know' responses and responses where the core question has not been answered.
	FFT				
	Number of Responses	N/A	N/A	N/A	

Safer Staffing Dashboard - July-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 - July-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			
% RN / Midw. % Care Staff Hours			
% RN / Midw. % Care Staff Hours			
RN / Midwives Care Staff			
Overall Day RN / Midwives			
Care Staff Overall Night			
HR Metrics Sickness Rate Turnover Rate Vacancy Rate	HealthRoster	10th - 15th of each month (Sickness and Turnover Rates); by 7th of each month (Vacancy Rate)	Figures for the Sickness and Turnover Rates are taken from the Caregroup End of Month Workforce reports produced and distributed by the Workforce Information Team. Figures for the Vacancy Rate are taken from the month end columns of the weekly Bank and Agency Report produced and distributed by the Workforce Information Team.
Temporary Staffing Prop. Bank Hours Prop. Agency Hours	HealthRoster	By the 7th of each month	Figures are taken from the month end columns of the weekly Bank and Agency Report produced and distributed by the Workforce Information Team.
Accreditation	Professional Standards Lead Nurse		Each month the Professional Standards Lead Nurse sends an email to notify of any changes to the accreditation status of any wards

Safer Staffing Dashboard - July-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 5.1.1)

	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 Ulcers' measure additionally filters for incidents with a Category of Pressure Ulcer' along with a Subcategory indicating Grade 2, 3 or 4. The 'Falls' measures additionally filter for incidents with a Subcategory containing 'Slip, Trip or Fall' and split by Severity to distinguish between No Harm and Harm.
	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.



Torbay and South Devon
NHS Foundation Trust

Financial Performance Report

Month 4

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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 July 2026 and forecast outturn (FOT) for the year ending 31st March 2027.

Year to date revenue position on plan, with key variances noted:

- Industrial Action Strike costs and income loss (£0.4m adverse)
- NR release of balance sheet flex (£0.4m favourable)
- Income Provision for activity lost due to EPR (£2.9m adverse)
- ASC and CHC overspends on packages of care (£0.6m adverse)
- Underspends on corporate budgets (£0.6m favourable)
- Other underspends mainly relating to undrawn reserves for inflation and growth (£2.9m favourable)

Forecast revenue position on plan, with key risks noted:

- Forecasting breakeven outturn but with base case delivery risks of £11.6m relating to low maturity CIP and impact of EPR on contract activity
- Base case forecast suggests risk of £7.2m against planned ULP

Year to Date CIP position £0.0m variance to plan:

- CIP delivery YTD of £9.6m against a £9.6m target
- The percentage of schemes assessed as fully developed has increased to 90% (£49.2m)
- Forecast CIP is on plan at £54.4m, but with lower recurrent delivery than planned (£4.9m adverse) and with indicators of delivery risk emerging.

Workforce Update

- The Trust is reporting worked WTEs 124 below plan.
- Bank and agency spend is below 2025-26 runrate, but above plan and national cap limits

Plan	YTD / Forecast	Measure	Month 04 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	(11.2)
Revenue Plan	Forecast	Recurrent Risk to Underlying Position	(7.2)
CIP Plan	YTD	Variance to Target (Adverse) / Favourable	(0.0)
CIP Plan	Forecast	Variance to Recurrent Target (Adverse) / Favourable	(4.9)
Capital Plan	YTD	Variance to Plan (Overspend) / Underspend	0.8
Cash Plan	YTD	Unplanned Cash Support	0.0
Cash Plan	Forecast	Unplanned Cash Support	0.0

Capital programme update:

- Year to date capital plan £0.8m underspend
- Forecast to deliver full programme, including additional allocation of £2.3m National PDC

Cash Update:

- The Trust closing cash balance for Month 4 was (£7.7m) below plan due to late payment from Torbay Council (cash has now been received).
- The Trust is not forecasting a need for cash support however risks have been identified that if not mitigated, may require PDC revenue support in M09-M12.

The Finance Committee is requested to agree the overall assurance level relating to the financial position of the Trust as **MODERATE** 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 4 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 July shows a month end position of **£8.2m** deficit, as planned. The position excluding DSF is **£27.5m** deficit at the end of July, as planned. The Trust was on plan overall, but with the following significant variances noted within this balanced position: costs of cover and lost income from Industrial Action (£0.4m adverse to plan) offset with non-recurrent balance sheet flex released to meet these costs (£0.4m favourable to budget), a provision against contract income was made to recognise activity lost through EPR implementation (£2.9m adverse to plan). These adverse variances were offset by other favourable budget variances (£2.9m favourable to plan) mainly undrawn reserves funding for inflation and growth. Adverse variances on frontline budgets were offset by underspends on corporate budgets, but the combined overspend on ASC and CHC packages of care £0.6m presents an ongoing risk reflecting recent high cost packages of care.

EPR implementation has significantly disrupted the Trust's operational productivity and ability to accurately capture and quantify contract earnings. Trust included a provision for underperformance against contract of c£2.9m in the position. Latest analysis suggests that the variance to contract (including some high level assumptions about corrections due to data quality and counting and coding issues) may be closer to £1.8m. The Trust is working at pace to identify and address issues, recover lost productivity and to project required activity levels and costs to deliver RTT performance

The Trust is forecasting delivery of the planned outturn but recognises forecast risks to delivery of between **£11.6m** in the base case and up to **£27.2m** in the downside risk assessment (with £7.2m risk to the ULP in the base case and £13.9m in the 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 4 the Trust has recognised CIP delivery of **£9.6m** against a **£9.6m** target (**£0.0m** variance to plan). Since the plan was submitted intensive work is continuing to be undertaken on developing the CIP plans. Fully developed plans have increased by £0.1m and low risk schemes have increased by £0.3m. The Trust is forecasting full delivery of the £54.4m target.

The Trust is reporting a cash balance of **£12.8m** as at 31st July 2026, **£7.7m lower** than planned, primarily due to a delay in receiving **£6.2m** regular contractual receipts from Torbay Council for M4, not received until after ledger close. 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 4 the Trust has spent **£6.0m** of capital compared to plan of **£6.7m**, an underspend of **£0.8m**. The Trust is forecasting to spend up to capital limits, including an additional £2.3m National PDC Capital including Tower Fire Safety and SDEC schemes.

The Finance Committee is requested to agree the overall assurance level relating to the financial position of the Trust as **MODERATE** 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	Passthrou gh	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	(7.3)	(7.8)	(0.5)	(29.9)	(30.6)	(0.7)	(81.9)	(88.5)	(6.6)	(0.7)	0.3	(0.0)	(0.5)	0.0	(0.4)
Medicine and Urgent Care	(8.4)	(8.4)	0.0	(33.1)	(33.1)	0.1	(94.6)	(98.7)	(4.1)	0.1	0.1	(0.2)	0.3	0.0	(0.2)
Planned Care and Surgery	(13.7)	(14.1)	(0.4)	(54.0)	(55.6)	(1.6)	(154.3)	(164.7)	(10.4)	(1.6)	0.6	(1.6)	(0.0)	(0.0)	(0.6)
Adult Social Care – Torbay	(2.3)	(3.0)	(0.7)	(9.6)	(10.7)	(1.0)	(23.8)	(29.6)	(5.8)	(1.0)	0.0	(0.0)	(0.3)	0.0	(0.7)
Total Frontline Services	(31.7)	(33.2)	(1.5)	(126.6)	(129.9)	(3.3)	(354.6)	(381.5)	(26.9)	(3.3)	1.1	(1.8)	(0.6)	0.0	(2.0)
Corporate	(5.3)	(5.0)	0.3	(21.2)	(19.4)	1.9	(62.7)	(60.4)	2.3	1.9	0.6	0.3	(0.4)	0.0	1.3
Workplace (Estates)	(2.4)	(2.6)	(0.2)	(9.8)	(10.3)	(0.4)	(29.0)	(31.2)	(2.2)	(0.4)	(0.0)	0.2	(0.2)	0.0	(0.4)
Total Professional Support Services	(7.7)	(7.6)	0.1	(31.1)	(29.7)	1.4	(91.7)	(91.6)	0.1	1.4	0.6	0.5	(0.6)	0.0	0.9
Healthcare Contract Income	36.1	36.0	(0.1)	143.4	140.5	(2.9)	431.0	435.8	4.8	(2.9)	(2.4)	0.0	(0.0)	0.0	(0.6)
Reserves	(0.6)	(0.1)	0.5	(3.6)	(0.3)	3.3	(12.6)	8.6	21.2	3.3	(1.8)	2.0	2.9	0.0	0.2
Prior Periods	0.1	1.1	1.0	0.2	1.6	1.4	1.0	1.6	0.6	1.4	0.0	0.0	(0.1)	0.0	1.4
Other Trust Budgets	(2.6)	(2.6)	0.0	(9.8)	(9.6)	0.2	(30.8)	(30.6)	0.2	0.2	0.6	(0.0)	(0.4)	0.0	(0.0)
Other Budgets	32.9	34.3	1.4	130.2	132.1	1.9	388.6	415.4	26.8	1.9	(3.6)	2.0	2.4	0.0	1.0
Total Excluding Deficit Support Funding (DSF)	(6.5)	(6.5)	(0.0)	(27.5)	(27.5)	(0.0)	(57.8)	(57.8)	(0.0)	(0.0)	(1.9)	0.7	1.2	0.0	(0.0)
Deficit Support Funding (DSF)	4.8	4.8	0.0	19.3	19.3	0.0	57.8	57.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Including Deficit Support Funding (DSF)	(1.7)	(1.7)	(0.0)	(8.2)	(8.2)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(1.9)	0.7	1.2	0.0	(0.0)

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 July shows a month end position of **£8.2m** deficit, as planned. The position excluding DSF is **£27.5m** deficit at the end of July, as planned.

The Trust was on plan overall, but with the following significant variances noted within this balanced position:

- costs of cover and lost income from Industrial Action (£0.4m adverse to plan) offset with non-recurrent balance sheet flex released to meet these costs (£0.4m favourable to budget),
- a provision against contract income was made to recognise activity lost through EPR implementation (£2.9m adverse to plan).
- ASC and CHC costs are significantly above budget (£0.6m adverse) due to very costly new packages of care, offset with corporate budget underspends.
- These adverse variances were offset by other favourable budget variances (£2.9m 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 **£11.6m** in the base case and up to **£25.8m** in the downside risk assessment, with risk to the recurrent underlying position of £11.2m (base case) and £17.9m (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 **moderate 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 4 YTD (Risks) / Mitigations £M	Forecast Outturn				
				Downside Risk	Difference Worst to Base Case	Base Case	Difference Best to Base Case	Upside Risk
				(Risks) / Mitigations £M	(Risks) / Mitigations £M	(Risks) / Mitigations £M	(Risks) / Mitigations £M	(Risks) / Mitigations £M
Plan			(8.2)	0.0	0.0	0.0	0.0	0.0
CIP	Delivery Risk ASC	NR	0.0	(2.2)	0.0	(2.2)	2.2	0.0
CIP	Delivery Risk acute beds and safer staffing	R	0.0	(1.5)	0.0	(1.5)	1.5	0.0
CIP	Delivery Risk held growth	R	0.0	(2.5)	0.0	(2.5)	2.5	0.0
CIP	Delivery Risk provision on other higher risk schemes	R	0.0	(8.9)	(5.7)	(3.2)	3.2	0.0
CIP	In Year slippage on recurrent schemes	NR	(4.8)	(4.8)	0.0	(4.8)	4.8	0.0
CIP	Delivery on Non-Recurrent Schemes	NR	4.8	4.8	0.0	4.8	(4.8)	0.0
Elective Recovery	Capped ERF Delivery	NR	0.0	(1.3)	(1.3)	0.0	0.0	0.0
Elective Recovery	Loss of Activity due to EPR Implementation	NR	(2.9)	(2.9)	0.0	(2.9)	0.0	(2.9)
Elective Recovery	Recovery of Activity within Financial Envelope	NR	0.0	0.0	(2.9)	2.9	0.0	2.9
Other Plan Variances	Industrial Action - Costs	NR	(0.4)	(1.2)	(0.8)	(0.4)	0.0	(0.4)
Other Plan Variances	Industrial Action - Funding	NR	0.0	0.0	0.0	0.0	0.4	0.4
Other Plan Variances	High Cost Drugs - ICB Risk Share Proposal	NR	0.0	(2.0)	0.0	(2.0)	0.0	(2.0)
Other Plan Variances	High Cost Drugs - Revert to full 12 month gain share	NR	0.0	0.0	(2.0)	2.0	0.0	2.0
Other Plan Variances	Winter Cost Pressures	NR	0.0	(0.5)	0.0	(0.5)	0.0	(0.5)
Other Plan Variances	Winter Cost Pressures Mitigation	NR	0.0	0.0	(0.5)	0.5	0.0	0.5
Other Plan Variances	ASC/PP overspends	NR	(1.3)	(3.9)	(1.4)	(2.5)	2.5	0.0
Other Plan Variances	ASC/PP gain from 2025-26	NR	0.7	0.7	0.0	0.7	(0.7)	0.0
Other Plan Variances	Slippage on reserves	NR	2.9	0.0	0.0	0.0	0.0	0.0
Other Plan Variances	Other Operational Budget Underspends	NR	0.6	0.0	0.0	0.0	0.0	0.0
Inflationary Pressures	Nurse Band 5 Job Profile Review Costs	R	0.0	(2.0)	(1.0)	(1.0)	0.0	(1.0)
Inflationary Pressures	Nurse Band 5 Job Profile Review Funding	R	0.0	1.0	0.0	1.0	0.0	1.0
Net Risks			(0.4)	(27.2)	(15.6)	(11.6)	11.6	0.0
Mitigations	Balancesheet Flexibility	NR	0.4	0.0	(0.5)	0.5	(0.5)	0.0
Mitigations	Unidentified Mitigations	NR	0.0	27.2	16.1	11.1	(11.1)	0.0
Mitigations			0.4	27.2	15.6	11.6	(11.6)	0.0
Plan Net Risk to Forecast			(0.0)	0.0	0.0	0.0	0.0	0.0
Outturn			(8.2)	0.0	0.0	0.0	0.0	0.0
	Net Non-Recurrent (Risk)/ Mitigation	NR	(0.0)	13.9	6.7	7.2	(7.2)	0.0
	Net Recurrent (Risk)/ Mitigation	R	0.0	(13.9)	(6.7)	(7.2)	7.2	0.0
Plan Underlying Deficit				(65.0)	0.0	(65.0)	0.0	(65.0)
Forecast Recurrent Risk	Total Trust ULP Risk	R	0.0	(13.9)	(6.7)	(7.2)	7.2	0.0
Forecast Underlying Deficit				(78.9)	(6.7)	(72.2)	7.2	(65.0)

The Trust is forecasting achievement of the breakeven revenue plan but recognises forecast risks to delivery of £11.6m in the base case, with up to £27.2m in downside risk.

The risks to ULP are estimated at between £7.2m in the base case and £13.9m in the downside risk.

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: Continue to pursue High Cost Drugs Gain Share through Devon ICB.

Action: Work with Performance and Ops teams to forecast impact of data corrections, productivity improvements and proposed additional capacity on contract delivery.

Forecast Risks and Mitigations



Torbay and South Devon
NHS Foundation Trust

CIP Risk (base assumption £9.4m adv): The Trust recognises risk to plan delivery of between £0m and £15.1m. At Month 4 10% of CIP schemes were still plans in progress / opportunity. The base forecast reflects an increase in risk, with delivery risk on CIP increasing, particularly on ASC, acute beds and held growth reserves schemes. As well as £6.2m delivery risk around these schemes the base forecast recognises a 25% delivery risk on all others schemes starting to trigger higher delivery risk flags at £3.2m risk. The base case reflects an assumption that 75% of all other higher risk schemes do not deliver, with a risk of £8.9m.

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 £0.0m adv): Data quality issues are preventing full assessment of contract activity and earnings, a provision was made against contract income in month 4 of £2.9m relating to variably funded income, with an assumption that income lost year to date can be recovered through Q2-4 at cost. The downside risk of £4.5m recognises the risk of sustained underperformance not fully matched by underspends.

Industrial Action Loss (base assumption £0.4m adv): Industrial action impacts of £0.4m 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 there are no further instances of industrial action and that no funding is made available to cover the costs that have been incurred to date.

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. The ICB has indicated willingness to meet the terms assumed by provider plans, this is not yet formalised.

Winter Cost Pressures (base assumption £0.0m adv): The Trust's Winter cost pressure from 2025-26 was c£0.5m. The base case assumes that the operational pressures are mitigable within planned capacity developments such as frailty expansion.

ASC Overspends (base assumption £1.8m adv): The Trust has overspent by £0.6m across ASC and CHC due to high costs of new packages of care, which includes a £0.7m non-recurrent benefit. The base case assumes this cost pressure continues unmitigated in forecast and the base case assumes that there will be some reductions to runrate during the year.

Other Operational Budget Over/Underspends (base assumption £0.0m adv): The Trust's reserves and operational budgets are underspent in Month 4, 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 of the funding available in CUF for reviewing Band 5 nurse job profiles is c£1.0m. 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 £0.5m fav): In the base case and downside risk forecast assumes deployment of remaining balancesheet flex to offset non-recurrent cost pressures.

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 202627 - Profiled



Torbay and South Devon
NHS Foundation Trust

The Trust forecast is profiled for delivery below, inline with the plan trajectory.

TAC30 description	Sum of Month 01	Sum of Month 02	Sum of Month 03	Sum of Month 04	Sum of Month 05	Sum of Month 06	Sum of Month 07	Sum of Month 08	Sum of Month 09	Sum of Month 10	Sum of Month 11	Sum of Month 12	Full Year Budget	Total Forecast	Forecast Variance
Income from patient activities	53.8	52.6	51.9	54.5	54.0	55.1	55.9	54.7	55.1	56.8	55.5	57.9	648.9	657.9	9.0
Other Operating Income	3.1	2.9	3.4	5.1	3.9	3.7	3.8	3.8	3.8	3.8	3.8	3.9	40.7	45.1	4.4
Operating expenditure - Pay	(32.0)	(31.8)	(31.8)	(32.6)	(32.4)	(32.5)	(32.8)	(32.2)	(32.2)	(31.9)	(31.9)	(28.9)	(377.1)	(383.0)	(5.9)
Operating expenditure - Non Pay	(30.5)	(30.4)	(29.6)	(33.0)	(31.1)	(31.2)	(31.2)	(30.6)	(31.0)	(31.0)	(29.4)	(32.0)	(361.3)	(370.9)	(9.7)
Finance expenditure	(1.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(3.0)	(3.1)	(0.1)
Finance income	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.6	1.6	0.0
Misc non-operating items	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(7.6)	(5.3)	2.3
Other gains/(losses)	(0.1)	0.1	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
Total Excluding Deficit Support Funding (DSF)	(7.1)	(7.2)	(6.6)	(6.5)	(6.2)	(5.5)	(4.7)	(4.7)	(4.6)	(2.7)	(2.5)	0.5	(57.8)	(57.8)	0.0
Deficit Support Funding (DSF)	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	57.8	57.8	(0.0)
Total Including Deficit Support Funding (DSF)	(2.3)	(2.4)	(1.8)	(1.7)	(1.3)	(0.6)	0.1	0.1	0.2	2.1	2.3	5.3	(0.0)	(0.0)	0.0

Forecast Bridge to Runrate



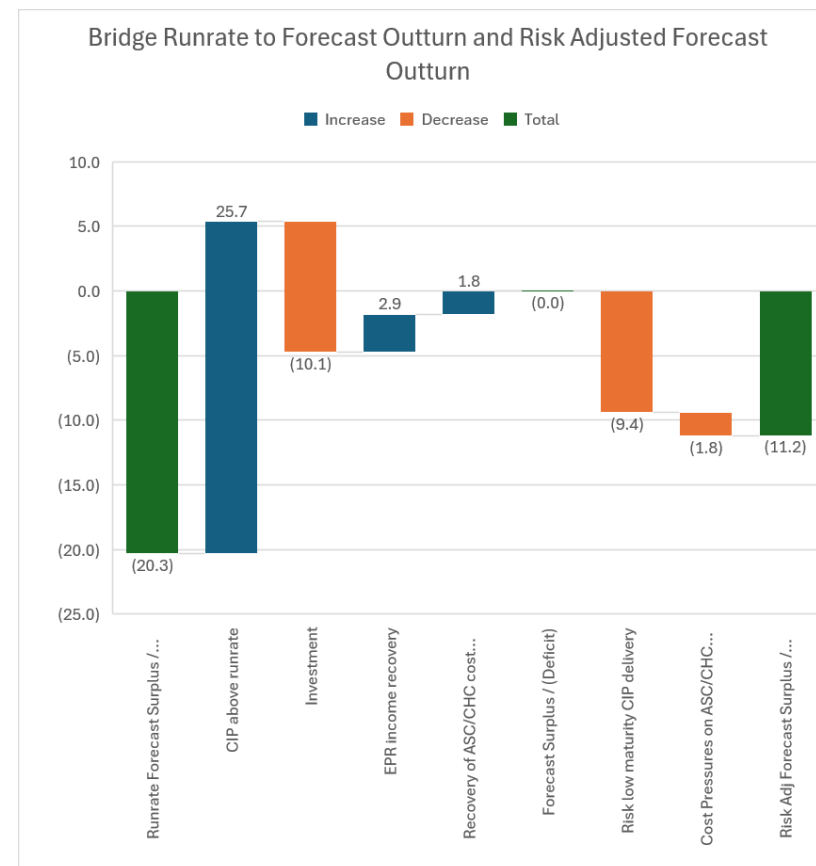
Torbay and South Devon
NHS Foundation Trust

Year to Date to Forecast Bridge	£M
YTD Surplus/(Deficit)	(8.2)
Adjust non-recurrent Industrial Action - Costs	0.4
Adjust non-Recurrent Industrial Action - Income	(0.4)
Adjust non-Recurrent Provision for EPR lost activity	2.9
Adjust other non-recurrent transactions	(0.8)
Recurrent YTD Surplus/(Deficit)	(6.1)
Recurrent Monthly Runrate	(1.5)
Recurrent runrate (M5-12)	(12.1)
Runrate Forecast Surplus / (Deficit)	(20.3)
CIP above runrate	25.7
Investment	(10.1)
EPR income recovery	2.9
Recovery of ASC/CHC cost pressures	1.8
Industrial Action Funding	0.4
Other	(0.4)
Forecast Surplus / (Deficit)	(0.0)
Risk low maturity CIP delivery	(9.4)
Continuation of ASC and CHC cost pressures	(1.8)
Risk Adj Forecast Surplus / (Deficit)	(11.2)

The Trust's detailed forecast for Month 4 reflects an expectation of full CIP plan delivery, commitment in full of all Trust reserve budgets for months 5-12 and recovery of income lost in EPR implementation phase up to full contract value to achieve breakeven.

This forecast requires run rate improvements of £2.54m 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 £9.4m and ASC/CHC continuing cost pressures to give a base adjusted risk to forecast of £11.2m.



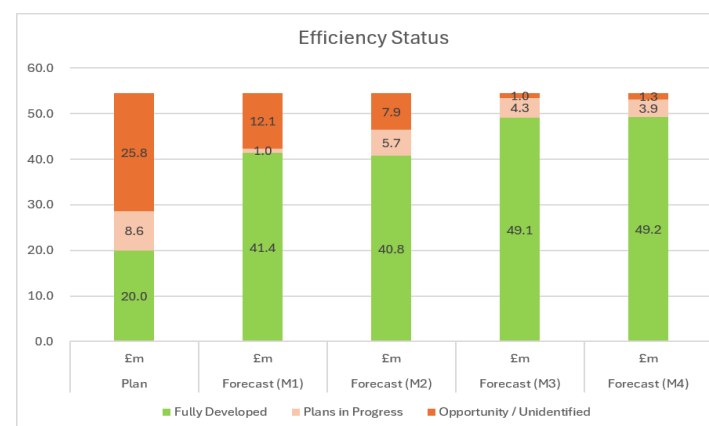
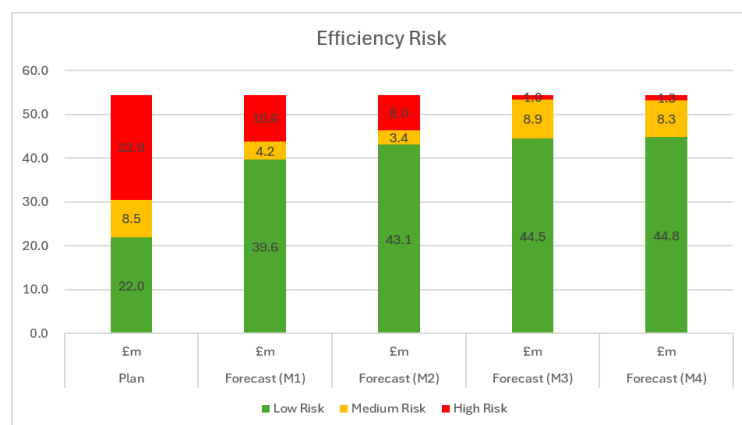
Efficiencies – Maturity and Risk



Torbay and South Devon
NHS Foundation Trust

	M4			Forecast Outturn		
	Plan CIP delivery £m	Actual CIP Delivery £m	Var +/- £m	Plan for the year £m	Forecast £m	Var +/- £m
Recurrent efficiencies	8.8	4.0	(4.8)	43.4	38.5	(4.9)
Non-recurrent efficiencies	0.8	5.6	4.8	11.0	16.0	4.9
Total	9.6	9.6	(0.0)	54.4	54.4	(0.0)
Recurrent %	92%	42%		80%	71%	
Non-recurrent %	8%	58%		20%	29%	

Year to date, the Trust has fully delivered savings against a £9.6m target, though this has been heavily supported with non-recurrent savings. 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, fully developed plans have increased by £29.2m. However, whilst good progress has been made significant delivery risks are emerging, particularly around ASC, acute beds and held growth reserves, with **limited assurance** around delivering the full efficiency requirement.

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	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0	7	2	5
Pay - substantive	(120.7)	(119.7)	1.0	(356.0)	(355.6)	0.5	6,154	5,921	233
Pay - bank	(5.8)	(6.9)	(1.1)	(17.0)	(21.9)	(4.9)	258	352	(94)
Pay - agency	(1.4)	(1.6)	(0.2)	(4.1)	(5.6)	(1.5)	36	56	(20)
Grand Total	(127.9)	(128.2)	(0.3)	(377.3)	(383.2)	(5.9)	6,454	6,330	124

At the end of July 2026, there are 124 worked WTE less than plan. At Month 4, undelivered CIP is higher than plan (103 WTE), offset with vacancies, including growth reserves (99 WTE vacancy).

At an average salary rate 124 WTE vacancy should equate to c£2.2m pay underspend and the Trust is reporting a £0.3m pay overspend. There are a variety of cost pressures which are driving this c£2.5m variance, significant impacts listed below:

- Redundancy costs (pay cost with no WTE impact) **£0.2m**
- Maternity cover (salary costs continue with no worked WTE) **£0.7m**
- Bank and agency premium (Trust has 114 worked WTEs above plan for agency and bank that were budgeted as substantive workers **£1.0m**
- Locally agreed session (pay cost with no worked WTE) **£0.5m**
- There remains some issues with the workforce assumptions allocation between planned care and reserves budgets which will be resolved in M5.

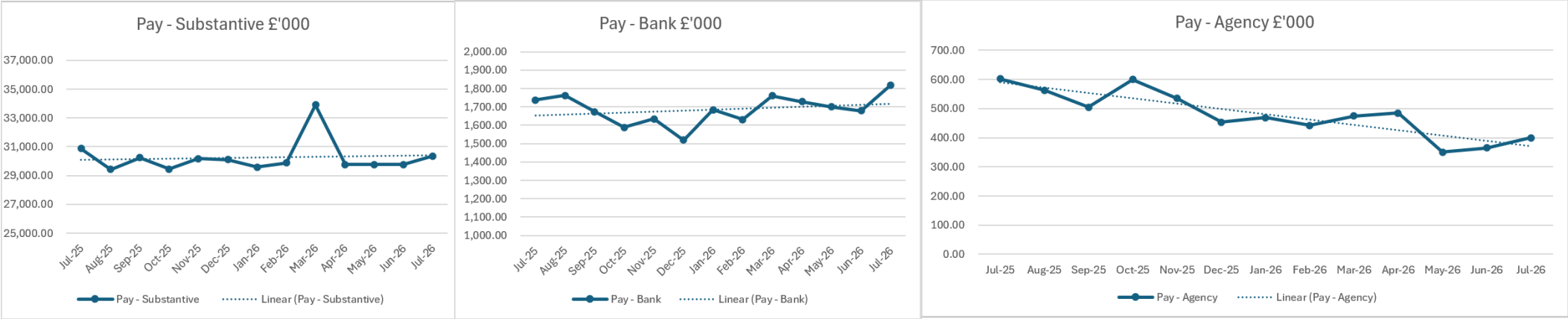
WTE	Narrative
5,975	ESR Reported contracted WTE 31st July 2026
56	Agency
352	Bank
95	Overtime and additional hours
(120)	Maternity and adoption leave
(28)	Sickness
6,330	Total reported worked WTEs 31st July 2026

Action: Trust will process budget and planned workforce distribution corrections between planned care and reserves in M5.

Workforce Trend

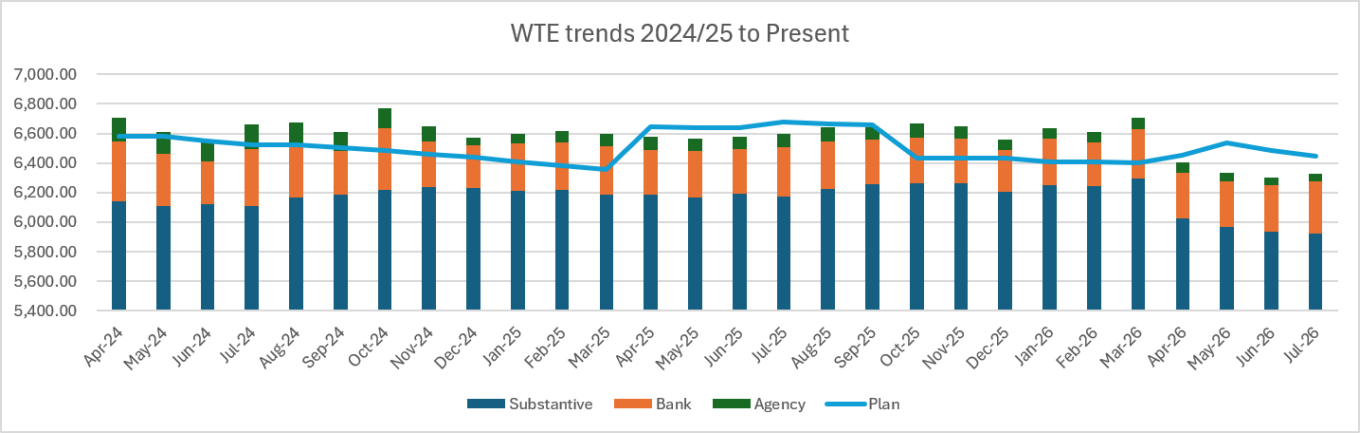


Torbay and South Devon
NHS Foundation Trust



Agency nursing spend has reduced significantly from Month 1 (and run rate) 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.



Contract Activity & Income



Torbay and South Devon
NHS Foundation Trust

Elective Recovery Risk – EPR Activity Loss: Data quality issues are preventing full assessment of contract activity and earnings, a provision of £2.9m was made against lost income. An assessment of activity against plan and contract has been undertaken and is included below and suggests that this provision may have been greater than required by c£1.1m. This assessment includes several significant assumptions, including £1.0m adjustment on outpatient activity including a procedure, where analysis suggests that a procedure may have taken place but was not been recorded.

The table below shows the Trust M4 plan position against initial actual activity view and then against adjusted activity view to reflect the estimate of the changes we expect to flow when data quality issues are resolved – totalling £1.7m above reported activity income.

				Activity		Income		Initial Plan Variance		Adjustments		Actuals		Plan Variance	
				26/27 Plan	26/27 Actual	26/27 Plan	26/27 Actual	Plan v Actual Activity Variance	Plan v Actual Income Variance	Activity Adjustments	Income Adjustments	Adjusted 26/27 Actual Activity	Adjusted 26/27 Actual Income £	Plan v Adjusted Actual Activity Variance	Plan v Adjusted Actual Income Variance
Is ERF	Data Type	Setting	Attendance Type												
Yes	APC	Day Case & RDA	Spell	12,330	10,538	12,285,551	10,596,598	-1,792	-1,688,953	228	114,000	10,766	10,710,598	-1,564	-1,574,953
		Elective	Spell	1,103	775	4,962,331	4,196,088	-328	-766,242	0	0	775	4,196,088	-328	-766,242
		APC Total			13,433	11,313	17,247,881	14,792,686	-2,120	-2,455,195	228	114,000	11,541	14,906,686	-1,892
	OPA	First	Attendance	28,688	23,928	6,606,036	5,468,236	-4,760	-1,137,799	1,920	651,214	25,848	6,119,450	-2,840	-486,586
			Procedure	9,912	8,724	2,071,551	1,574,031	-1,188	-497,521	493	114,176	9,217	1,688,207	-695	-383,345
		Follow-up	Procedure	24,605	19,219	5,368,137	3,671,205	-5,386	-1,696,932	3,460	864,247	22,679	4,535,451	-1,926	-832,686
	OPA Total			63,204	51,871	14,045,724	10,713,472	-11,333	-3,332,252	5,873	1,629,636	57,744	12,343,108	-5,460	-1,702,616
	Yes Total			76,638	63,184	31,293,605	25,506,158	-13,454	-5,787,448	6,101	1,743,636	69,285	27,249,794	-7,353	-4,043,812
	Grand Total			76,638	63,184	31,293,605	25,506,158	-13,454	-5,787,448	6,101	1,743,636	69,285	27,249,794	-7,353	-4,043,812

List of activity and income adjustments are:

SDEC to APC movement reflects the late national guidance confirming SDEC should be recorded as APC, not emergency activity. An estimated activity and tariff impact change has been added to the M3 position.

Not in SUS Data-activity identified that has not been submitted nationally. Estimate of what data type this activity is and an associated income tariff.

OPA Community to Acute - where activity is flagged as Community in Epic but, is actually Acute activity. Applied relevant acute HRG income tariffs.

OPA Pathway Change - Epic recording has meant that some pathways have changed. This means some activity is not showing as expected and we believe understating the activity and therefore, income earned. An estimate of the income expected has been added.

OPA Procedure Backcoding - adjustment added where activity in Epic has not been correctly flagged as an outpatient procedure. Estimate of this activity and income has been included

Non Elective Best Practice Tariff (BPT) - this has not been applied in the processed income files. A BPT tariff value has been added to match to plan values at M4

This table shows the adjusted Trust position (as above) compared to the Commissioner plan values. This view shows an estimated underperformance against Commissioner plans of c£1.8m (£2.8m M3), compared to £4m against the Trust plan view.

				26/27 Plan	26/27 Plan £	Commissioner Adjusted Plan Vol	Commissioner Adjusted Plan £	Adjusted 26/27 Actual Activity	Adjusted 26/27 Actual Income £	Plan v Adjusted Actual Activity Variance	Plan v Adjusted Actual Income Variance
Is ERF	Data Type	Setting	Attendance Type								
Yes	APC	Day Case & RDA	Spell	12,330	12,285,551	10,672	11,615,524	10,766	10,710,598	94	-904,926
		Elective	Spell	1,103	4,962,331	654	4,444,478	775	4,196,088	121	-248,390
	APC Total			13,433	17,247,881	11,326	16,060,002	11,541	14,906,686	215	-1,153,316
	OPA	First	Attendance	28,688	6,606,036	27,780	6,304,119	25,848	6,119,450	-1,932	-184,669
		First	Procedure	9,912	2,071,551	9,912	2,071,551	9,217	1,688,207	-695	-383,345
		Follow-up	Procedure	24,605	5,368,137	23,311	4,576,650	22,679	4,535,451	-631	-41,199
	OPA Total			63,204	14,045,724	61,002	12,952,320	57,744	12,343,108	-3,258	-609,212
	Yes Total			76,638	31,293,605	72,328	29,012,322	69,285	27,249,794	-3,043	-1,762,529
	Grand Total			76,638	31,293,605	72,328	29,012,322	69,285	27,249,794	-3,043	-1,762,529

Productivity



Torbay and South Devon
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.

Productivity Metrics (national data) – M12 25/26 vs M12 24/25

M12	M12 2526 vs M12 2425
Inflation adj. expenditure growth	1.50%
Cost weighted activity growth	-0.30%
Implied productivity growth	-1.80%

- 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 12, implied productivity has deteriorated from same period in 24/25 by 1.8%. The position to M11 was 3.3% favourable, this movement is likely to be due to significant year-end transactions.
- 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%.

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.



Torbay and South Devon
NHS Foundation Trust

Finance Plan Delivery - Capital and Cash

Cash Position



Torbay and South Devon
NHS Foundation Trust

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	(5.3)	(5.2)	0.0	7.1
Capital Non-Cash movements (depr&amort)	8.5	8.5	(0.0)	25.3
Working Capital Movement	(2.7)	(9.3)	(6.6)	(8.4)
Net cash generated from / (used in) operations	0.5	(6.1)	(6.6)	24.0
Net Capital Expenditure (Purchase/Disposals)	(25.3)	(14.3)	11.0	(43.0)
Interest Received	0.5	0.6	0.0	1.6
Net cash generated from/(used in) investing activities	(24.8)	(13.7)	11.0	(41.4)
PDC paid/received	8.2	0.0	(8.2)	(1.2)
Loans paid/received	(0.7)	(0.7)	0.0	(2.0)
Capital on finance leases and PFI	(1.4)	(1.4)	0.0	(5.1)
Interest element on loans, finance lease and PFI	(0.7)	(0.6)	0.1	(2.1)
Net cash generated from/(used in) financing activities	5.4	(2.8)	(8.1)	(10.4)
Closing cash balance	20.5	12.8	(7.7)	7.7

Cash Risk: Non-cash backed balance sheet releases and failure to meet CIP targets remain as potential risks. The M04 contracted income from Torbay Council was received on 31st July after the ledger closed and the total contractual amount for the year has been confirmed, however late receipt of these amounts (after final Wednesday each month) still presents a moderate risk. A payment schedule for the full financial year has been requested.

The closing cash balance for M4 is £7.7m lower 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 is **£6.6m** below plan, primarily driven by the delay in receipt of the scheduled M4 payment of **£6.2m** from Torbay Council (received in M5).
- Investing activities show a **£11.0m** positive variance, reflecting slower than planned defrayal of capital accruals.
- **£8.2m** PDC per the plan has not been drawn accounting for the variance in financing activities.

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(5.2)
Finance income	0.6
Finance expense	(1.6)
PDC dividend expense	(2.0)
Other gains/(losses) including disposal of assets	(0.0)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(8.4)
Capital donations/grants/peppercorn lease I&E impact	(0.3)
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.4
TOTAL Provider Surplus/(Deficit) - System performance measure	(8.2)

Cash Forecast



Torbay and South Devon
NHS Foundation Trust

	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27
Start Date 01.08.2026	£m	£m	£m	£m	£m	£m
Cash Balance B/F	18.6	14.8	6.2	16.5	10.3	0.9
Total Receipts	59.5	58.1	77.1	56.4	56.5	71.1
Total Payments	(63.3)	(66.7)	(66.8)	(62.6)	(65.9)	(59.4)
Net Movement	(3.8)	(8.6)	10.3	(6.2)	(9.4)	11.7
Cash Balance C/F	14.8	6.2	16.5	10.3	0.9	12.6

The Month 4 cashflow forecast has been prepared on the following basis:

- The forecast for M05 – M10 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 any 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 4 Trust capital 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 and is received quarterly in advance.
- This forecast assumes significant non-cash backed balance sheet releases are not required to support the position.

Capital Programme and Funding Sources



Torbay and South Devon
NHS Foundation Trust

Gross capital expenditure	YTD M4			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Property, land and buildings	0.9	2.8	1.9	9.1	18.1	9.0
Plant and equipment	0.9	1.8	0.9	3.3	4.4	1.1
IT	3.7	1.9	(1.7)	9.0	4.2	(4.8)
Other	1.3	0.0	(1.3)	2.6	0.5	(2.1)
Disposals / other deductions	0.0	0.0	0.0	0.0	(0.5)	(0.5)
Gross capital expenditure	6.8	6.5	(0.3)	24.0	26.8	2.7
Less PFI capital (IFRIC12)	0.0	0.0	0.0	(0.7)	(0.7)	(0.0)
Gross capital expenditure (excluding PFI/IFRIC12 impact)	6.8	6.5	(0.3)	23.3	26.0	2.7
Less grants, donations and peppercorn leases	(0.0)	(0.5)	(0.5)	(0.1)	(0.5)	(0.4)
Total CDEL (Including National PDC)	6.7	6.0	(0.8)	23.2	25.5	2.3
Total CDEL (Excluding National PDC)	6.7	5.8	(0.9)	22.3	22.3	(0.0)

Capital Cash Sources	YTD M4			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
National PDC Funding	0.0	0.2	0.2	0.9	3.2	2.3
Capital Support PDC	0.0	0.0	0.0	1.1	1.1	0.0
Depreciation	8.5	8.5	(0.0)	25.3	25.3	(0.0)
Lease funding	1.4	0.0	(1.4)	3.6	2.0	(1.6)
Lease capital repayments	(1.0)	(1.0)	0.0	(3.1)	(3.1)	0.0
PFI Capital repayments	(0.4)	(0.7)	(0.3)	(1.9)	(2.0)	(0.1)
Repayment of Borrowing	(0.7)	(0.7)	0.0	(2.0)	(2.0)	0.0
Donations	0.0	0.5	0.5	0.1	0.5	0.4
Other	(0.3)	0.0	0.3	(0.8)	0.8	1.6
Total Funding Sources	7.5	6.8	(0.7)	23.3	25.9	2.6

Capital CDEL Limits	Forecast Outturn		
	Plan	Forecast	Variance
	£m	£m	£m
Trust CDEL Limit	22.3	22.3	0.0
Trust Funded CDEL	22.3	22.3	0.0
National PDC: Community Diagnostics Centres	0.8	0.3	(0.5)
National PDC: Endoscopy	0.2	0.2	0.0
National PDC: Tower Fire Safety	0.0	1.8	1.8
National PDC: Create standalone SDEC	0.0	1.0	1.0
National PDC Funded CDEL	0.9	3.2	2.3
Total CDEL	23.2	25.5	2.3

Capital Spend Month 4

- At Month 4 the Trust has spent £6.0m of capital compared to plan of £6.7m, an underspend of £0.8m.
- The most significant variance to plan relates to EPR, where spend was £2.0m against a plan of £3.4m, an underspend of £1.4m.
- Community Diagnostics Centres (CDC) funding is forecast to be £0.5m lower than originally planned following agreement to rephase funding as £0.3m in 26/27, £1.7m in 27/28 and £1.0m in 28/29.
- Additional PDC funding of £1.0m has been confirmed for the creation of SDEC.
- LoF funding of £0.5m for surgical robot has been received.

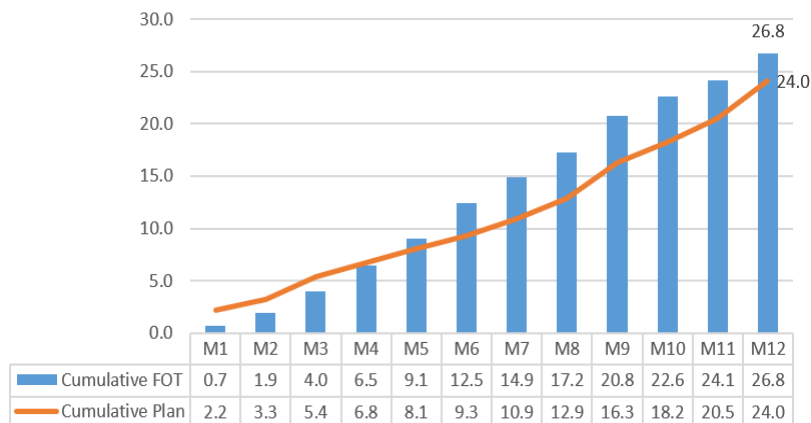
Capital Programme Forecast



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	0.7	1.2	2.0	2.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	6.5
Property, land and buildings	0.1	0.4	1.5	0.8									
Plant and equipment	0.0	0.0	0.0	1.7									
IT	0.6	0.8	0.5	0.0									
Other	(0.0)	0.0	0.0	0.0									
FOT	0.7	1.2	2.0	2.5	2.6	3.4	2.4	2.3	3.6	1.9	1.5	2.6	26.8
Property, land and buildings	0.1	0.4	1.5	0.8	1.8	1.9	2.2	2.2	1.8	1.7	1.3	2.4	18.1
Plant and equipment	0.0	0.0	0.0	1.7	0.3	0.0	0.1	0.0	1.6	0.0	0.1	0.6	4.4
IT	0.6	0.8	0.5	0.0	0.6	1.0	0.2	0.1	0.1	0.1	0.1	0.0	4.2
Other	(0.0)	0.0	0.0	0.0	(0.1)	0.5	0.0	0.0	0.0	0.0	0.0	(0.4)	0.0

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 MoU has been received.
- The Trust is forecasting to spend up to capital limits and continues to bid for additional national funding opportunities as they become available.
- Confirmation has been received of £1.0m PDC funding for the creation of SDEC.

Statement of Financial Position



Torbay and South Devon
NHS Foundation Trust

Statement of Financial Position (SOFP)

	Plan £m	Actual £m	Variance £m
Fixed Assets	320.0	301.6	(18.4)
Other Non-Current Assets (Receivables)	4.0	4.2	0.2
Cash & Cash Equivalents	20.5	12.8	(7.7)
Working Capital (excl cash)	(46.7)	(43.5)	3.2
Non-Current Liabilities (Loans/Leases/Other)	(51.5)	(51.3)	0.2
Total Assets Employed (Assets + Liabilities)	246.4	223.9	(22.5)
Public Dividend Capital	364.2	359.5	(4.7)
Revaluation	60.7	55.0	(5.7)
Surplus / (Deficit) Sub Total	(8.8)	(8.4)	0.4
I&E reserves	(169.8)	(182.4)	(12.6)
Reserves Total	246.4	223.9	(22.5)

Surplus/(Deficit) Reconciliation

	Actual £m
Operating Surplus/(Deficit)	(5.2)
Finance income	0.6
Finance expense	(1.6)
PDC dividend expense	(2.0)
Other gains/(losses) including disposal of assets	(0.0)
Corporation tax expense	(0.0)
Surplus/(deficit) before impairments and transfers	(8.4)
Capital donations/grants/peppercorn lease I&E impact	(0.3)
Impact PFI revenue costs IFRS 16/UK GAAP basis	0.4
TOTAL Provider Surplus/(Deficit) - System performance measure	(8.2)

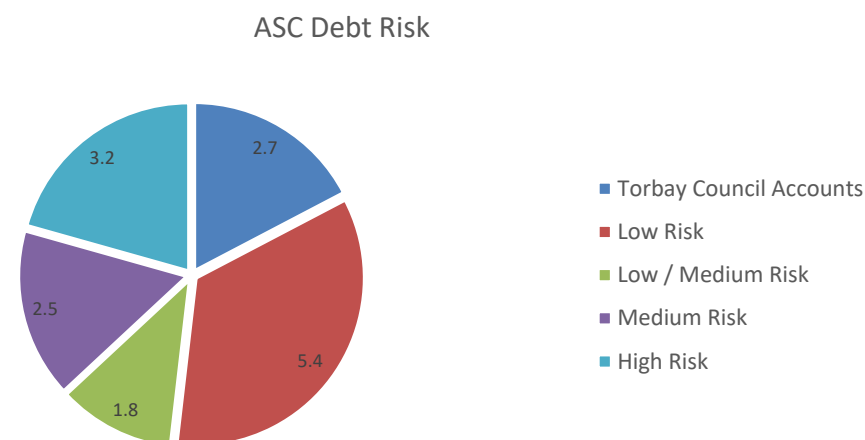
- Fixed assets are **£18.4m** below the plan. This is driven by the 2025/26 asset revaluation of **£15.5m**. The remaining variance reflects capital underspend YTD of £0.3m and movements in capital accruals.
- Cash is **£7.7m** below plan, explained in detail in cashflow report.
- Working capital, excluding cash, shows a **£3.2m** variance. This is mainly due to movements in inventories of £4.9m.
- The revaluation reserve movement of **£5.7m** relates to the DV asset revaluation of **£4.4m**, recognised through reserves, and the transfer of the cumulative revaluation surplus following the disposal of Dartmouth Hospital of £1.3m.
- PDC variance of **£4.7m** reflects the net impact of £3.5m of system capital funding for EPR, allocated late in M12 and therefore not included in the planning return, together with £8.2m of planned Revenue PDC support that had not yet been received by M4.
- I&E reserves variance of **£12.6m** reflects the DV PPE revaluation in 2025/26.

Adult Social Care Client Debt Overview



Torbay and South Devon
NHS Foundation Trust

Debt Type	Risk	£m's
Historic Torbay Council debt	Torbay Council Accounts	0.2
DPA's Torbay Council	Torbay Council Accounts	2.5
Secured - Legal Charges	Low Risk	1.6
Unsecured - Pending DPA	Low Risk	0.8
Unsecured - Pending Property Sale	Low Risk	3.0
Unsecured - Pending Probate	Low / Medium Risk	1.8
Unsecured - Ongoing	Medium Risk	2.5
Unsecured - Static	High Risk	0.6
Unsecured - Legal services	High Risk	2.7
	Total	15.6



ASC Client debt totals £15.6m but circa £2.7m of this debt (Historic / DPA's) is already accounted for within Torbay Council accounts.

Of the remaining £12.9m of Debt within the Trusts accounts £5.4m is deemed as **lower risk**. This incorporates debt with a legal charge against the client's property, debts pending a DPA agreement being completed and debts that are pending the sale of the client's property.

There is £1.8m of debt deemed as **lower / medium risk** this relates to cases that are currently going through the probate system (can be a lengthy process).

There is £2.5m debt relating to clients still with an **ongoing** package of care (**medium risk**).

Finally £3.2m is classified **high risk** which includes £0.6m of **static** in relation to clients no longer receiving an ASC service and £2.7m is with the Trust / Torbay Council **legal** teams. The Trust has resourced additional legal support over the last twelve months to gain greater grip and control over this high-risk element. It is envisaged that over the next 3 months that this legal services debt will be sub-divided between medium / risk.

Against the debt held on the Trust accounts there is a **current bad debt provision** in the region of £2.1m.



Torbay and South Devon
NHS Foundation Trust

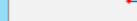
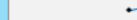
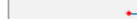
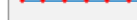
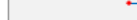
Regional Performance Monitoring

Red Flag Dashboard



Torbay and South Devon
NHS Foundation Trust

South West Red Flag Dashboard - Breakdown by Theme - Month 3 2026-27

Please select >>>	T&SD		Provider				Movement	
			Trend	Month 3 2026-27		Month 2 2026-27		
				Raw	Rounded	Raw		Rounded
Financial Position	YTD Variance		1.0	1.0	1.0	1.0	⇒ 0.0	
	Run Rate FOT		4.0	4.0	4.0	4.0	⇒ 0.0	
	Movement in YTD Variance		1.0	1.0	1.0	1.0	⇒ 0.0	
	YTD provider pay variance to plan		1.0	1.0	3.0	3.0	⬆ (2.0)	
	Forecast + Total Risk		1.0	1.0	1.0	1.0	⇒ 0.0	
	YTD Actual		4.0	4.0	4.0	4.0	⇒ 0.0	
	Regional Adjusted Forecast Outturn (RAFOT)		3.0	3.0	3.0	3.0	⇒ 0.0	
	Change to Forecast		1.0	1.0	1.0	1.0	⇒ 0.0	
	Planned surplus / deficit exc DSF		4.0	4.0	4.0	4.0	⇒ 0.0	
Efficiency	Efficiency delivery vs national average		4.0	4.0	3.0	3.0	⬇ 1.0	
	Efficiency Variance FOT		1.0	1.0	1.0	1.0	⇒ 0.0	
	High Risk Efficiency		1.0	1.0	3.0	3.0	⬆ (2.0)	
Cash	Cash metric		4.0	4.0	1.0	1.0	⬇ 3.0	
	Opex Days (RAM)		4.0	4.0	3.0	3.0	⬇ 1.0	
	Revenue Cash Support		1.0	1.0	2.0	2.0	⬆ (1.0)	
	Capital Cash Support		3.0	3.0	4.0	4.0	⬆ (1.0)	
	BPPC		3.0	3.0	3.0	3.0	⇒ 0.0	
Workforce	Workforce Variance		1.0	1.0	1.0	1.0	⇒ 0.0	
	Workforce Change Required		3.0	3.0	2.0	2.0	⬇ 1.0	
	Temporary staffing - Agency		4.0	4.0	4.0	4.0	⇒ 0.0	
	Temporary staffing - Bank		4.0	4.0	4.0	4.0	⇒ 0.0	
Productivity	In-Year Implied Productivity		3.0	3.0	1.0	1.0	⬇ 2.0	
	Implied Productivity Direction of Travel		1.0	1.0	1.0	1.0	⇒ 0.0	
ULP	Underlying Position		4.0	4.0	4.0	4.0	⇒ 0.0	
Other	NOF Rating		4.0	4.0	4.0	4.0	⇒ 0.0	
	Provider Capability Rating		3.0	3.0	3.0	3.0	⇒ 0.0	
	CQC Rating		3.0	3.0	3.0	3.0	⇒ 0.0	
Plan	Plan Sign Off Conditions		3.0	3.0	3.0	3.0	⇒ 0.0	
Overall Score	Raw Score		2.5	3.0	2.7	3.0	⬆ (0.2)	
	Raw Score with Override		2.5	3.0	2.7	3.0	⬆ (0.2)	

NHS England has created a 'Red Flag Dashboard' to monitor financial performance.

These are still in draft, but expected to be refined and published each month in arrears.



Torbay and South Devon
NHS Foundation Trust

Actions

Actions



Torbay and South Devon
NHS Foundation Trust

Description of action	Delivery Date
Trust will continue bi-monthly FDG meetings to maintain focus on accelerating plans through maturity and into delivery and resolve other emergent risks	Ongoing
Trust will continue to pursue High-Cost Drugs gain share through Devon ICB	August 2026
Work with Performance and Ops teams to forecast impact of data corrections, productivity improvements and proposed additional capacity on contract delivery.	Ongoing
Trust will process budget and planned workforce distribution corrections between planned care and reserves in M5.	August 2026



One Devon Monthly Progress Report

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OVERALL PROJECT STATUS



Watch

APPENDIX 1

OVERALL SCORE: **7.0/10.0**

AVERAGE EPIC CUSTOMER SCORE FOR
POST LIVE: **6.80/10.0**

GO-LIVE DATES:
3 April 2026 (TSD) & 23 July
2026 (UHP)

RECIPIENTS

To: Arunangsu Chatterjee, Adrian Harris, Chris Tidman, Joe Teape, James Brent, Neil MacDonald, Sam Higginson, Sam Wadham-Sharpe, Sarah Brampton, Paul Richards

From: Tara Kneller, Implementation Director

cc: Adel Jones, Kath Potts, Kevin Pirie, Gervaise Khan-Davis, Helen Vigne, Richard Collins

OVERVIEW

UHP went live successfully on 23 July at 2:52am, making One Devon the first ICB to operate on a single instance of Epic. This is a significant achievement, and there is a lot to be proud of. Super Users supported the go-live from across Devon and from other Epic sites around the UK and Ireland, and the command centre managed more than 10,000 tickets during the go-live period and resolved over 8,500 of them. Staff and patients are already seeing the benefits, including an impressive number of MyChart sign-ups. Trust and divisional leadership led their teams through a demanding transition with confidence.

The programme moves to a watch status this period. The go-live itself went well, but early indications show the trust now needs to focus on adoption, benefits realisation, and performance to resolve emerging issues early. Drawing on the lessons from TSD stabilisation, the programme is placing an early and deliberate focus on data quality and activity recovery, with leadership monitoring both closely. The key focus areas for the next month are TSD cancer and elective performance recovery, UHP activity recovery and data quality, and the return of NICU documentation into Epic. *Please refer to Issues Needing Executive Intervention and Oversight sections for detail on each and the plan to resolve them.*

Training will also be key focus over the next month: post-live Thrive training will help staff personalise the system and work efficiently, and the programme needs to finalise the wider training strategy, covering both post-live and ongoing new-hire training. The programme has now agreed to the overall long-term governance structure, which is good. The focus now shifts to logistics and execution: all three trusts and all staff groups need to understand how to request changes and how they will be prioritised. This means getting the right people at the right governance meetings and being transparent about what the programme is prioritising and why. Separately, the configuration team needs to complete recruitment and finalise staffing, as this team will support the programme long term, so confirming these roles and responsibilities is now critical.

In September, the programme will hold the first UHP Post Live Visit and combine it with the second TSD Post Live Visit. A Post Live Stabilisation Assessment (PLSA) at UHP will also give operational and clinical leadership the chance to report on their status and where they need support to stabilise. Together, the visits and the assessment will show which areas are thriving and which are struggling, so the programme can provide direct support accordingly. Staying vigilant through stabilisation is what will turn a strong go-live into the lasting benefits the One Devon programme set out to deliver.



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ISSUES NEEDING EXECUTIVE INTERVENTION

TSD's elective performance remains below pre-live baselines. While the trust exceeded its overall outpatient activity plan in July, some specialties and clinicians have not returned to 100% pre-Epic activity, and 18-week RTT performance fell from the 63.6% go-live baseline to around 57%. After detailed analysis by the Epic and performance teams, they determined the two main contributors to deteriorating performance:

- **RTT counting review.** Kevin Pirie, Justin Quigley and Derren Westcott identified counting changes between legacy systems and Epic contributing to inflated clock starts and RTT performance pre-live, including direct access diagnostics and to-be-prioritised referrals. Kevin, Justin, and Derren will review legacy submission data to compare against Epic data and complete deep dives with the three services with the highest variances to confirm the accuracy of the in-Epic RTT position for those specialties by 14 August. Paul Proctor will compare the position before and after go-live to establish the true RTT position and he will escalate to Joe Teape by 23 August if additional support is needed to meet this timeline.
- **Activity recovery.** Following the review of clinician firebreak data with Mike Green, Joanne Watson and Nick Mathieu, Sam Wadham-Sharpe will ensure clinicians remove any remaining firebreaks and resume full activity by 21 August, supported by Thrive training to improve efficiency and personalisation. If this is not achieved, Sam and Kevin Pirie will escalate to Joe Teape and Kate Lissett by 26 August for intervention with the specific clinicians who are not removing the firebreaks.

ISSUES NEEDING EXECUTIVE OVERSIGHT

UHP faces two risks to its RTT position: sustaining and confirming the recovery of planned activity, and growing pathway data quality issues.

- **Activity recovery.** Services have not yet validated their post live activity volumes, so the trust cannot confirm the true position for activity recovery. Only 57% of services have validated their line-level activity, and some services (Midwifery, Clinical Oncology, Dermatology, Gynaecology, and Neurology) appear to be very off track on booking to meet their recovery plans. Jacqui Beer and the Service Directorate Managers will use the twice-weekly stabilisation calls and service-level deep dives to validate volumes and support the services that are behind with booking by 28 August.
- **Data quality.** A high volume of pathway data quality issues continues to grow faster than services resolve them, distorting the reported position. The patient access team and the admin IOs are running regular drop-in sessions to clear the backlog, and Jacqui Beer is working with Kath Potts to stand up a joint clinical and operational forum focused on resolution of the issues which require clinical input. UHP will target getting to green thresholds (fewer than 500 pathways with no next step, fewer than 150 Epic first-seen waiting lists without a pathway, fewer than 100 potential duplicate pathways) by 4 September.

The UHP NICU is not fully live on Epic and is using it only for notes and ordering lab tests. The unit reverted to paper twice during the go-live period, following concerns about assessments, fluid balance, ventilator device integration, medications, and prescriber ordering privileges, and has not returned to Epic since. Given staffing outages over the coming month and the need to validate the fixes safely, the unit will remain primarily on paper until 7 September. Ali Geale and the Stork team are leading the work, meeting with the unit daily and using a shared tracker to confirm the team completes and validates the build, and will run shadow charting with NICU staff through 4 September once the unit's core leadership returns from leave. Twice-weekly Gold meetings with trust leadership track progress on build and validation to keep the right oversight in place.



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PROJECT STATUS			
APPLICATION STATUS			
↑○ Ambulatory	○ ASAP	↑○ Beacon	▲ Beaker
○ Beans	○ Clin Doc	▲ Dorothy & Compass Rose	▲ Cupid
○ Grand Central	○ HIM	○ MyChart	▲ OpTime & Anaesthesia
↓▲ Orders	↓⬢ Patient Access & Springboard	↑○ Phoenix	○ Research
↓⬢ Stork	▲ Willow		
CROSS-APPLICATION AREAS			
○ Benefits Realisation	○ Budget	▲ Business Continuity Planning	○ Business Intelligence
○ Charge & Code Generation	○ Clinical Specialty Review	● Cutover	↑○ Day Cases
○ Decision Support	↓▲ Device Integration	↓▲ Electronic Data Migration	↑○ End User Devices
○ Environment Management	↑○ Estates	○ Facility Structure	▲ Good Install
○ Interfaces	↑○ Interoperability	↑○ Manual Data Migration	▲ Materials Management
○ Operational Readiness	○ Patient Confidentiality	○ Patient Safety Surveillance	↓⬢ Performance & Activity Stabilisation
▲ Service Desk	↑○ Staffing	↑○ Super User Programme	○ Surgical & Procedure Orders
↑○ Testing	● Third Party Contracts	▲ Training	○ User Provisioning

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



One Devon Monthly Progress Report

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PROJECT ASSESSMENT – AREAS OFF TRACK

CROSS APPLICATION AREAS

Performance & Activity Stabilisation		See Issues Needing Executive Intervention & Oversight for more.
Device Integration		See NICU issues above in Issues Needing Executive Oversight.
Electronic Data Migration		Electronic Data Migration decreases to a status of watch due to issues with various data migrations including PAS, historical lab results, and ophthalmology procedures. To improve to good, the team will continue to monitor and confirm that there are no more unexpected issues coming up related to data migration.
Good Install		The Good Install status remains at a status of watch as only 5% of doctors across UHP and TSD have registered for post-live Thrive training. To increase to good, booking managers will register at least 25% of doctors by 31 August so that 20% have attended Thrive by 23 September, two months post-live. In addition, Mark Catolico, Simeon Brundell, Mike Green, Joanne Watson, and Nick Mathieu will work with clinical leadership across the trust to repurpose learning days and department meetings as Thrive sessions by 28 August. Thrive has been shown to increase user efficiency and satisfaction in the system and is a key part of a successful install. If 20% of doctors have not attended by 23 September, Good install will be reduced by a quarter which will be in the range of £66,000 – £92,750 credit lost.
Service Desk		Service Desk remains at watch as there is not a plan for long-term service desk strategy across the trusts. To increase to good, a medium-term plan will be implemented and the long-term strategy agreed by 28 August.
Materials Management		Materials Management remains at a status of watch due to a high number of one-time supplies being documented in Epic and logs not being verified by theatre staff. The impact is that these one-time supplies do not trigger an outgoing depletion message so their stock will not be sent to Genesis. To improve in status Dan Schwartzstein and Mike Potter will work with theatre leads to track unposted logs and increase log verification compliance by 28 August.
Training		The status of training remains at a watch due to the outstanding structure of business as usual training at UHP and the lack of overall resources for UHP training. To improve to a status of good, Sarah Connolly and Tori Webster will work with Sarah Dormor to confirm a plan to support UHP with business as usual training by 28 August. There are still outstanding questions about the plan for an overall business as usual training plan for all of One Devon. Andy Kerslake and Tori Webster to outline necessary training resources to deliver the 295 Thrive courses between 17 August and 16 December 2026.
Business Continuity Planning		Business Continuity Planning remains at a status of watch. While the trust reached go-live with the essentials in place, some foundations still need strengthening before the area can move to good. The trust needs to close gaps in operational ownership and device readiness to be confident it could

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



One Devon Monthly Progress Report

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		recover smoothly in the event of system downtime. To increase to good, Gemma Taylor will work with Mandy Stewart and Rich Buckley to educate operational owners on required tasks, audit individual BCA device readiness, and create a weekly process for device compliance forms by 4 September.
APPLICATION AREA ISSUES		
NICU Adoption		Stork decreases to serious due to NICU Adoption issues. See issues needing executive oversight for more.
Booking & Activity Recovery		Patient Access decreases to a status of serious due to concerns that some specialties are not meeting the booking numbers required to achieve their agreed activity recovery plans, waiting list data quality issues, and issues with new-to-follow-up classification. To increase in status, admin IOs and Epic will continue leading weekly Turborooms until services resolve the data quality issues, and will monitor booking volumes closely and escalate to divisional leadership if booking has not resumed to expected rates by 19 August. Jacqui Beer will work with reporting leads from TSD and RDUH to agree any changes to the defined visit type and reporting logic that affect new-to-follow-up reporting by 28 August.
GP Discharge Backlog		Orders decreases to a status of watch as there are 410 discharge summaries that have not yet been sent to GPs since 24 July. Although the trust made huge progress the second week of go-live decreasing these outstanding letters, it's critical to work down this backlog and get to a more business as usual pace. To increase in status, Simeon Brundell will work with division leadership to ensure there is dedicated time to work down these backlogs by 21 August.
GP Result Confidence		Beaker remains at a status of watch as Clinisys ICE GP LabComm downstream codes were not updated by the vendor ahead of go-live, which impacted GP EPR view of results at go-live. Although this issue is now resolved, GPs still remain cautious on trusting the lab results they are receiving and are uncertain they are seeing all results. To improve to good, trust leadership will support Path IT in an effort to review a 5% sample of results and provide assurance to GPs that they are now accurately receiving these results.
ECG Filing Failures		Cupid remains at a status of watch as 27% of UHP ECGs are not filing successfully back into Epic, requiring users to manually scan in the ECGs and significantly slowing down the workflow. The Cupid team has confirmed that this is either due to workflow adherence or wifi connectivity issues and previous issues with the barcode scanners have been resolved. To increase to good, the team will work target education for the wards and areas where the most ECGs are not filing back into Epic and reduce this number to less than 5%.
Pharmacy Inventory Build		Willow remains at a status of watch as pharmacy has been unable to provide a valuation to the finance team for end of month reporting due to the pharmacy procurement team not feeling confident due to some gaps with missing medication and inventory build. To increase to good, the Willow

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		



One Devon Monthly Progress Report

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		team will work with the procurement team to ensure they feel confident providing this information to finance and the Willow team will prioritise these gaps for build by 21 August.
Device Integration & OpTime Tickets		OpTime and Anaesthesia remains at a status of watch due to anaesthetic device integration gaps and a high volume of tickets. To increase in status, John Flippance, Kyla Leacox, and Harrison Kirwin will implement an interface filter to remove unnecessary device variables by 17 August. The OpTime team will establish ticket resolution turbo rooms to reduce ticket volume by 21 August.
Community Liver Pilot Build		Dorothy and Compass Rose remain at a status of watch as 3 teams were raised over go-live as possibly requiring Compass Rose workflow and build, of which the Community Liver Pilot has no interim workflow. To increase status, James Fellows and Hannah Hall will work with the Community Liver Pilot team to determine and set up the necessary build by 28 August.

STATUS KEY

Excellent	Satisfactory	Watch	Serious	Critical	Not Applicable	Improved	Declined
					N/A		

Appendix 2 - 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 4, July 2026, compared against the FBC plan numbers. Values are split between the sub-headings as required for reporting to NHSE.

Capital

Month 4 - July	Current Month			Year to Date (YTD)			Forecast Future Months			Full Year Effect (FYE)		
Capital Spend	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Forecast	Variance	Plan	FYE Spend	Variance
People	158,187	158,187	0	1,839,765	1,839,765	0	-401,765	-401,765	0	1,438,000	1,438,000	0
Infrastructure	0	0	0	31,137	31,137	0	3,014,768	3,014,768	0	3,045,905	3,045,905	0
Software	0	0	0	75,206	75,206	0	3,156,889	3,156,889	0	3,232,095	3,232,095	0
Data	0	0	0	0	0	0	0	0	0	0	0	0
Other	81,751	81,751	0	51,967	51,967	0	52,033	52,033	0	104,000	104,000	0
Contingency	0	0	0	0	0	0	165,000	165,000	0	165,000	165,000	0
Totals	239,938	239,938	0	1,998,075	1,998,075	0	5,986,925	5,986,925	0	7,985,000	7,985,000	0

There are no variances showing for capital in Month 4. This is because there was no phasing undertaken in the FBC and so focus is on reviewing expected spend against the total budget value of £7.985m. The areas for expected spend in 2026/27 are now very different to those included in the FBC.

Note: From month 5, the capital plan table value has been updated to reflect the latest capital funding available of £6.659m, rather than the FBC value of £7.985m.

Revenue

Month 4 - July	Current Month			Year to Date (YTD)			Forecast Future Months			Full Year Effect (FYE)		
Revenue Spend	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Forecast	Variance	Plan	FYE Spend	Variance
People	358,719	464,627	105,908	1,339,565	754,972	-584,593	2,464,838	2,323,431	-141,407	3,804,403	3,078,403	-726,000
Infrastructure	32,203	25,859	-6,344	128,813	76,114	-52,699	257,626	310,325	52,699	386,439	386,439	0
Software	365,966	283,162	-82,804	1,463,866	1,101,138	-362,728	2,927,731	3,290,459	362,728	4,391,597	4,391,597	0
Data	42,221	21,802	-20,419	168,883	21,802	-147,081	337,767	484,848	147,081	506,650	506,650	0
Other	0	0	0	0	1,494	1,494	0	-1,494	-1,494	0	0	0
N/R CIP	0	0	0	-726,000	0	726,000	0	0	0	-726,000	0	726,000
Non pay Revenue to capital recharge	-43,946	0	43,946	-153,067	0	153,067	-89,338	-242,405	-153,067	-242,405	-242,405	0
Totals	755,163	795,450	40,287	2,222,060	1,955,520	-266,540	5,898,624	6,165,164	266,540	8,120,684	8,120,684	0

The in-month People variance is because we have stopped capitalising Programme staff costs from M4 but, we have incurred extra costs relating to M1-3 ie covering for Go Live, which are a one-off additional expense. Software is showing underspent and this is a mix of timing issues with invoices from suppliers and costs being lower than planned in the FBC. Data is showing an underspend, and this is likely to continue, although the exact value is still to be confirmed. The non recurrent CIP line reflects the decision to capitalise M2 & M3 Programme staff costs, so less revenue budget was required in these months.

Through the Devon wide Finance and Commercial group, we have developed appropriate governance processes to meet the requirements of both the Programme as a whole and each Trust individually. This includes a regular meeting with Epic to ensure alignment with funding schedules and payments.

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 Management Strategy in place, along with Benefits Manager working in conjunction with the PMO to support delivery.
- Benefits Realisation plans aligned with Project Outline Documents, which will be regularly monitored and reported against.
- Benefits are being mapped to delivery plans, and emergent benefits are being identified. Progress around both areas will be reported into the Benefits Delivery Group.

- Lack of organisational engagement or capacity for change

There is a risk this might result in poor data quality, inability to produce accurate reports, creating a negative impact on activity recording, income, benchmarking, data quality and other national submissions.

Mitigating actions include having a:

- One Devon Reimbursement Group who are responsible for the agreement of data recording rules and qualification of the impact on income, benchmarking, coding, costing and all other forms of internal and external financial and activity reporting.

- Regular catch ups between the Programme and Execs to ensure an escalation route is available, if required.

- Wider System Working

There are risks and benefits in working with System partners, rather than creating a standalone business case. 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.

Mitigating Actions:

- Individual teams (ie Finance colleagues in UHP/TSD/RDUH) are building relationships to support working together to ensure alignment in assumptions.
- A One Devon BAU Governance structure is being established to receive papers requiring decisions by 3 provider Trusts.
- A System wide strategic Board for oversight and sign off of decisions has been created and is chaired by the ICB.
- There is also the opportunity for ongoing sharing of resources and therefore costs to the benefit of all organisations in Devon.

Annex A

Reporting period 1 April 2025 – 31 March 2026

1A – General

The Executive Board of Torbay and South Devon NHS Foundation Trust (TSDFT) can confirm that on behalf of **Torbay and South Devon NHS Foundation Trust and Rowcroft Hospice**:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Dr Catherine Lissett to continue as Responsible Officer (RO) for Torbay and South Devon NHS Foundation Trust and Rowcroft Hospice.
Comments:	N/A
Action for next year:	Kate Lissett to continue

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Dr Rebecca Green to take over as Appraisal Lead. Dr Rosie Davis to start as Deputy Appraisal lead.
Comments:	2 senior medics in these roles ensures good continuity of appraisal support, along with the admin support for the appraisal team from Medical Workforce. These medics regularly attend regional appraiser/RO discussion/educational events which have covered topics such as – sexual harassment in the workplace and supporting neurodivergent senior medics.
Action for next year:	Ensure both roles remain covered. Ongoing work on delineating admin support role. Ongoing work with the education team to support Locally Employed Doctors (LEDs) in the Trust (increasing number in workforce).

	Ongoing work to identify locum doctors within the Trust, who meet the Standard Operating Procedure (SOP) for TSDFT to be the designated body. Once identified, support for this group to be adequately prepared for revalidation.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year	Maintain list as accurately as possible
Comments:	LED and long-term locum problem groups to identify and support. We have set up better links with the education team and team who induct LEDs, so that this group are more identifiable and better supported with appraisal and revalidation. Video produced on how to undertake input form for appraisal. Induction sessions attended with presentation on appraisal and revalidation.
Action for next year:	Make video to support Educational Supervisors for LED on how to do output forms and what information is required for revalidation. Improve links with Trust locum agency to identify Locum Doctors better. Seek GMC support to identify which doctors link themselves with our organisation as designated body.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Continue to support
Comments:	Review of Trust revalidation website with improved up to date information links provided. Update of late appraisal SOP.
Action for next year	Seek support for improved IT systems to identify and communicate with medics late to gain appraisal.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	Await date for review.
Comments:	We have had no date for a higher-Level Responsible Officer Review visit.
Action for next year:	Await date of HLRO Quality Review visit.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Communicate policy widely and provide appraisal and revalidation support to doctors based on their individual circumstances. Remain involved with LED induction to explain appraisal and revalidation policies. Written advice on completing the appraisal input form is sent to all new LED and senior medical staff.
Comments:	We have developed regular meetings with Appraisal Leads from neighbouring Trusts to consolidate practice and ensure comparable services are offered to our doctors.
Action for next year	Support locum doctors based on their individual circumstances. Develop regular meetings with Trust locum agency to improve appraisal team knowledge of locums working in the Trust.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Continue to encourage as many doctors as possible to have an annual appraisal for professional and personal development
Comments:	There are ongoing challenges to engage a small cohort of senior doctors. There are issues associated with the increasing group of LED and locum doctors who traditionally would be in training posts and who are not accustomed to the responsibilities of revalidation. Appraisal and Revalidation is part of the induction session for new LED and new senior medics.
Action for next year:	Continue to promote the value of appraisal to departments and individuals. Identify and engage with the non-consultant, non-SAS group of doctors who are “not in training”.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Communicate policy on LED and locum doctors within the Trust. Continue to provide support to doctors working within the organisation where this satisfies our agreed policies.
Comments:	As detailed above we continue to have difficulties identifying all these doctors. We are updating our locum doctor policy to ensure that it better mirrors the policies of our neighbouring Trusts, some of these doctors work for more than one organisation in the region. We provide regular induction appraisal and revalidation sessions for the LED workforce.
Action for next year:	Improve links to the Trust locum workforce team to identify these doctors and all relevant details about them.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year	Continue to encourage all senior medical staff to have a yearly appraisal for personal and professional development.
Comments:	Premier IT revalidation system continues to be used for yearly appraisals. This covers health and wellbeing issues as well as continuing professional development alongside statutory requirements. Late appraisal SOP to manage doctors who are more than 18 months from their last appraisal. The appraisal team have developed a video to assist doctors in completing their input form on the system. All senior medical appointments have a meeting with an appraisal lead to discuss their responsibilities and the requirements for Revalidation.

	The appraisal leads provide a session for the new senior medical induction program on appraisal and revalidation.
Action for next year:	Continue encouragement for regular appraisal. Gain IT assistance for more automated reminder systems for late appraisal.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes (using retired doctors working on our Bank),
Action from last year:	To support retired doctors to provide appraisal services. To encourage the recruitment and training of new appraisers from across the full range of medical specialties, so that each department has an appraiser for every 7 appraisees. Appraisal Lead to present to senior non-medical management team on the legal requirement for appraisers and appraisal work across the Trust.
Comments:	Work in progress. We are reliant on the retired doctors to complete appraisals within the Trust. Presentation to the non-medical managers has been undertaken. The severe financial restrictions across the Trust continue to cause the appraisal team difficulties in recruitment and payment for our appraisers.
Action for next year:	Continue to recruit, particularly from specialties we are short of appraisers in. Medical Director (RO) to challenge sign off for new senior medical job agreements in departments who do not supply sufficient appraisers

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	Continue to provide drop-in sessions for appraisers, twice yearly CPD for appraisers, and anonymised feedback from their appraisees.
Comments:	Session delivered on difficult appraisal on 5th November 2025 from senior appraiser. Monthly drop-in Teams meetings continue. Appraisers are provided with their anonymised feedback from appraisees. New appraisers are offered a feedback session with an appraisal lead after their first 3 appraisals.
Action for next year:	To continue to provide CPD sessions. To alter the days these sessions are provided on so that different appraisers can more easily attend. Continue with other actions.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Continue to review appraisal output form template to assist appraisers. Provide direct feedback to appraisers struggling to complete quality output forms or who gain poor feedback from appraisees. Continue to meet with potential new appraisers so that they are aware of the requirements.
Comments:	Continue as above

Action for next year:	Continue

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue
Comments:	The RO has regular meetings with the GMC Employment Liaison Officer to discuss any potential fitness to practice issues. All recommendations have been made in the expected timescale.
Action for next year:	Continue.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue
Comments:	All Revalidation recommendations have been submitted to the GMC prior to the doctor's revalidation date. Revalidation recommendations are communicated to the doctor after submission via GMC connect. Deferral and non-engagement recommendations are communicated to the doctor before submission to the GMC and an action plan is discussed with the doctor by the Appraisal Lead or Deputy Appraisal Lead.
Action for next year:	Continue

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes.
Action from last year:	Continue.
Comments:	Increase in clinical tariff for Governance in the Job Planning Policy. Incidents, complaints and litigation cases recorded on the DCIQ system.
Action for next year:	Continue.

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Continue.
Comments:	Performance monitored by annual appraisal; complaints and incidents data via the DCIQ system; divisional performance data; departmental clinical governance meetings; Dr Foster data; Maintaining High Professional Standards policy; Transfer of information requests.
Action for next year:	Continue.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Continue
Comments:	Mandatory training records available from the Hive. Incidents, complaints and litigation data available from the DCIQ system.
Action for next year:	To continue to explore ways to streamline the process of providing this data.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Continue.
Comments:	Maintaining High Professional Standard and Remediation Policies remain in place. Close liaison continues between the Responsible Officer, Appraisal Lead, Deputy Appraisal Lead and Medical Workforce team. The RO will let the appraisal team know, with the doctor's consent, if any conduct and performance issues need to be included in the appraisal discussion.
Action for next year:	Continue.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Continue
Comments:	Following a Maintaining a High Professional Standards Investigation, the Case Manager will meet with the Case Investigator and Medical Workforce Team to debrief and consider any lessons that can be learned. There are communicated to the Responsible Officer. The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No individual will receive less favourable treatment on the grounds of the nine protected characteristics as governed by the Equality Act 2010.
Action for next year:	Look at establishing a Case Management System.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Continue.
Comments:	Transfer of Information requested from the previous organisation and provided, on request, to the doctor's next employer. Regular liaison meetings between the Responsible Officer and the GMC Employment Liaison Officer provide a forum to discuss any concerns about a doctor who may be relocating to another employing organisation.

Action for next year:	Continue.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	Continue.
Comments:	The Responsible Officer and Medical Workforce Service Lead meet on a regular basis with the GMC Employment Liaison Officer to discuss, in confidence, any concerns and agree the best way of handling these concerns balancing the safety of patient with supporting the clinician.
Action for next year:	Continue.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Continue.
Comments:	Regular meetings are scheduled with the Chief Medical Officer and Appraisal and Deputy Appraisal Leads to discuss the outcome of any of the above which may have implications for the Trust's approach to appraisal and revalidation. The Higher-Level Responsible Officer Quarterly meetings are a good example of this.
Action for next year:	Continue.

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	Continue.
Comments:	The Chief Medical Officer, Appraisal and Deputy Appraisal Leads work closely together to ensure medical professional standards are maintained Trust wide. The Chief Medical Officer, Chief Nursing Officer and Chief Finance Officer work closely to align professional standards arrangements.
Action for next year:	Continue.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	Continue.
Comments:	All medical staff, both substantive and locum, are subject to pre-employment checks as per the NHS Employers Employment Check Standards and NHS Employers Guidance on appointment of Locum Doctors
Action for next year:	Continue.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Continue.
Comments:	Systems are in place to ensure professional standards activities support the organisational culture of the Trust to include Mandatory training and Study leave.
Action for next year:	Continue.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue.
Comments:	Systems are in place with a proactive approach including: Equality, Diversity and Inclusion session Inclusion mandatory training Equality and diversity training New Consultant and SAS Leadership Programme runs twice yearly.
Action for next year:	Continue.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue.
Comments:	Systems embedded within the organisation including: Freedom to Speak up Guardians. Wellbeing Buddy system Manager Guidance Programme – Mental Health Crises
Action for next year:	Trust actively working towards embedding a Just and Learning culture.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Continue.
Comments:	Mechanisms are in place that support feedback about the Trust's professional standards which include: Grievance Procedure 'See Something, Say Something' Campaign Annual Staff Survey
Action for next year:	Continue

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	Continue
Comments:	The Head of Medical Workforce oversees all formal processes involving medical staff with consideration given to the ethnicity of the Case Investigator. Further review of individual cases is undertaken by the Chief Medical Officer and GMC Employment Liaison Officer.
Action for next year:	Continue

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standard processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Continue
Comments:	Attendance at Network Responsible Officer meetings by RO. Appraisal Lead and Deputy Appraisal Lead. Devon and Cornwall wide Head of Medical Workforce Group that reviews consistency of approach across NHS Trusts in the region.
Action for next year:	Continue

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	424, including Rowcroft Hospice. (354 due an appraisal during this time period)
Total number of appraisals completed	296
Total number of appraisals approved missed	7
Total number of unapproved missed	51
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	40
Total number of late recommendations	0
Total number of positive recommendations	33
Total number of deferrals made	7
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	11
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer ²	1
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	30
Median duration of concerns processes closed (working days) ³	N/A
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	3

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	75 Consultant, SAS and LEDs
Total number of new employment checks completed before commencement of employment	75
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

Current issues:

Annual appraisal and GMC revalidation was a structure originally designed for senior medics (consultants and SAS doctors) in permanent posts. Resident doctors were generally part of training rotation and Health Education England would revalidate these doctors as part of the training structure.

In recent years a new group of young doctors have emerged, who are unable to, or unkeen on being part of a formal training rotation. Many of these doctors have portfolio careers involving locum and locally employed posts, that change frequently and may span several organisations at once. Because these doctors are not under the remit of Health Education England, they require annual appraisal and revalidation within the Trust that they are currently employed by.

We are refining the processes to identify these doctors, but this does not appear to be straightforward. Additionally, many of these doctors do not realise that they need annual appraisal and that it is their responsibility to collect the data required for revalidation. We continue to offer education to this group and the teams that are responsible for these posts.

TSDFT now employs 72 non-training grade “locally employed doctors” and 13 Trust locums for whom we are the designated body.

Of the 51 unapproved missed appraisals, 17 number of these are locally employed or locum doctors.

Actions for next year

Dr Catherine Lissett to continue as Responsible Officer

Dr Rebecca Green to continue as Appraisal Lead.

Dr Rosie Davis to continue as Deputy Appraisal Lead.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld”.

Continue to maintain list of all licensed practitioners with a connection to our RO as accurately as possible. Liaise closely with medical staffing and the TempRe Medical Bank.

Continue to support the opportunity for retired doctors to continue as medical appraisers. Continue to actively monitor and review policies which support medical revalidation.

Await date of HLRO Quality Review visit.

Communicate policy widely and provide appraisal and revalidation support and information to doctors based on their individual circumstances. Remain involved with LED Induction to explain appraisal and revalidation policies. Written advice on completing the appraisal input form to be sent to all new LED and senior medical staff.

Continue to encourage as many doctors as possible to have a yearly appraisal for personal and professional development.

Continue to use late appraisal SOP.

Continue to develop process for actively managing situations where doctors are late with appraisals.

Continue to actively monitor and review policies which support medical revalidation.

Appraisal Lead to speak to Operational Managers about the requirement for yearly appraisal for all senior doctors within their divisions and the need for adequate numbers of appraisers to provide this (one for every seven senior doctors) RO to continue to support this message.

Continue to recruit and train new appraisers.

Continue to provide drop-in sessions, twice yearly CPD sessions, new appraiser 1:1's, and feedback from appraisees to each appraiser.

Continue to review and update output form template to standardise content. Encourage appraisers to use template. Provide direct feedback to appraisers where output form information is inadequate.

Continue to meet with new appraisers after two appraisals.

Continue with timely recommendations to the GMC.

Continue to deliver effective clinical governance for doctors.

Continue to maintain systems for monitoring the conduct and performance of all doctors working in this organisation.

RO, Medical Workforce and informatics department to streamline process for providing Datix information.

Continue to maintain processes for responding to concerns about a medical practitioner's fitness to practise.

Continue to maintain a quality assurance process around the system for responding to concerns about a doctor in our organisation.

Continue to maintain process for transferring information and concerns between Responsible Officers.

Continue to maintain safeguards to ensure clinical governance arrangements are fair and free from bias and discrimination.

Continue to attend HLRO quarterly meetings to ensure national guidance is integrated at Trust level.

Continue to maintain systems to review professional standards arrangements.

Continue to ensure that appropriate pre-employment checks are undertaken.

Continue to support an organisation culture where clinical care will flourish and be continually enhanced.

Continue to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Continue to ensure that transparency and freedom to speak and a learning culture are enhanced within the organisation at all levels.

Continue to ensure that mechanisms are in place to support feedback about the Trust's professional standards.

Continue to ensure that parity is maintained between doctors involved in concerns and disciplinary processes.

Continue to ensure that the Trusts professional standards are consistent with other organisations.

Concluding comments:

Need to continue to develop a robust structure for delivery, oversight and quality assurance of medical appraisal.

Section 4 – Statement of Compliance

The Executive Board of Torbay and South Devon NHS Foundation Trust have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated bodies:

Official name of the designated body:	Torbay and South Devon NHS Foundation Trust and Rowcroft Hospice

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Appendix 1

QPC Report: 10-point plan - Improving the working lives of Resident Doctors

Dr Josh Tulley - Peer Lead for Resident Doctor Experience

Summary

Since the update provided to the board in April, progress towards meeting the aims of the 10-point plan (10 Point Plan) has continued with consistent momentum.

The major update within our work comes from the publication by NHSE of national minimum standards for resident doctor (RD) annual leave. This publication sets out a national mandate for improvement to equity of annual leave access for all RDs and begins work in standardising the role of rota managers. A timeline for the implementation of these standards has not been set nationally; however, at a local and regional level we are striving for rapid adoption.

Below are short summaries of progress and current assurance ratings against each point on the 10 Point Plan.

We continue to maintain a moderate level of overall assurance with meeting the aims of the 10 Point Plan and our planned work, with particular focus on RD annual leave, aims to maintain if not exceed this rating.

Local Progress

Below, progress towards achieving the aims of the 10 Point Plan has been described using the 10 Point Plan headings:

1: Trusts should take action to improve the working environment and wellbeing of resident doctors; parking, self-directed learning, mess facilities, lockers, 24/7 food access

Assurance: Moderate

All RDs have access to the doctor's mess rest area, regardless of their membership status. Existing and new appointments to the trust are provided with information regarding access to parking permits annually, and resulting disputes are considered on an individual basis with support from the Resident Doctor Representative Committee (RDRC).

Currently, access to rest facilities out of hours and after on-call shifts varies between clinical departments. A project assessing the current provision will begin this summer with plans to standardise and streamline access to such facilities trust-wide.

2: Resident doctors must receive work schedules and rota information in line with the code of practice; GWS 8 weeks prior and detailed rotas 6 weeks prior to rotation start date; 90% RD information from NHSE to trusts 12 weeks prior to rotation start date.

Assurance: Moderate

Torbay already meets this requirement with medical workforce asking practice managers for compliance data in order to centralise monitoring.

On a handful of occasions, these deadlines have not been met, and direct lines of communication have been established between the departments in question and those RDs affected in order to provide prompt transfer of information.

3: Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing

Assurance: Limited

NHSE has now published national minimum standards for RD AL with five key objectives identified: 1: Ensure trusts are managing AL in line with current guidance; 2: Every RD within each 12-month period should be able to request 2 consecutive weeks away from work; 3: Professionalise the rota manager role; 4: Improve the use of e-rostering; 5: Improve the use of preferential rostering. Regarding point 3, to be agreed nationally are specific rota role success metrics and rota role training needs. Full details can be found here.

<https://www.england.nhs.uk/long-read/minimum-standards-for-annual-leave-for-resident-doctors/>

Whilst locally we already meet some of these requirements, a considerable amount of work is required to achieve full compliance. Due to the cross-speciality and multiple stakeholder nature of this issue, a task and finish group chaired by the RDPL has been established to set out a clear plan in order to meet these minimum standards before August 2027.

4: All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the trust board.

Assurance: Significant

Dr Josh Tulley has been re-elected as the Chair of the RDRC and therefore continues his role as the RDPL for another 12 months. Dr Kate Lissett remains the named Senior Lead for Resident Doctor Experience. The Chair of the Quality and People Committee remains the named Non-Executive Director for resident doctor experience as agreed prior to April's QPC meeting.

5: Resident doctors should never experience payroll errors due to rotations

Assurance: Moderate

Via the local 10 Point Plan working group, the RDPL continues to engage with local payroll leaders to ensure oversight of payroll errors is maintained and highlight learning for subsequent RD rotation cycles.

6: No resident doctor will unnecessarily repeat statutory and mandatory training when rotating.

Assurance: Significant

RDs are informed prior to arriving at the trust that on provision of in-date evidence of previous statutory and mandatory training completion, they will be exempt from training repetition.

The lead employer model will further ensure reforms to HR processes for RDs (see point 9). Updates from NHSE in July 2026 report proposals for the lead employer model progressing nationally, with further updates regarding implementation planned before the Autumn.

7: Resident doctors must be enabled and encouraged to exception report (ER) to better support doctors working beyond their contracted hours

Assurance: Significant

Following the end of Dr Claire Blandford's tenure as the Guardian of Safe Working Hours, Dr Richard Eve has now taken up this role.

The RDPL, as chair of the RDRC, sits on the Guardian Oversight Group, which discusses trends in exception reporting and proposes actions to address working conditions leading to such ERs.

Following the implementation of the new ER system and reforms early in 2026, we continue to see an increased number of ERs in comparison to the same period prior to the reforms. Where the GoSWH has implemented fines to local departments for breach of contract, the RDPL is involved in ensuring appropriate allocation of these monies and approval of spending thereafter.

8: Resident doctors should receive reimbursement of course-related expenses as soon as possible

Assurance: Significant

RDs can claim for reimbursement of course related expenses at the time at which the expense was incurred. Payment is processed at the next available pay run but within 6 weeks of submission.

9: We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery

Assurance: Moderate

Ongoing work nationally.

10: We will minimise the practical impact upon resident doctors having to move employers when they rotate

Assurance: Moderate.

Ongoing work nationally.

Appendix 2

Postgraduate Medical Education

Quality Assurance Annual Report Summary 2025-2026

Report by:

Mr Jeremy White	Postgraduate Medical Education Manager
Ms Jacqui Rees Lee	Director of Medical Education
Dr Elizabeth Ginn	Associate Director of Medical Education (Quality)

Date: 23/7/2026

Prepared for: Quality and People Committee – August 2026

Introduction

The evidential base for the quality processes at TSDFT includes:

- NHSE Quality Panels for the Foundation programme and GPST programme,
- Feedback from Trainee Surveys,
- Information from discussions with trainees,
- Submitted reports from NHSE and TSDFT
- Feedback received by the Postgraduate Medical Team,
- RDRC meetings and the Guardian Oversight Group
- Any other sources that relate to the overall quality of trainees' programmes at TSDFT

Annual Cycle

Activity	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
NTS Analysis												
Follow up with Depts'												
SED provided by Depts												
NETS Analysis												
Soft intelligence												
Ongoing quality practices (depths)												
Trainee Surveys (as needed)												

Action Plans agreed												
Benchmark / Share practice (ADMEQ mtg)												
Review Processes												

External Quality Activity 2025/26

Intervention	Body	Timing	Outcome
MEQR (NHSE) Moderate	NHSE	Oct 2025	
Triggered visit Haematology/Oncology Moderate	NHSE	Oct- Dec 2025	
Follow-up meetings O&G Moderate.	NHSE	Dec- April 2026	
Response GMC NTS written comments Moderate	NHSE	June 2026	
NHSE NETS Summary with actions	TSDFT	May 2026	Report
GMC NTS Survey with actions	TSDFT	August 2026	Report

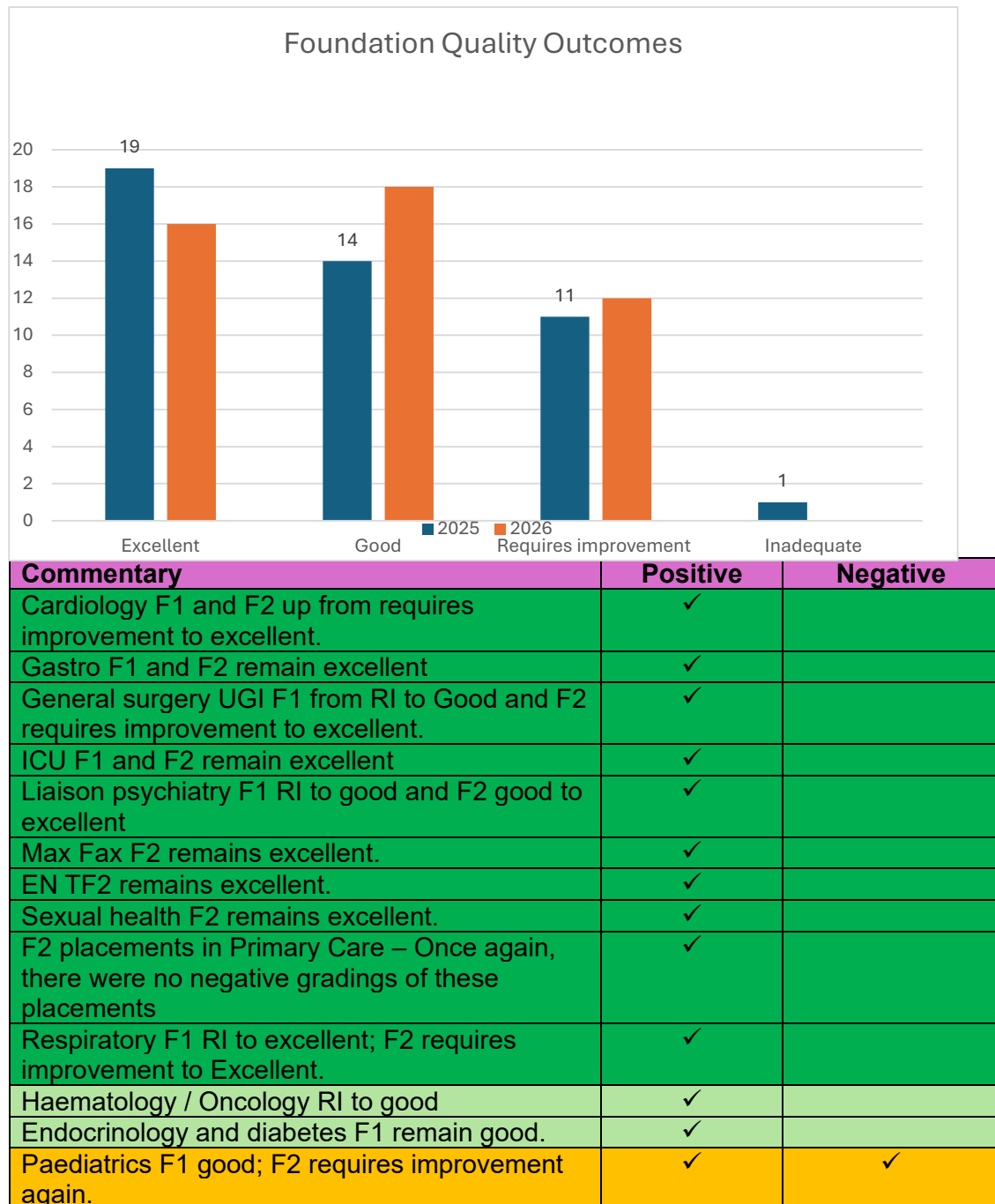
Quality Panels

Foundation Quality Panel 2026 (see appendix 4)

The Foundation Quality Panel this year took place in April 2026. Placements for Foundation Doctors are offered in hospital placements and primary care (GP Practices)

There are no inadequate posts in the 2026 Foundation Quality Panel this year. Of the 46 posts this year, 16 were Excellent, 18 Good and 12 Required Improvement.

Foundation Quality Panel Post Trend: 2026 outcomes against previous 2025 outcomes



Trauma and Orthopaedics F1 remains good, F2 improved from inadequate to requires improvement.	✓	
Acute Medicine F1 and F2 are down from excellent to requires improvement.		✓
ED F1 and F2 down from excellent to requires improvement.		✓
General psychiatry F2 from good to requires improvement.		✓
General surgery F1 remains requires improvement.		✓
General surgery colorectal F2 good to requires improvement.		✓
Geriatric medicine F1 Simpson requires improvement.		✓

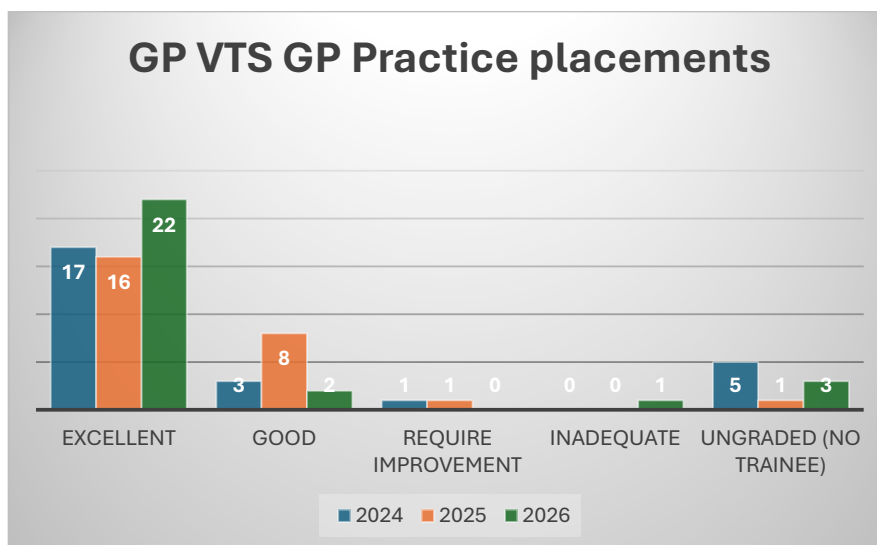
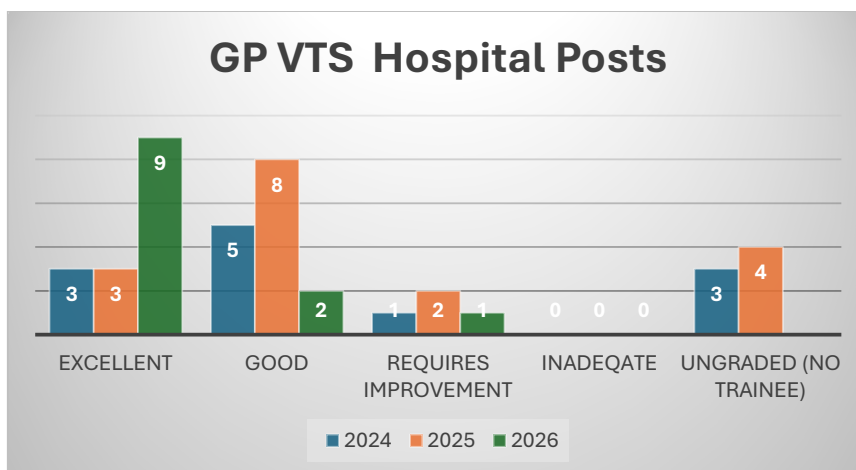
Foundation Quality Panel Outcome Summary

Placement	Ungraded		Inadequate	Requires Improvement	Good	Excellent
Secondary care						
F1 Acute Medicine				✓		
F1 Emergency Medicine				✓		
F1 Cardiology						✓
F1 Colorectal				✓		
F1 Diabetes & Endo (Forest)					✓	
F1 Gastro						✓
F1 Geriatric Medicine (Cheetham)					✓	
F1 Geriatric Medicine (Simpson)				✓		
F1 Haematology/ Oncology					✓	
F1 ICU						✓
F1 Liaison Psychiatry				✓		
F1 Paediatrics					✓	
F1 Respiratory				✓		
F1 Geriatric Stroke (George Earle)				✓		
F1 T&O					✓	
F1 Upper GI					✓	
F1 Urology					✓	
F2 Acute Medicine				✓		

F2 Cardiology					✓	✓
F2 Colorectal					✓	
F2 Emergency Medicine				✓		
F2 ENT						✓
F2 Gastro					✓	
F2 General Psychiatry						
F2 Geriatric (stroke)					✓	
F2 Haematology/ Oncology	NHSE Triggered visit				✓	
F2 ICU						✓
F2 Liaison Psychiatry						✓
F2 O&G	NHSE visit				✓	
F2 Oral and Max Fax						✓
F2 Paediatrics				✓		
F2 Respiratory						✓
F2 Sexual Health						✓
F2 T&O				✓		
F2 Upper GI						✓
F2 Urology					✓	
Primary Care						
F2 GP Ashburton						✓
F2 GP Buckfastleigh					✓	
F2 GP Channel View					✓	
F2 GP Catherine House					✓	
F2 GP Chilcote						✓
F2 GP Corner Place						✓
F2 GP Kingsteington					✓	
F2 GP Mayfield						✓
F2 GP Leatside					✓	
F2 GP Pembroke						✓
Total Year 2026			0	12 (26%)	18	16
Previous Year 2025			1	11 (24%)	14	19

Quality Panel GP (Appendix 5)

- The GP quality panel this year was well received in April 2026. Placements for GPST Trainees are offered in Secondary Care (Hospital placements) and Primary Care (GP Practices); in addition, voluntary ITP posts are also offered to trainees.
- For Hospital posts there has been a year-on-year improvement, most notably in the current year, with 9 of the 12 posts offered getting an excellent grade from trainees.
- The GP practices that undertake training for the trainees in years 2 and 3 of their programme continue to highly value the general practices used for training. In the current year, 22 out of 25 practices receive an excellent grading.



The two areas that require improvement are detailed below.

Placement/Post	QP 2023 Overall Grade	QP 2024 Overall Grading	2025 grading	2026 grading 0=Excellent 1= Good, 2= RI, 3= Review	Actions to improve grade	General comment
Obstetrics and Gynaecology	Excellent	Excellent	Good	Requires Improvement	However, we understand there have been some recent changes within the department and we would like to review the post in 6/12 months. Positive feedback mentioned for Mr Singh – excellent	Concerns from trainees relate to staffing issues resulting in trainees missing VTS and departmental training, and struggling to access AL and SL. Concerns around support and access to trainees via whatsapp to contact and review clinical decisions –
Paediatrics	Requires Improvement	Good	Requires Improvement	Requires Improvement	Significant improvements in multiple areas – e.g. thorough and regular handovers, education time within posts, generally good support during shifts, and improvement with induction	Significant concerns around GP trainees holding the neonatal bleep, and expectation to independently attend all bleeps, without formal NLS certification. Ongoing concerns regarding staffing and inability to

Pastoral Services

The postgraduate medical education team undertake a monthly meeting with Senior PG Medical Staff, the PG Pastoral Support team and Medical HR to monitor the progress of doctors who may be struggling. This meeting has been undertaken for many years and plays an important part in supporting and signposting the team to help support resident doctors who may be in distress.

Over the last three years, there has been a significant increase in the number of doctors that are being discussed at this meeting and the support that is provided.

The work of the pastoral team has been and continues to be invaluable. Further, the demands on the service over the last five years have undergone an exponential increase, which has been managed by all involved, but particularly much of the heavy lifting is done by the pastoral team, who are an incredibly dedicated team of senior clinicians.

In June 2026, a report was produced by the Associate Director for Medical Education, Dr Kathryn Blackmore, who has the overall responsibility for the support of resident doctors and leads the pastoral team. The survey of 2026 confirms the benefits provided to resident doctors who find themselves in a challenging position in their lives.

The survey reveals that.

- the vast majority of the respondents used the service in 2025/26.
- Until referred, 90% of the respondents were unaware of the service.
- Respondents accessed the service through a variety of different means, including self-referral, referral by their ES/CS, PGMED ED, pastoral tutors reaching out and the wider postgraduate team.

- There are four trained pastoral tutors that doctors can talk to
- The majority of each case took place over 2-3 meetings, but some require ongoing involvement 6+ meetings.
- 90% of respondents found it either useful or very useful and 100% would recommend the service.
- A range of comments are provided in the survey which exemplify how effective and important the service has become to Doctors at the Trust.

Appendix 3

Guardian of Safe Working (GOSW) Hours Report

Introduction and background

The following report aims to ensure Resident Doctors are working contracts compatible with their Contractual Terms and Conditions of Service 2016, that are sustainable and fair and that they are able to claim money/time off in lieu should they need to work extra hours to maintain patient safety/attend educational opportunities or complete career enhancing objectives.

Exception reporting is encouraged and supported by the trust. Dr Claire Blandford has stepped down from the role as GOSWH(May 2025), and after a gap in which reporting review was supported by Dr E Thomas, Dr R Eve has taken on the role of GOSW. Due to this handover and leave, this report has been prepared by Dr Lissett with data provided by the medical HR team.

Table 1 – Exception Reports by Area

Specialty	No. exceptions raised in reporting period	No. exceptions closed	No. exceptions outstanding	Comment
General Medicine	61	57	4	
Emergency Medicine	12	11	1	
Acute Medicine	20	19	1	
General Surgery	67	61	6	
Obs & Gynae	3	3	0	
Paediatrics	5	5	0	
T&O	8	5	3	

Total	176	161	15	

Table 2 – Exception reports by Grade

Grade	No. exceptions raised in reporting period
F1	117
F2	10
CT1-3	40
ST 4-9	9
Total	176

Table 3 – Nature of Exception

Additional Hours	171
Immediate Safety Concerns	0
Pattern of Work	5
Educational Opportunities	n/a
Service Support	n/a

Table 4 – Outcome of Exceptions

TOIL	58
Payment	102
Work Schedule Review	1
Agreed no further action required	9
Unresolved	6

Comments on Exception Reporting

Exception reporting remains a key source of assurance and risk visibility for resident doctor safe working. The August report records **176 exception reports** for **16 April–4 August 2026**, a small reduction from **192 reports** in the April report covering **4 February–28 April 2026**, but still at a materially elevated level following the February 2026 national exception-reporting reforms. Nationally, NHS Employers explicitly expected an increase in exception reporting after implementation until underlying issues are resolved through work schedule reviews, and the revised framework is designed to remove previous barriers through improved confidentiality, HR/medical workforce routing of additional-hours reports, continued GoSWH oversight, and resident choice of pay or TOIL except where safety mandates TOIL. The current volume should therefore be interpreted as both an operational pressure signal and evidence of improved visibility/reporting culture, rather than deterioration alone.

The pattern of reporting has shifted. In April, **General Medicine** was the dominant specialty, with **90 reports**, and ward-level hotspots were identified in **Cheetham Hill Ward, George Earl Ward, McCallum Ward and Simpson Ward**; in August, **General Surgery** is now the highest reporting specialty with **67 reports**, followed by **General Medicine** with **61**, and **AMU and Cromie wards** are noted as the current high-reporting areas. F1/FY1 doctors remain the most affected grade, increasing from **99 FY1 reports** in April to **117 F1 reports** in August, indicating continuing pressure at the most junior resident doctor level; CT1–3 reporting also remains material at **40 reports** in August.+1

The nature and outcomes of reports continue to point primarily to workload and rota resilience rather than isolated events. April reporting was dominated by **unscheduled late finishes** and described recurring themes of below-minimum staffing, lack of senior support, high patient turnover and difficulty handing over safely; it also recorded **nine safety concern reports** and **seven fines**. August continues the workload theme, with **171 of 176 reports** classified as **Additional Hours**, **five** as **Pattern of Work**, and **zero Immediate Safety Concerns** recorded in the dataset. Payment remains the main outcome, although it reduced from **118** to **102 reports**, while TOIL increased from **47** to **58 reports**; six August reports remain unresolved and should continue to be monitored.+1+1

Overall, the Committee can take assurance that exception reporting is active, visible and supported; the April report found no unresolved access issues and no evidence of detriment, and national reforms reinforce confidentiality and the right to report. However, the persistence of high additional-hours reporting, concentration among F1 doctors, changing specialty and ward hotspots, and unresolved reports means assurance should remain **limited for safe working hours and rota resilience** until there is sustained improvement in recurrent late finishes, rota gaps, senior support and

hotspot ward pressure. The key action is targeted specialty and ward review of workload against work schedules, minimum staffing levels and escalation arrangements.+1

Torbay and South Devon NHS FT MATERNITY BOARD REPORT

QUARTER 1 – APRIL – JUNE 2026

Control

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



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Introduction

Purpose

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

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

Glossary

Maternity and Newborn Safety Investigations Programme (MNSI)

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

Clinical Negligence Scheme for Trusts (CNST)

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

Avoiding Term Admissions into Neonatal Units (ATAIN)

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

Perinatal Mortality Review Tool

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

Essential Reporting: Trust Board & LMNS Oversight

Item	Source	Frequency (Min.)
Minimum Data Set 1. CQC rating (as updated) 2. MSSP status 3. Findings of PMRT & HSIB reviews 4. Incident reports moderate & above 5. Training compliance 6. Minimum safe staffing 7. Service user feedback. 8. Staff feedback 9. HSIB/NSHR/CQC concerns or requests for action. 10. Coroner Reg 28 11. CNST progress 12. Staff survey (Midwives & Obstetricians)	Implementing a Revised Perinatal Quality Oversight Model	Monthly
All Maternity SI Reports	Ockenden Interim (IEA1)	Quarterly
Maternity Dashboards	Ockenden Interim (IEA1)	Quarterly
Multidisciplinary training	Ockenden Interim (IEA3)	Quarterly
Minimum staffing levels (if not nationally agreed levels)- to be locally agreed with LMNS	Ockenden Final (IEA1)	As required
Sustained inability to meet staffing levels	Ockenden Final (IEA2)	As required

Learning from reviews of maternal deaths	Ockenden Final (IEA6)	As Required
Content of Human Factor Training	Ockenden Final (IEA7)	Annually
Neonatal care outside agreed pathways- including births <27 weeks at units <Level 3 NICU Care outside agreed pathways must be monitored & reviewed by Trusts, the LMNS & the ODN	Ockenden Final (IEA14)	Quarterly
Trusts to ensure that there is proper representation of maternity care on their boards	Reading the Signals	Ongoing
SDP Outcomes: 1) Staff Survey	Single Delivery Plan	
SDP Progress	Single Delivery Plan	As required
SDP Evidence	Single Delivery Plan	As required
SDP Regulation & Incentivisation: 1) CQC 2) CNST	Single Delivery Plan	

1.0 Introduction and background

1.1 This report provides oversight and assurance regarding the safety, quality and effectiveness of maternity and neonatal services (Perinatal Services) at Torbay & South Devon NHS Foundation Trust (TSDFT) and informs the Committee of current and emerging risks, concerns and areas for improvement. The report aligns with the NHS England Perinatal Quality Oversight Model (PQOM) and supports delivery of the ambitions set out within the Three-Year Delivery Plan for Maternity and Neonatal Services, the Maternity (Perinatal) Incentive Scheme (MIS) Year 8, and associated national maternity and neonatal safety programmes.

The report brings together intelligence relating to clinical outcomes, patient safety, workforce, training, service-user and staff experience, equity and inequalities, learning from incidents and investigations, and progress against national safety initiatives and care bundles. It supports the Trust Board and its delegated committees in discharging their responsibility for perinatal oversight, ensuring that risks are identified early, learning is embedded, and timely action is taken to improve outcomes for women, babies and families.

The PQOM provides a structured framework for the monitoring and escalation of quality and safety intelligence across Trust, Integrated Care Board (ICB), regional and national systems, ensuring clear accountability and effective oversight of maternity and neonatal services.

1.2 Assurance is derived through a tiered governance framework which enables the systematic review and escalation of Perinatal quality and safety intelligence. Detailed scrutiny is undertaken through the Perinatal Governance Committee, where information relating to clinical outcomes, incidents and investigations, workforce, training, service-user feedback, staff experience and improvement activity is reviewed. This intelligence is subsequently triangulated through the Perinatal Safety Champions Committee, providing a forum for multidisciplinary challenge, assessment of emerging themes and oversight of actions. Through the Board Safety Champions, the Committee maintains a direct line of sight to the Trust Board, strengthening organisational oversight of perinatal safety. Matters requiring formal escalation are reported through the Quality Governance Committee and onwards through established organisational governance routes. In addition, key perinatal quality and safety indicators are incorporated within routine Care Group governance arrangements and the Integrated Quality Performance Report, ensuring continuous visibility of performance, risk and improvement activity across the Trust.

2.0 Listening to Women & Families with Compassion –**2.1 User Feedback-**

FEEDBACK	Comments	Impact	Ongoing Actions	Timescales
Service User Feedback: 1) Compliments	Women and families praised the kindness, friendliness and professionalism of staff. They felt well supported emotionally, valued the understanding and non-judgemental approach of the team, and appreciated the continuity of care provided. Feedback also highlighted the helpful advice and guidance given, support with newborn care, inclusion of partners in conversations, and the high standard of clinical care, with many describing staff as knowledgeable, supportive and amazing throughout their experience.	Celebrate the positive work that is done daily.	Work with ward managers and staff to increase feedback response from patients. Work with MNVP to increase feedback from more diverse population.	Ongoing
2) Themes of complaints	Themes remain with concerns around care when transferring to other units. Themes also around communication between staff and patients around pain relief in labour.	Investigation ongoing.	Plan to revisit transfer process specifically with LWC team to streamline actions. Plan to share complaint's themes at Maternity Connect Meeting.	July 2027

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. DMNVP Trust lead part of triage working party to service user voice integral to the service improvements	Ongoing
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.	Project plan in place. Engagement with stakeholder to commence in August 2026	Oct 2026

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

3.1 Staff Feedback

You Said / We Did – Staff Feedback April to June 2026

This summary has been drafted from feedback themes identified through listening events, staff discussions, safety champion feedback, Datix themes, governance reviews and the culture work associated with the maternity and neonatal improvement plan.

You Said

- Staffing and workload pressures are affecting teams.

- Burnout and wellbeing remain significant concerns.
- Staff want better communication and leadership visibility.
- Psychological safety and speaking up need improvement.
- Systems and infrastructure create additional pressures.

We Did

- Established a dedicated Culture and Leadership workstream within the Maternity and Neonatal Improvement plan.
- Began development of a Psychological Safety Strategy.
- Increased engagement and visibility of senior leaders.
- Created formal mechanisms for sharing staff feedback and actions.
- Convened Band 7 leaders to develop solutions to staffing pressures.

Safety Champions meetings

Safety Champion walkarounds continue to provide satisfactory assurance regarding staff engagement, patient experience and safety culture. Feedback obtained through walkarounds is consistent with intelligence from staff listening events, governance processes and improvement workstreams. Action is underway to address identified concerns relating to workforce pressures, communication, psychological safety and digital systems, whilst maintaining focus on areas of good practice and positive patient experience

Table 1

Date	Attendees	Feedback
April 2026	Board Safety champion- NED and Board Safety champion- NED and CNO. Maternity Safety Champion, MNVP Devon Trust lead,	Triage Visited the maternity triage dept to view the estate changes that have been made. It has a very positive impact on the space available and the team. Discussed formal opening – Chairman to consider opening, also discussed MP attendance so ability to meet constituents – positive view of investment for Trust.

May 2026	Board safety champion (NED) Maternity Safety Champion, Obstetric safety champion, MNVP Devon Senior lead.	Met with some of the midwives to discuss the impact of Epic on Triage. Most felt it had improved and streamlined processes although is taking time to get used to the system. Some of those in specialist roles had felt more difficulty due to cross organisational working Labour ward The Safety Champion Walkaround identified several positive developments and operational themes. Staff provided favourable feedback regarding refurbishment of the pool room, particularly improvements to the environment and lighting which supported a more home-from-home experience for women and families. Clinical discussions focused on fetal monitoring practice, including appropriate use of CTG and Doppler monitoring. Feedback regarding EPIC remained mixed; midwifery staff described improving familiarity and workflow benefits, while consultants reported increased administrative workload, longer appointments and capacity pressures associated with system use.
June 2026	Board level safety champion (NED and CNO) Maternity safety champion, neonatal MNVP lead.	SCBU Security and access – discussion around parent and infant identification processes with reassurance that systems are in place to manage risks appropriately. Workforce and Staffing – Neonatal nurse staffing was discussed and the mitigations and plans to strengthen the workforce model. Current position is table but fragile. Estates and Infrastructure – Further explanation of the issues affecting them were described – limited capacity to provide parent-led facilities and constraints in meeting best practice standards for space utilisation.

SCBU parent feedback - Strengthen visibility of specific parent and family feedback related to SCBU and ensure routine reporting via Trust Quality people Committee.

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.	4	This is delayed IOL commencement due to high level acuity to maintain safety.
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing).	4	This is delayed IOL commencement due to high level acuity to maintain safety.

		Discussion with LWC to document these cases in correct place.
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).	0	
Delay of more than 30 minutes in providing pain relief.	0	
Delay of 30 minutes or more between presentation and triage.	1	Short time patient had to wait due to room being cleaned/prepared during time of high acuity.
Full clinical examination not conducted when presenting in labour	0	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.	5	Short term delays in commencing process of IOL due to acuity to maintain safety.
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	7 – not providing 1:1 care 2 – providing 1:1 care	Short periods of time where LWC providing care whilst awaiting re-deployed mw to attend LW. Also, LWC providing postnatal care during brief period of high acuity to assist in maintaining 1:1 care for women in labour and covering triage phone at 3am on one occasion.
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.	Rota Covered
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.	Two staff members nearing completion of QIS course and work-based placements. Further confirmation needed they have achieved requisite ITU practice hours to support completion. Results of course not

	QIS as % of registered workforce is 52 % (BAPM min 70%)	expected until late Autumn 2026. Further period of consolidation will be required alongside leadership development before able to take in charge shifts, however in the interim this should support a degree of agility with staffing. Two staff members have applied for 26/27 cohort. 1WTE B6 QIS recruited and starting late June 2026. 1 WTE B6 to be advertised again. 1 WTE new to neonates B5 started in May and a further 0.92 B5 (experienced paediatric nurse) to start in July with aim to support fast track of mandated foundation programme to facilitate swift transition to QIS training. Organisational change process ongoing to redesign establishment structure to ensure workforce is fit for purpose for now and the future. QIS staffing remains fragile, but stable. Recognising the challenges in recruiting experienced QIS, there is also now a focus on strengthening the B5 workforce, recognising and harnessing talent to grow our own QIS workforce for the future. Ongoing challenges are anticipated in the short to medium term, and the consideration

Medical staffing	Improvement in sickness absence - we continue to ensure minimum safe staffing numbers and QIS cover. Very limited suitable resource (QIS/neonatal experience) via NHSP. Meets BAPM standards for level 1 special care unit. Revised BAPM medical staffing standards released in Nov 25 which will have future implications for the organisation meeting medical staffing requirements	of potential system wide solutions will need to be explored. 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. Devon wide MNIP review and costing meeting with the ICB took place at end of April which touched on the impact of new standards. No outcome yet, however ICB now have a greater insight into the complexity of both staffing and estates/resource challenges across the system.

3.2.1 Safe Maternity Staffing- Fill rates – planned verses actual

	Day		Night	
	Midwives %	MSW's %	Midwives %	MSW's %
April 2026	79	94	100	77
May 2026	77	80	97	71
June 2026	78	91	95	80

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

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

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

- Temporary staffing solutions – bank staff or staff working additional hours.
- Request midwifery staff undertaking specialist roles to work clinically.
- 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 Birthrate Plus midwifery workforce study was undertaken in September 2025 and the finalised report was presented at the Executive Committee meeting in December 2025. The report evaluated midwifery staffing needs for the entirety of the Maternity Services at TSDFT.

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. There is also a significant proportion of safeguarding and social complexity within the demographic, particularly focussed within three of the six community midwifery teams.

The finalised report evidences an overall deficit of 3.81 WTE, with a particular need identified within the specialist midwifery team, consideration has been given to offering these roles at Band 6 and, in some cases, as rotational roles, to support potential career progression opportunities. 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. A business case has been written to address this deficit and will be presented to the Trust Investment Group in July 2026.

3.3 Multidisciplinary Training Compliance

TRAINING COMPLIANCE	PROMPT	Fetal Monitoring	Safeguarding
All Staff	82%	82%	99%
Midwives	84%	91%	98%
Maternity Support Workers	80%	NA	90%
Obstetric Resident Drs	67%	75%	58%
Obstetric Consultants	55%	27%	82%
Anaesthetists	76%	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, an additional teaching session will significantly improve consultant compliance and will run in July. 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.

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

4.1 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 one baby delivered at 28+6 weeks, spontaneous labour; woman assessed as unable to be moved to a Tertiary centre due to bleeding and rapid progression of labour. Delivered at Torbay and transferred out for uplift in care.

Exceptions are reviewed and reported on monthly to provide rationale, with oversight of the SW Neonatal network. Locally the neonatal medical lead and the governance co-ordinator review all births at Torbay outside of service specifications to ensure appropriate escalation actions have been taken and to identify any learning.

In Q1 a thematic review of all deliveries at TBH <32 weeks was undertaken. Key themes were:

- 12 very preterm births (23+3–31+3 weeks), Jan 2025–Apr 2026.
- 10/12 women low risk at booking – risk evolved later.
- Health inequalities (ethnicity, deprivation, language) prominent.
- High intrapartum acuity with emergency escalation.

Actions:

Recommendations Mapped to Saving Babies' Lives Care Bundle



Torbay and South Devon
NHS Foundation Trust

SBLC Element	Learning from Review	Recommended Actions
Element 1 – Smoking	Low smoking prevalence	Continue routine smoking surveillance.
Element 2 – Risk Assessment	Booking risk status poorly predicted outcome	Embed dynamic, <u>personalised</u> antenatal risk review throughout pregnancy
Element 3 – Fetal Surveillance	Intrapartum response generally timely	Maintain standards; focus improvement on early presentation and access to the unit.
SBLC v3 – Inequalities	Ethnicity, deprivation, language modified risk	Explicitly include inequality markers in triage, escalation and governance learning
Other Factors	Precipitous labour and delayed attendance noted	Maintain low threshold for face-to-face triage for preterm symptoms

4.2 Neonatal Deaths – Safety Measures and Escalation- update

In the last 12 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. Given the clustering and nature of the incidents, a thematic learning review was 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. The thematic review findings are presented in a separate paper to this committee.

4.3 Safety Improvement Plan –Maternity and Neonatal Improvement Support Team

Between April and June 2026, the Maternity and Neonatal Improvement Plan has demonstrated measurable progress across governance, leadership, quality improvement and external assurance. Governance arrangements are now established and functioning effectively, workstreams are aligned to national priorities, and the programme has received positive feedback through the June 2026 Mat Neo Insight Visit, resulting in progression from targeted support to regional oversight. Whilst areas requiring continued focus remain, there is evidence of sustained improvement delivery and increasing organisational assurance regarding the safety, quality and leadership of maternity and neonatal services.

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	• Estates works completed to provide adequate clinical room for the implementation of BSOT's. • EPIC go live provided implementation of documentation for BSOTs system recording. • Task and finish group established to ensure correct implementation. • Antenatal Clinic Manager shadowed RDUH Triage to share best practice. • Introduction of acuity coding via white board for easy visibility of acuity as well as differentiation between DAU and Triage • Project manager following up audit schedule to ensure compliance. • Standardised how triage calls and reasons for admission are recorded in Epic to support patient flow / categorisation, audit and learning.	What we are working on • Training package for maternity triage trialled and plan for rollout in the service made. • Improving consistency of telephone triage, including use of Netcall across 24 hours • 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 Next steps • Completion of audits to provide data to ensure implementation is correct or to allow for improvements to be made.

		Review and implementation of NHSE National Maternity Triage Specification.
Obstetric theatre	- Dedicated emergency theatre - Improved process for out of hours theatre provision has improved relations between maternity and theatres. - Initial Labour Ward Forum established with theatres as member to ensure regular space for discussion. - Blood fridge to be shared between maternity and theatres project progressing, improving joint working. - 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.	- The Trust wide transformation team and local team working on a Quality Improvement project to review both elective and emergency pathways. - Quarterly progress meeting with both care groups to provide oversight of actions. - Data quality actions around measurement of timings now new system in place.
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 – This is on the trust risk register.

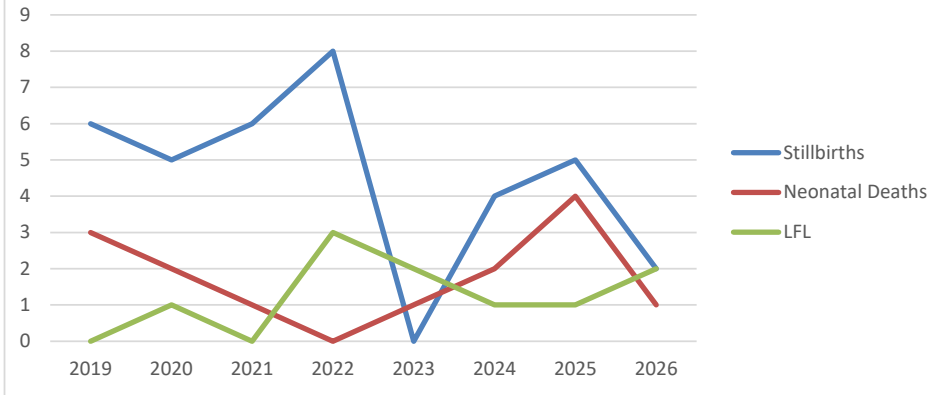
Medical staffing – safeguarding children training compliance	- Improvement in compliance figures. Practice educator collaborating with clinical director to support attendance. - Safeguarding support in place within unit as part of day to day working. - Bespoke, local safeguarding input as part of induction	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. - Stepping down of MNIST Targeted support following Insights visit from national and regional teams. - Governance Toolkit finalised and ratified. - Floor to board reporting changes agreed and socialised. - Perinatal Safety Champions Committee established. - Perinatal Governance Committee agenda agreed and first meeting planned.	- Communication system and SoP to be written and ratified. - Correct monitoring of action plans to ensure clear Perinatal oversight of themes whilst providing assurance for Trust via DCIQ needs to be further explored and finalised. - Posts in Governance need to be made substantive for improvements to be sustained.

4.5 Patient Safety

4.5.1 Perinatal Morbidity and Mortality Summary for the period

	April 2026

Torbay Stillbirths and Neonatal Deaths
2019 - To Date



Year	Stillbirths	Neonatal Deaths	LFL
2019	6	3	0
2020	5	2	1
2021	6	1	0
2022	8	0	3
2023	0	1	2
2024	4	2	1
2025	5	4	1
2026	2	1	2

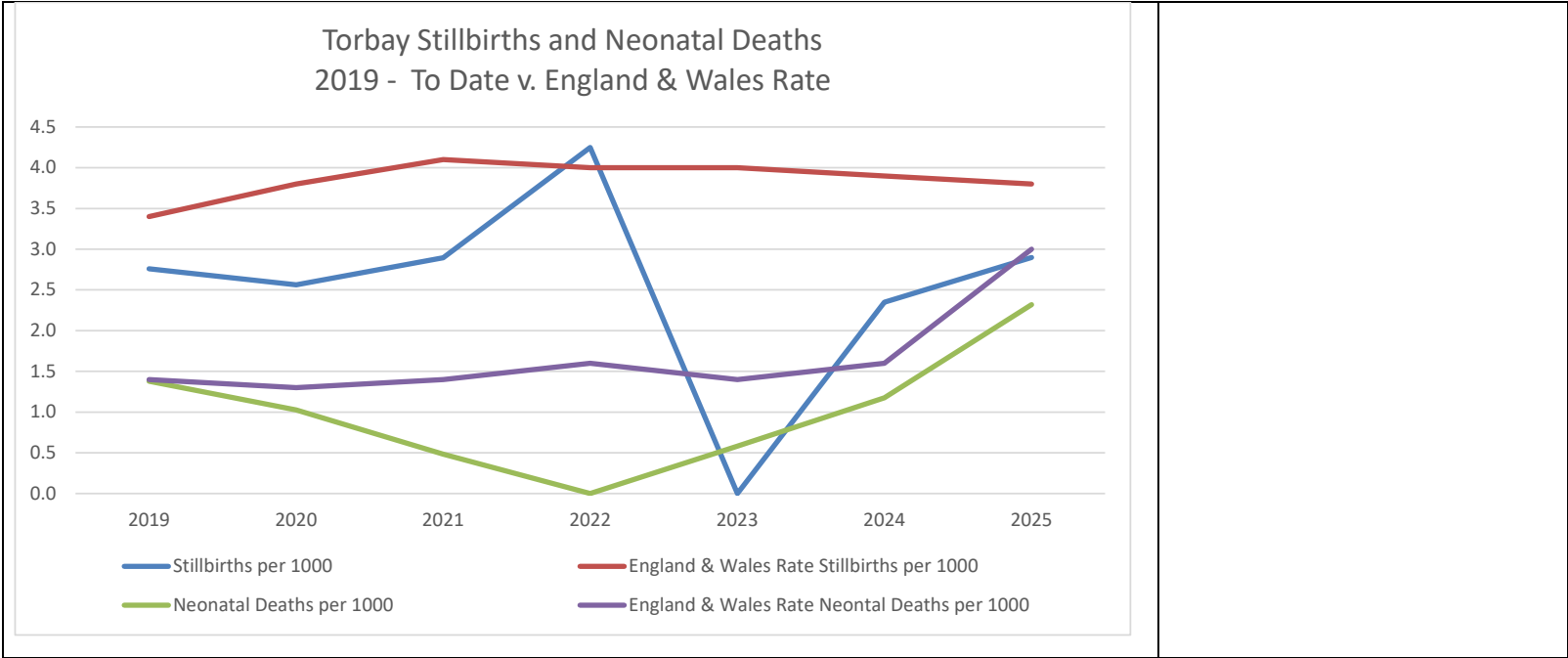
No perinatal mortality in April.

May 2026

No perinatal mortality in May.

June 2026

- 1 x Stillbirth at 27/40 – DCIQ 38251
- 1 x Late fetal loss 23+3 weeks.



4.5.2 Patient Safety Incidents

PATIENT SAFETY Incidents (PSI)	Number	Key themes/ trends/ escalations
Serious Incidents	2 in total	1st April 2026 – 30th June 2026 April 2026 • No Serious incidents reported in April. May 2026: • No Serious incidents reported in May. June 2026 • DCIQ 38251 – Death – Stillbirth at 27/40 gestation – HELLP Syndrome • DCIQ 38787- Severe - Baby transferred to higher level unit due to significantly raised bilirubin levels.

Moderate Incidents	7 in total	1st April 2026 – 30th June 2026 April 2026 • DCIQ 36142 – Moderate – Admission to the Intensive Care Unit following collapse in theatre during a caesarean section. • DCIQ 36878 – Moderate – Preterm Delivery <32/40 – 28+6 - Rapid delivery followed by cervical tear. May 2026: • DCIQ 37906 – Moderate – Large Postpartum Haemorrhage following emergency caesarean section – Baby resuscitated and transferred to level 1 unit for cooling. • 37990 – Moderate - Ongoing issues with obstetric scanning capacity, unable to fulfil requests to meet time requirements. June 2026 • DCIQ 38518 – Moderate - Secondary Postpartum Haemorrhage (PPH) leading to Postnatal Readmission

		• DCIQ 38527 – Moderate - Major Obstetric Haemorrhage - 2.45l • DCIQ 39323 – Moderate - 3.7l PPH leading to Intensive Care Unit admission

PATIENT SAFETY	Number	Key themes/ trends/ escalations
New referrals to MNSI	1	• DCIQ 38787- Severe - Baby transferred to higher level unit due to significantly raised bilirubin. Referred to MNSI under the criteria of brain injury. Awaiting notification of staff interviews.
Findings of final MNSI reports returned (themes only)	1	MNSI report received in April 2026. In relation to a baby born with Severe HIE who sadly died. Notified to MNSI and ENS via SPEN. Key themes are:

		• Earlier escalation of fetal compromise. • Improved informed choice regarding student midwife involvement. • More effective embedding and assurance of organisational learning. • Consistent and accurate documentation during neonatal emergencies. • Improved clinical decision-making regarding vascular access. • Stronger multidisciplinary communication and shared situational awareness during rapidly evolving neonatal resuscitations.
Findings of cases reviewed under PMRT. (themes only)	1	One PMRT report was completed cases were reviewed in this period. • Datix No: 32804 – Notified to MBRRACE via SPEN. PMRT MDT meeting held 7th May 2026 – external participants present, Report due by 11th July 2026. No cause of death was identified, key themes: • Consistency of post-diagnosis care processes. • Confidence in fetal heart assessment and documentation. • Access to specialist pathology and investigation services. 2 PMRT review is pending. Date due for completion:

		- Datix No: 38251 – Notified to MBRRACE via SPEN – 100% Factual Questions complete, DOC sent to family and feedback sought. PMRT MDT meeting date TBC – Report due by 2nd December 2026. - Datix No: 38814 – Notified to MBRRACE via SPEN – 100% Factual Questions complete, DOC sent to family and feedback sought. PMRT MDT meeting date TBC – Report due by 20th December 2026 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.

Quarterly Themes and Learning

Key themes identified from PMRT reviews, MNSI investigations, PSIRF reviews and patient safety incidents:

- Recognition and escalation of clinical deterioration.
- Documentation and record keeping.
- Multidisciplinary communication and situational awareness.
- Obstetric haemorrhage and emergency response.
- Neonatal deterioration including jaundice management.
- Capacity pressures affecting obstetric ultrasound services.
- Consistency of bereavement and post-diagnosis care pathways.

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

Datix Number	Ethnicity	IMD Decile (1=Most Deprived, 10=Least Deprived)
32804	White British	5
32978	White British	3
38787	Asian or Asian British - Any other Asian background	1
38251	Asian or Asian British - Any other Asian background	7
38814	White British	7

*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	Discuss at Mandatory Training around lessons learnt from incidents to	Clinical Governance Coordinator	Completed

		domestic abuse in her pregnancy	communicate the importance of asking about DV at any contact where the woman attends alone send information via Clinical Updates WhatsApp group and email. – Consider an audit of DV enquires in pregnancy.		
Datix No: 22060	Fetal Growth monitoring	Period for measuring subsequent symphysis fundal heights following a scan.	GAP institute contacted for response to issue, discussion of whether to include follow up scan as additional intervention. Not to be progressed as not a national mandate from NICE.	Antenatal Clinic Lead Midwife	Completed
Datix No: 22736	Decision making and escalation	This mother had an operative delivery, but this was not carried out with appropriate urgency	Discussion to be held with staff members involved to reflect on the care given and identify any learning points or additional training requirements from the care given.	Supervisors of relevant staff.	Completed
Datix No: 22736	Decision making and escalation	The mother should have been asked to attend the unit after her first call to the triage line	BSOTs implementation, when full triage works are complete to help with the situational awareness of women that are high risk e.g. multiple pregnancy versus amber flags for singleton pregnancies.	Outpatient Matron	Completed

Datix No: 22736	Record Keeping	The review group felt that some aspects of the documentation in this case were lacking in detail. This is to be addressed as part of a wider project around improvements in documentation.	Continue with updates to policies around record keeping in maternity, continue with ongoing notes audits and highlight importance of documentations as part of EPIC launch. Consider documentation workshop/learning session in conjunction with litigation team?	Inpatient Matron and Clinical Governance Coordinator(s)	Ongoing
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 debrief 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)	Ongoing
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	Action plan produced by bereavement midwives. Correct labelling protocol	Bereavement Midwives	Completed

		labelled, the genetics for Deceased twin reported his sex as female, additional distress was caused to parents.	to be updated in relevant guidelines.		
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 from the staff involved at the time of the event.	Governance team to ensure that memory captures are sent to staff who are involved in serious events, shortly after the event. This will help with gathering facts for the case as well as prove to be good practice for those involved in reflective practice.	Maternity and Child Health Clinical Governance Coordinators.	Ongoing
Datix No: 26398	Fetal Growth monitoring	It was overlooked that due the woman's bicornate uterus she did not need to be measured at 28 weeks.	Reminder to go out to all staff that a uterine anomaly should be treated as a risk factor for preterm birth and care should be consultant led.	Outpatient Matron	Completed
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

Datix No: 32804	Bereavement Services	Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	The local maternity service has since commissioned a private pathology service.	Bereavement Midwives	Completed
Datix No: 32804	Guidelines	Maternal observations not completed following diagnosis of stillbirth	Remind staff via Bereavement session on Mandatory that it is important to check a woman's observations prior to auscultating the fetal heart	Bereavement Midwives	31.12.2026
Datix No: 32804	Communication	The Woman went home prior to commencing her induction of labour with very little information.	Bereavement Midwives have written a leaflet to give to women in this situation, this is now available and will be available via smart-phase on EPIC.	Bereavement Midwives	Completed
Datix No: 32804	Guidelines	There was no consultant available to confirm the baby's death on ultrasound scan, therefore the woman had to return the following day for a scan to confirm the baby's death.	Guideline to be rewritten to ensure a follow up scan to be completed by another qualified ultrasound technician before administration of Induction of Labour drugs commences.	Bereavement Midwives	31.12.2026

Recommendations Mapped to Saving Babies' Lives Care Bundle



Torbay and South Devon
NHS Foundation Trust

SBLC Element	Learning from Review	Recommended Actions
Element 1 – Smoking	Low smoking prevalence	Continue routine smoking surveillance.
Element 2 – Risk Assessment	Booking risk status poorly predicted outcome	Embed dynamic, <u>personalised</u> antenatal risk review throughout pregnancy
Element 3 – Fetal Surveillance	Intrapartum response generally timely	Maintain standards; focus improvement on early presentation and access to the unit.
SBLC v3 – Inequalities	Ethnicity, deprivation, language modified risk	Explicitly include inequality markers in triage, escalation and governance learning
Other Factors	Precipitous labour and delayed attendance noted	Maintain low threshold for face-to-face triage for preterm symptoms

Impact of Previous Learning

- Labour Ward portable ultrasound scanner replaced and upgraded.
- Bereavement pathway revised including placental labelling processes.
- Documentation improvements incorporated into EPIC implementation work.
- Ongoing audit of documentation standards.
- Enhanced education regarding sepsis documentation and escalation.
- Improved access to specialist perinatal pathology services.

Q1 scorecard review

Claims Scorecard April 2015 – March 2025

Top injuries by volume: - Unnecessary pain - Stillborn - Hypoxia - Loss of Baby - Brain Damage	Top injuries by value: - Hypoxia - Brain Damage - Down Syndrome - Add/Unnecessary Operation - Bowl 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 - Fail/Delay Diagnosis - Fail to Warn – Informed Consent - Forceps Delivery

Complaints and Concerns Q1 26-27

Complaints

Communication in Labour (1)

Concerns

Inadequate pain relief-postnatally and during caesarean section

Birth pool unavailable

Caesarean- delays with booking and during surgery

Extravasation of iron transfusion

Incidents (moderate or above) Q1 26-27

Death - IUD @ 27/40 – HELLP Syndrome – 38251

Severe - Baby transferred to higher level unit due to suspected Kernicterus - 38787

Moderate - PPH – 38518, 38527, 39323, 37906

Moderate - Ongoing issues with obstetric scanning capacity, unable to fulfil requests to meet time requirements – 37990

Moderate – Admission to ICU following collapse in theatre during Cat 2 LSCS – 36142

Moderate – Preterm Delivery <32/40 – 28+6 - Rapid delivery followed by cervical tear – 36878

Maternity Incentive Scheme 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.



Themes Q1 26-27

- Communication with women and families
- Booking and process with caesarean sections
- Post Partum Haemorrhage (PPH) (4)
- Women admitted to ICU postnatally (2)
- Baby for cooling – Hypoxia (1)
- Baby with Kernicterus (1) – Delay/Failure in Treatment

Learning Q1 26-27

Large PPH's to have full case reviews following identified learning from thematic review as per care bundle requirements.

Multiple learning points following admission of neonate with Kernicterus. Immediate Action plan completed. Business case started for Bilirubinometers.

MDT case review booked for cooled baby and women admitted to ICU.

Action Plan Q1 26-27

Not started

In progress

Completed

Urgent update to midwifery practice in light of incident and maternity guideline not being aligned with NICE recommendations guideline.

Develop and implement a systematic jaundice screening approach in the community.

Introduce transcutaneous bilirubinometers (TCB/TBM), with a recommendation of one device per community team to enable timely and objective assessment.

Plan for the anticipated increase in hospital attendances, ensuring capacity and escalation pathways are clear.

4.6 Saving Babies Lives Care Bundle

Element 1	Element 2	Element 3	Element 4	Element 5	Element 6
Reducing smoking in pregnancy	Fetal growth- risk assessment, surveillance & management	Raising awareness of reduced fetal movement	Effective fetal monitoring during labour	Reducing preterm births and optimising perinatal care	Management of pre-existing diabetes in pregnancy
OnTrack	On Track	Compliant	On Track	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. Smoking cessation training compliance	Increase capacity for face-to-face booking appointments. Mandatory training halted during epic rollout. Plan is in place to achieve 90% compliance by end Sept 2026
2	GAP and GROW training for measuring fundal height.	Action plan to ensure 90% of staff are compliant by end Sept 2026
4	Fetal monitoring training	Mandatory training halted during epic rollout. Plan is in place to achieve 90% compliance by end Sept 2026
5	Rise in preterm birth rate in first Quarter of 2026 Change to requirement to use regional born in the right place data.	There was an increase in preterm births <34/40 in the first quarter of 2026. A thematic review has been completed, and an action plan is in place.

	Full course of antenatal steroids given to babies <34 weeks. Magnesium Sulphate administration to babies <30 weeks Thermoregulation for preterm babies	

For 2025-26 Q4 (January 26 - March 25) compliance has fallen from to 85.51 from 91.3% compliant in the last quarter. This is due to training compliance not meeting the required 90% compliance during the rollout of EPIC. A plan is in place to ensure our training compliance is at 90% by the end of September 2026.

There are issues with data entry and reporting data from EPIC which will impact our compliance with Saving Babies Lives bundle in Q1 2025-2026, and this will particularly impact our smoking data.

For Year 8 of the Maternity Incentive Scheme ICBs have stepped back from their previous assurance role and the responsibility for assurance of compliance with the Saving Babies' Lives Care Bundle v3 now sits with the Trust Board.

4.7 Perinatal Leadership Team (PLT) – Collaborative Working

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 and 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.

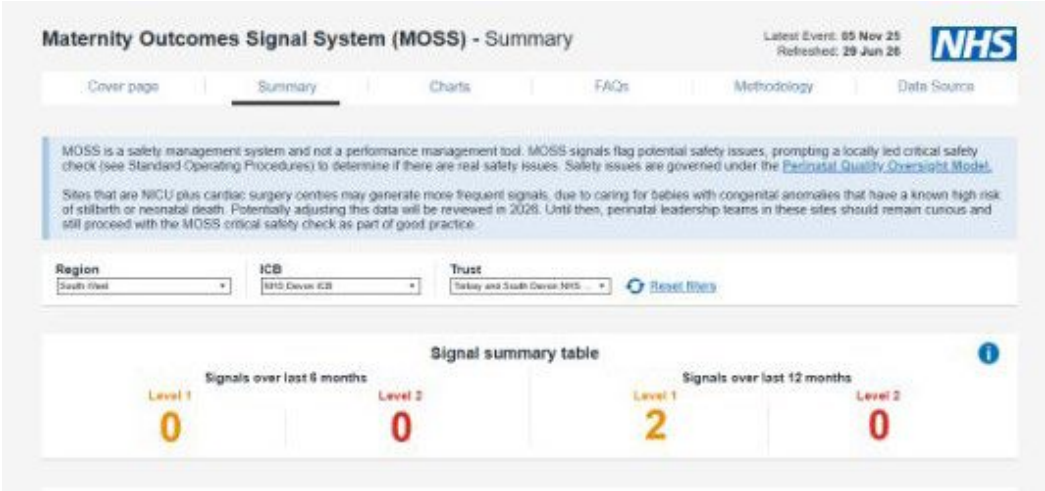
During April–June 2026, the Perinatal Leadership Team worked in close partnership with the Trust's Board-level Maternity Safety Champions through a programme of Safety Champion walkarounds, service-user engagement and governance oversight. These visits enabled direct engagement with women, families and frontline staff, providing valuable intelligence regarding communication, induction pathways, maternity estate improvements, EPIC implementation and workforce experience. Feedback from these visits directly informed improvement actions, including strengthening communication with women and families, supporting optimisation of the new

triage model and digital systems, and ensuring that women's voices continue to shape service development. They also provided direct engagement with the regional Insights visit in June. This collaborative "floor to board" approach has strengthened assurance, supported delivery of the Maternity and Neonatal Improvement Plan and reinforced a culture of openness, learning and continuous improvement.

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.

During quarter one of 2026/27 the Trust received no MOSS alerts; the system is reviewed monthly which is reported to board.



A site-specific draft SoP has been produced for TSDFT's MOSS alert response, and a tabletop exercise is planned for July in line with MIS standards and to ensure that systems are working as intended.

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

Year 8 of the Maternity Incentive Scheme (MIS) launched on 1st April 2026. The national webinar was 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 greater emphasis on outcomes and board oversight for this year's programme. Year 8 builds on the Year 7 requirements with a continued focus on equity, safety actions, and training compliance.

In line with the revised MIS standards, we must declare a Trust selected checkpoint via QPC and for this to be acknowledged. This is alongside our mandatory MIS checkpoint of 30th November 2026. We would like to propose a submission date for the Maternity Mandatory training data on 31st October 2026. Whilst this is close to the mandatory date, this is mostly due to the impact of the recently implemented EPIC system within our Trust. A mid-point date will be

chosen for next years (Year 9) MIS submission, but we felt this date gives the best opportunity to achieve our 90% compliance rate for the year (Year 8) following the training freeze due to EPIC training.

In the meantime, we are running additional mop-up training sessions to ensure training is 90% complaint in all areas by October. For example, we are running an additional PROMPT training day, which will be attended by multi-professional staff groups in August. October is also the preferred month as this will not include our new rotational resident Drs, who join in October, and will allow for new preceptee midwives to have attended the training in September, prior to our first data submission checkpoint.

In the interim, additionally, close monitoring of all maternity mandatory training remains in place and escalation to line managers as required.

With the Perinatal Compliance Lead in post, work is already underway with the preparation of evidence for submission, identifying the leads for each of the Safety Actions, and the review of the newly launched Maternity Care Bundle (MCB), which sits within Safety Action E of the MIS. Resources and discussions continue through the MIS Futures NHS workspace and webinars.

A reminder that a declaration of full compliance for all ten safety actions was submitted for Year 7 by the Trust. It was confirmed by NHS Resolution that the Trust had met all ten safety actions for Year 7 of MIS.

5.0 Actions to improve care for women and families- Ockenden and Amos Reports.

In June 2026, two national reports were published. The Ockenden report exposed severe long standing clinical and cultural failures at Nottingham University Hospitals NHS Trust where hundreds of mothers and babies suffered avoidable harm.

Concurrently the nationwide Amos Report concluded that England's entire maternity system is no longer fit for purpose demanding urgent structural reforms to tackle systemic safety issues and racial discrimination. More detail around the next steps Trust's need to take are explored in the executive summary of this paper.

6.0 Conclusion.

This report provides a comprehensive overview of the safety, quality, and governance arrangements within maternity and neonatal services for quarter one 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. An executive summary of this report is presented in full to the Committee and presented by members of the PLT.

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Presented to:	Quality and People Committee					
Title of Report	Mortuary Services Assurance Declaration					
Date of Meeting	28/07/2026		Author	Ria McCoy, ADP		
Executive Lead	Dr Catherine Lissett		Executive Sign Off			
Governance Route						
Recommended Action	For Approval	For Assurance	To Update	For Information		
		X				
Executive Summary	In response to the Nottingham Maternity Review Findings on Post-Death Care and Key Actions Following the Fuller Inquiry and System letter on mortuary oversight 2026. This report has been developed to provide assurance to the Trust Board, via express delegation to the Quality and People Committee, to enable the completion of the Board Assurance Statement required by NHSE by 31st July 2026. Previous detailed reports in response to the Fuller Inquire phase 1 have been presented to Board and approved. The full report for the Fuller Inquiry phase 2 with an update on ongoing monitoring of compliance with previous recommendations has been presented to the Chief Medical Officer, as the Designated Individual, and via Care Group Governance and is due to be presented at Public Board in September 2026. This will comprise of the completed Board Assurance Statement along with a gap analysis and mitigations from both the findings of the Ockenden Independent Review of Maternity Services at Nottingham University Hospital Trust, related HTA report and the Fuller Inquiry. The combined recommendations from the reports total 39 recommendations. The Trust has actioned and ensured full compliance with 32 of these recommendations, with 7 requiring further action but with mitigations on place. The Committee is asked to review the action plan and agree whether each of the assurance statements can be confirmed					
Link to Strategic Signature Moves	Living well in our neighbourhoods	Reimaginin g acute and specialist care	Caring, skilled people ready for tomorrow	Joined up care, every step of the way	Smart use of technology for better care	Foundation
		X				X
How this paper supports delivery of the Strategy	This paper supports delivery of the Trust Strategy by providing assurance on mortuary service oversight, governance and compliance. It demonstrates the Trust’s response to national learning and supports the Foundation signature move through strengthened risk management, regulatory compliance and public confidence in safe, dignified care					

Board Assurance					
BAF Ref	Principle Risk		Current Score	Impact of this paper	
BAF-QS	Quality, Safety, Clinical Outcomes and Patient Experience		3x4=12	Positive - Provides assurance on safe, dignified post-death care through strengthened oversight, compliance monitoring and mitigation of identified gaps.	
BAF-LG	Leadership and Governance		2x4=8	Positive - Strengthens Board assurance on governance, regulatory compliance and risk management, supporting completion of the NHSE Board Assurance Statement	
Link to CQC Quality Statement	Safe	Caring	Responsive	Effective	Well-led
	X	X			X
Compliance / Regulatory Requirements	Supports completion of the NHSE 2026 Mortuary Oversight Board Assurance Statement and provides assurance against Fuller Inquiry, Nottingham/Ockenden and HTA expectations.				
Ethical or EDI implications?	The paper supports dignified, respectful and culturally sensitive post-death care, helping ensure equitable treatment for deceased patients and bereaved families.				
Assurance rating	Significant	Moderate	Limited	Inadequate	
	X				
Assurance rationale	The paper and supporting appendices provide a clear evidence base that the relevant controls are appropriately designed and operating effectively. Where further actions are required, these are supported by identified mitigations, defined timescales and ongoing monitoring arrangements, enabling the Committee to take significant assurance.				
Appendices	PRN02500 System Letter July 2026 Mortuary action plan				

Classification: Official



To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors
- clinical directors
- estates and facilities leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2026

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors
- estates and facilities leads
- communications leads

Dear colleagues,

Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry

The NHS holds a special responsibility for the care of patients from birth, throughout their lives and in death. At every stage, we must deliver care with dignity, respect and compassion.

When dignity after death is not preserved, the NHS betrays the trust that is placed in it and not only fails those that have died, but also their loved ones, adding to their grief and harm. As leaders, we must ensure this never happens by putting in place the right support and oversight, so that all staff working in the NHS consistently uphold dignity and care.

The further instances of unacceptable care of the deceased, amongst the many distressing findings of Donna Ockenden's [Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust \(NUH\)](#), are shocking. We must

remember that this is not the first time that unacceptable care and poor oversight of mortuaries have been uncovered, and there is already a clear set of actions to strengthen and improve this area of care. The findings of Donna Ockenden's report should be considered alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, [published in July 2025](#). The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

We know that the NHS has been working hard to meet the recommendations following the independent inquiry into the actions of David Fuller. However, in light of these further terrible findings, we are asking you not only to ensure compliance, but that you are rigorously reviewing your mortuary departments on a regular basis. To do this, ask yourselves the question 'what do you really know about the culture of your services, and the values and behaviours of your staff?'.

No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

To support this oversight, **Annex 1** summarises the guidance and support NHS boards should consider, and **Annex 2** maps the NHS-focused Fuller Inquiry recommendations to this guidance.

Trusts are asked to cascade this letter to relevant teams, including estates, safeguarding, pathology, bereavement, mortuary, corporate services, and your Freedom to Speak Up Guardians. Issues requiring support or escalation should be raised through regional teams.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. **All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.**

For NHS trust chief executives, medical directors and chief nurses, there will be a chance to discuss this and broader issues in maternity and neonatal care when we come together in London on Tuesday 30 June.

Thank you for all you have already done in response to the Fuller recommendations to date. However, there is still more work to do. We owe it to those who have died, and to their families and loved ones to ensure the findings of the Donna Ockenden review, the HTA report on NUH, and the Fuller Inquiry recommendations lead to meaningful and lasting change.

Yours sincerely,



Duncan Burton

Chief Nursing Officer for England



Sarah-Jane Marsh

NHS England Chief Operating Officer

Annex 1 - Summary of national updates made or planned in response to the Fuller Inquiry

1. NHS Premises Assurance Model (PAM) (15 April 2026)

[The NHS Premises Assurance Model \(PAM\)](#) supports boards, directors of finance and estates and clinical leaders to make more informed decisions about the development of their estates and facilities services and provides assurances that the estate is safe, efficient, effective and of high quality. The NHS Standard Contract requires providers to comply with the PAM. A new set of high-level self-assessment questions reflecting relevant recommendations made by the Fuller Inquiry has now been incorporated into the latest version of the PAM. The submission window for the NHS runs from 8 May 2026 to 8 September 2026.

For assurance by trust boards: Trusts should assure themselves against the latest version of the PAM self-assessment questions.

2. Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (May 2023)

Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.

[Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services](#) was updated in 2023, to enhance levels of security, access and CCTV, however we will be providing further update during 2026 to provide additional guidance to NHS trusts on recommendations raised by the Fuller Inquiry.

For assurance by trust boards: Trusts should consider best practice guidance set out in the HBN for ongoing planning.

3. Insightful provider board guide (November 2024)

Trusts are reminded that the [insightful provider board guide](#) is intended to help boards to identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively. This guidance already references mortuary practices but will be updated later in 2026 and will incorporate relevant content to reflect Fuller findings and recommendations. It should be read alongside the [Code of governance for NHS provider trusts](#) (March 2026) and [Guidance on good governance and collaboration](#) (April 2023).

For assurance by trust boards: Trust boards should use the guidance provided to reflect and consider whether the leadership, culture, systems and processes they have in place are using information in the best way to lead their organisations effectively in respect of matters relating to mortuaries and body stores.

4. Assessing provider capability: guidance for NHS Trust Boards (August 2025)

[Assessing provider capability: guidance for NHS trust boards](#) provides a self-assessment framework to strengthen boards' governance and assurance. These self-assessments are used by regional oversight teams along with their own views and information held by 3rd-party bodies (including the Human Tissue Authority) to take a view of management, governance and grip. This guidance is also due to be updated later in 2026.

For assurance by trust boards: As per [Insightful provider board guide](#) (see entry 3).

5. Advanced Foundation Trust Programme (12 November 2025)

For existing NHS foundation trusts and NHS trusts who wish to become advanced foundation trusts, the [Advanced Foundation Trust Programme](#) requires evidence that trusts applying for advanced foundation trust status have considered relevant insights and learning from inquiry recommendations and have implemented them or are in the process of implementing them (question 2, advanced foundation trust criteria – quality governance arrangements are effective in practice).

For assurance by trust boards: As per [Insightful provider board guide](#) (see entry 3).

6. NHS Safeguarding accountability and assurance framework (April 2026)

The [NHS Safeguarding Accountability and Assurance Framework](#) (SAAF) sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This includes requirements for an executive lead for safeguarding. In April 2026, the SAAF was updated to include reference to the deceased. Trusts should also note this addition will require a supporting reference to be made in the annual report about

safeguarding children, adults and children in care. This must be submitted to the trust board.

NHS England is also updating related training to include reference to the deceased. These updates will be made during 2026.

For assurance by trust boards: Providers must demonstrate that these updates to safeguarding are embedded at every level in their organisation, with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

In line with updates to the SAAF, executive leadership should now include oversight of arrangements for the deceased. Trust boards are encouraged to consider their local arrangements accordingly. Executive leadership for safeguarding, estates and related security matters may vary according to local arrangements (for example, operating via a dual accountability between the executive lead for statutory safeguarding and the executive lead for estates) and trust boards should ensure this is clearly articulated.

Local take-up of safeguarding training and resources requires ongoing assurance by trusts.

7. Related Third Party Guidance

HTA Guidance

The Human Tissue Authority (HTA) [Codes of Practice](#) provide practical guidance to professionals carrying out activities within the scope of the HTA's remit, which includes licensed mortuary facilities in the NHS estate. This includes detail on the required appointment of a Designated Individual. The Human Tissue Authority have additionally published [good practice guidance for those responsible for the dignity and care of the deceased](#). This is voluntary guidance and applicable to all settings, including unlicensed body stores.

Hospice UK Guidance

[Hospice UK](#) have several resources to support clinical and non-clinical staff in a hospice role. Their [Care After Death](#) guidance provides a comprehensive guide for all staff who are responsible for the care of a deceased adult.

Annex 2 – NHS specific Fuller Inquiry report recommendations and supporting guidance. Please refer to annex 1 for additional context on supporting guidance.

Recommendations 1 to 9 (relevant to security, CCTV, access and audit)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.264-265).

Supporting guidance

NHS Premises Assurance Model (see entry 1 in Annex 1).

Health Building Note 16-01: Facilities for mortuaries, including body stores and post-mortem services (see entry 2 in Annex 1).

Other third-party guidance: Human Tissue Authority code of practice and Human Tissue Authority voluntary guidance (see entry 7 in Annex 1).

Recommendations 10, 11, and 12 (relevant to the role of the Designated Individual)

The full text of these recommendations can be found in the [Phase 2 Report](#) (p.265).

Supporting guidance

Third party guidance: Human Tissue Authority guidance, including the role of the Designated Individual (see entry 7 in Annex 1).

Recommendations 13 and 14 (relevant to the role of the Mortuary Manager)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.265-266).

Supporting guidance

Local HR policies and resource allocations.

Recommendations 15, 16, 17 and 18 (relevant to the board assurance and reporting)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.265-266).

Supporting guidance

The Insightful provider board guide (see entry 3 in Annex 1).

Assessing provider capability: guidance for NHS trust boards and third-party information (see entry 4 in Annex 1).

Advanced Foundation Trust Programme (see entry 5 in Annex 1).

Recommendations 19, 20 and 21 (relevant to safeguarding)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.266-267).

Supporting guidance

NHS Safeguarding Accountability and Assurance Framework (see entry 6 in Annex 1).

Recommendations 24 and 25 (relevant to medical education settings)

The full text of these recommendations can be found in the [Phase 2 Report](#) (pp.267-268).

Supporting guidance

Where relevant to the NHS, these actions have been reflected in the NHS Premises Assurance Model (see entry 1 in Annex 1)

Recommendation 27 (relevant to hospice settings)

The full text of this recommendation can be found in the [Phase 2 Report](#) (p.268).

Supporting guidance

NHS trusts directly providing a hospice service that includes provision for either a mortuary or body store should be aware of wider updates, as set out in **annex 1**. Other related third-party guidance has also been updated in line with inquiry findings: Hospice UK guidance (Care After Death) and Best practice guidance from the Human Tissue Authority (see entry 7 in Annex 1).

Recommendations 30 to 33 (relevant to ambulance policies and data)

The full text of these recommendations can be found in the [Phase 2 Report](#) (p.269).

Supporting guidance

The government's interim update sets out what action should be taken. A further update is expected in summer 2026.

In addition to the Government's interim update, ambulance trusts are individually responsible for introducing operational policies as described in the recommendation, and for ongoing monitoring of their use. Boards should assess compliance against these recommendations.

Annex 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by **31 July 2026** to: england.nhsinquiryteam@nhs.net

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.		
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.		
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.		

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)

The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.

For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.

Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date

Combined Fuller and Ockendon Actions for Torbay & South Devon NHS Foundation Trust

F = Fuller inquiry recommendation

O = Ockendon Maternity review recommendation.

Fuller Phase 2 Action Plan						
	Recommendation	Progress	Action	Owner	Deadline	RAG
Recommendation 1 -	All Trusts with Mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of 1. The systems in place to identify any unauthorised access to the facility 2. The strength and effectiveness of barriers to prevent unauthorised access to the facilities 3. The systems in place to identify any access to deceased people for unauthorised purposes 4. How CCTV is used, including its monitoring and any audits undertaken	Partially met. A full local review of security of the Mortuary was undertaken in response to Fuller 1 Inquiry. This was undertaken with the Mortuary Manager, Director of Operations and Security team. Access to the Mortuary is via individual swipe cards and CCTV and swipe card audits are carried out each week. All access requests must be signed off by the Mortuary Manager, Director of Operations and DI.	One remaining action is to arrange for an external review of security arrangements, however, this comes with a cost which has not currently been identified. The HTA inspection on 2025 also provided this external oversight with positive feedback on security processes	Ria McCoy, ADO	TBD pending finance sign off for expenditure	

Recommendation 2	All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the postmortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges	Completed in response to Fuller 1 Inquiry – CCTV in place in all areas referenced	Complete – no action	N/A	N/A	
Recommendation 3	All NHS trusts should routinely audit the access data of all facilities used to store deceased people	Completed in response to Fuller 1 Inquiry. Mortuary security audit carried out every Monday	Complete – no action	N/A	N/A	
Recommendation 4	The practice of using shared electronic swipe cards for specific staff groups should cease immediately	Completed in response to Fuller 1 Inquiry. All shared access cards revoked and individual access cards in use	Complete – no action	N/A	N/A	

Recommendation 5	All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons	No rule in place currently that prevents electronic devices within the Mortuary. Trust mobile phone policy in use, along with Policy for use of mobile communication devices within hospital buildings. A process assessment was carried out to see if enforcing tighter controls of mobile phones would be feasible. In most cases it wouldn't be feasible to remove phones from all Funeral Directors entering the department. It was agreed with the DI that signs prohibiting use of mobile phones would be installed in the Mortuary department and non-mortuary staff are required to be escorted at all times with portering teams in pairs.	Complete – No further action	N/A	N/A	
Recommendation 6	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be	Security breaches reviewed by Mortuary Manager, with input from Security team where required, these are	Complete – No further action	N/A	N/A	

	developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	documented on datix and escalated to ADO and DI				
Recommendation 7 – not applicable	The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority	N/A. No Body stores in use by the Trust. Only fully licenced Mortuary at Torbay Hospital	N/A	N/A	N/A	
Recommendation 8	All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	No swipe to exit system currently in use. Work has been costed and would be quite expensive to install all the required readers, plus upgrade the electric panel to be able to cope with them. Current price was sitting at over £8,000, and there wasn't a clear route to pay for this. This was discussed at the recent HTA meeting and the current control measures that are in place with audits was deemed to be adequate. It was felt the funding that would be required would be better spent in	Undertake a risk assessment to document the residual risk involved in not completing the work.	Simon Hughes, Mortuary Manager	31/08/2026	

		other areas of the department.				
Recommendation 9	All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.	Complete. This is carried out by the Mortuary Manager each Monday via an automated Swipe permissions list and access log being sent, that is reviewed. Results of these audits are held on Q-Pulse. Senior APT is now trained in these audits and also completes them.	N/A	N/A	N/A	
Recommendation 10	NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	Complete. CMO stated that she had enough time to complete her functions as DI	N/A	N/A	N/A	

Recommendation 11	NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	Complete. Senior Managers and the Chief Executive were involved in HTA inspection feedback, and understand the importance of the HTA and DI role.	N/A	N/A	N/A	
Recommendation 12	NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	Complete. DI attends the correct governance forums	N/A	N/A	N/A	
Recommendation 13	A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager	Complete. Mortuary Manager has background in Mortuary services and holds Certificate and Diploma in Anatomical Pathology Technology. This is essential criteria within the job description	N/A	N/A	N/A	
Recommendation 14	NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	Partially met. There are processes in place in the department to assist the Mortuary Manager to complete all relevant tasks and staffing levels increased in 23/24 – duties and processes still in development as well as competencies Due to Long term absence in the	It has been agreed that the service can advertise to backfill the long term absence with a fixed term post which was approved via TIG – recruitment is progressing. This will ensure that the Mortuary	Simon Hughes – Mortuary Manager Ria McCoy - ADO	01/12/2026	

		department there has been short staffing for the last 7 months. Workload is manageable for day-to-day operation, but some strategic operations are delayed.	Manager is not covering front line duties			
Recommendation 15	All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: 1. Staffing Matters 2. Security Incidents 3. All Serious Incidents 4. HTA Reports (where applicable) 5. All Security Audits, including audits of access and any access breaches	Partially met. A formal board report has been agreed and due to go to Trust Board in September -headings and info will be included in the report. Director of Operations updates on Mortuary matters via Divisional and Care Group governance Board report to be presented at September Board	N/A	N/A	N/A	
Recommendation 16	Trust boards should assure themselves that the recommendations in this Report have been implemented.	Board report was developed and signed off in response to Fuller 1 Inquiry - A further formal board report has been agreed and due to go to Trust Board in September 2026	Board report to be presented at September Board	N/A	N/A	

Recommendation 17	Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people	Temporary storage facilities have been assessed by the Mortuary manager, including site visits to Funeral Directors that the Trust holds SLAs with. This information will be contained in the board report.	Board report presented at September Board	N/A	N/A	
Recommendation 18	Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements	Complete – represented by DI as Board member	n/a	n/a	n/a	
Recommendation 19	NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	Confirmed as completed by CNO	N/A	CNO	N/A	
Recommendation 20	The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores	Complete	n/a	n/a	N/A	
Recommendation 69	Where organisations work together to care for people after death, the arrangements should be formalised through contracts or service level agreements. This should include	Partially met. SLA's are in place that state the steps that have to be taken for	Develop shared SOPs in line with SLA's	Simon Hughes - Mortuary	01/11/2026	

	joint Standard Operating Procedures. The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively, and that they seek assurance that the arrangements protect the security and dignity of people after death.	third parties to manage the safety and security of deceased patients in their care on behalf of the Trust, though there are currently no shared SOP's in place. Workforce constraints have meant that this action is not fully completed although the SLAs are in place but we will look to get SOP's in place before winter pressures start.		Manager Ria McCoy - ADO		
Ockenden Independent Review of Maternity Services at Nottingham University Hospital Trust – Action Plan						
Recommendation 1	Review and update the post-death care policy to explicitly require secure, respectful and dignified care of all deceased patients, including babies, in line with HTA expectations and the David Fuller Inquiry findings.	No Current post-death care policy currently in place. However, as mitigation, the mortuary team ensure training is provided to ward staff, porters and as part of any induction, including student nurses. This is documented	Approved policy published and communicated to all relevant teams.	Simon Hughes - Mortuary Manager	09/10/2026	

Recommendation 2	Introduce a standard family communication process requiring honest, accurate and timely updates where incidents, errors, delays or deterioration have occurred.	SOP's and Policies in place within the mortuary with appropriate signposting, but this could be expanded.	Communication checklist implemented and audited in a sample of cases within the mortuary	Simon Hughes Mortuary Manager Bereavement midwife lead	09/10/2026	
Recommendation 3	Implement guidance on respectful language for all documentation and family communication relating to babies and deceased patients.	Generic Training in place for Equality and Diversity and Inclusion	Guidance issued and incorporated into staff induction and refresher training.	Bereavement midwife lead	09/09/2026	
Recommendation 4	Strengthen identification and traceability processes for deceased patients, retained tissue and organs, including clear escalation where checks are incomplete or inconsistent.	Standard operating procedure in place and compliance audit completed. HTA inspection raised no concerns around traceability. 3 points of ID used for any procedures or releases.	N/A	N/A	N/A	

Recommendation 5	Ensure babies and deceased patients are stored only in appropriate mortuary facilities and remove any routine use of domestic or unsuitable clinical storage areas.	Within the Mortuary no Domestic fridges in use for refrigeration of babies or adults. Areas where babies and adults are stored are secure and suitable.	N/A	N/A	N/A	
Recommendation 6	Introduce mandatory condition checks on admission to the mortuary and at agreed intervals throughout storage, with clear documentation standards.	SOP in place that states the need to check the condition of a patient on admission to the Mortuary, as well as every 7 days whilst in the care of the Mortuary. Deterioration is documented and addressed, where possible.	N/A	N/A	N/A	
Recommendation 7	Require a documented baseline condition assessment on admission so any subsequent deterioration can be identified, escalated and communicated.	SOP in place that states the need to check the condition of a patient on admission to the Mortuary, as well as every 7 days whilst in the care of the Mortuary. Deterioration is documented and addressed, where possible.	N/A	N/A	N/A	

Recommendation 8	Implement a trigger process requiring review for frozen storage at 30 days in refrigerated storage, or earlier where condition concerns are identified.	Trigger process embedded in mortuary workflow, reinforced with an SOP, and exceptions reviewed through governance. A traffic light system on the EDEN Mortuary system provides a strong visual indicator to trigger the process for transfer to deep freeze if necessary.	N/A	N/A	N/A	
Recommendation 9	Assess freezer capacity, including bariatric freezer provision, and develop a capacity plan to ensure safe and dignified storage.	Bariatric and standard freezer spaces available. At present, the storage is suitable, but future business cases will incorporate modelling of death rates to ensure adequate capacity is provided.	N/A	N/A	N/A	
Recommendation 10	Introduce an early family-wishes assessment covering viewing, dressing, embalming, funeral timing and cultural or religious preferences.	Assessment form implemented and completed in relevant cases within the mortuary. The mortuary does not undertake embalming, funeral timing – this sits with the Funeral Directors	Further assurance needed from Maternity on what processes are used on the Maternity unit	Maternity lead	August 2026	

Recommendation 11	Establish a process for prompt communication with families and funeral directors where deterioration or delays may affect viewing or other post-death arrangements.	Process in place for informing FD's of clearance, which is documented in the communications section for the patient on EDEN. Meeting held every Wednesday between Mortuary, Coroners and ME Office to ensure patients are followed up and any delays investigated and addressed. Deterioration is communicated with FD's if it occurs	N/A	N/A	N/A	
Recommendation 12 – not applicable	Review the location and process for perinatal post mortem examinations and agree arrangements to use HTA-licensed mortuary facilities wherever possible.	Perinatal Post Mortems not carried out at Torbay.	N/A	N/A	N/A	
Recommendation 13	Identify and implement operational safeguards that prevent the security and dignity of deceased patients from being compromised.	Security measures in place to limit access to controlled areas, which is audited weekly. CCTV in place that covers the access points to all areas where deceased patients are stored within the	CCTV to be installed in Lullaby room on Delivery Suite.	Maternity Lead	09/11/2026	

		Mortuary. CCTV is pending installation in Delivery Suite where infants are stored, but this is access controlled.				
Recommendation 14 – not applicable	Redesign the baby X-ray, post mortem and reconstruction pathway so these steps are completed in the shortest practicable timeframe, ideally as one continuous process where appropriate.	Infant Post Mortems are not carried out at Torbay Hospital.	N/A	N/A	N/A	
Recommendation 15 – not applicable	Introduce a requirement that babies are reconstructed promptly after post mortem examination or receive a dignified interim reconstruction where organs or tissue are retained.	Infant Post Mortems are not carried out at Torbay Hospital.	N/A	N/A	N/A	

Recommendation 16	Mandate two-person checks at post mortem, reconstruction, transfer and disposal stages, with documented confirmation at each stage.	Two person checks are implemented at all stages within the Mortuary, whether this is with 2 APT's, and APT and Pathologist, or and APT and a Funeral Director's Operative.	N/A	N/A	N/A	
Recommendation 17	Create and maintain a training and competency matrix for all staff involved in mortuary-related processes, including laboratory support staff where applicable.	Competency assessments and training in place for staff.	Mortuary service lead to work with Quality team to utilise Q-Pulse to or other appropriate system to create a competency matrix.	Simon Hughes – Mortuary Manager and Pathology Quality team	09/10/2026	
Recommendation 18	Review role allocation for post mortem support and reconstruction tasks to ensure qualified Anatomical Pathology Technologists are used where the task falls within their expertise.	All tasks within the Mortuary, including post mortem support and reconstruction are undertaken by either qualified or trainee APT's (with supervision)	N/A	N/A	N/A	

Board and Sub Committee

Mortuary Activity Report June 2026

Date of meeting	Date report produced
23 rd June 2026	20 th May 2026

Author(s)		Report approved by	
Name and title:	Simon Hughes, Mortuary Manager	Name and title:	Ria McCoy ADO – Cancer and Clinical Support Services Dr CA Lisset (CMO and Designated Individual)
		Date:	4 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 assurance on the safety, quality, and governance of mortuary services, including compliance with the Human Tissue Act 2004 and alignment with best practice following the Fuller Inquiry.

Appendices
Appendix 1 – Fuller Inquiry: Phase 2 report gap analysis. <i>Included in the Quality and People Committee Items for Information Pack</i>

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

Key recommendations and actions requested

This report provides assurance on the safety, quality, and governance of mortuary services, including compliance with the Human Tissue Act 2004 and alignment with best practice following the Fuller Inquiry.

Overall assurance rating: Satisfactory

- The service delivers a **high standard of care**, with **full compliance with statutory requirements** and **no outstanding regulatory concerns**
- **Clinical quality and operational performance are strong**, evidenced by a successful HTA inspection and sustained high-quality service delivery.
- **Workforce development and governance arrangements are positive**, with good progress against professional standards and oversight requirements.

However, **overall assurance is moderated by infrastructure-related risks**, which sit outside direct clinical control but have the potential to impact service resilience:

- **Air Handling Unit (AHU) – Limited assurance**
 - Ageing infrastructure presents a **material operational risk**, despite current compliance
 - Failure would result in **cessation of post-mortem activity**, with associated **regulatory, reputational, and system-wide impacts**
- **Mortuary facilities – Limited assurance**
 - Estate constraints are **increasingly impacting workflow, capacity, and optimal patient/family pathways**
 - Current mitigations allow safe operation but are **not sustainable long-term without capital investment**
- **– Fuller Inquiry recommendations – Satisfactory assurance**
 - The majority of recommendations are in place
 - **Residual gaps relate to enhanced (non-statutory) best practice controls**, with a clear plan for completion
 -

In summary:

- **What is working well:** compliance, quality of care, governance, and workforce capability
- **What is limiting assurance:** estate and infrastructure risks (AHU and facility constraints)
- **What is required:** targeted **capital investment and estates progression** to reduce operational risk and support future service resilience
-

Key message for Board:

The mortuary service is **safe, compliant, and delivers high-quality care**. To sustain this position and move to **Significant assurance overall**, **timely investment in critical infrastructure is required**, particularly the **AHU replacement and phased estate improvements**.

How does this report further our Trust strategy?

This report seeks to provide assurance that deceased patients within Torbay Hospital Mortuary are being cared for to a high standard, in line with all Human Tissue Authority Legislation and Codes of Practice.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	Adequately store deceased patients and care for deceased patients in a dignified, respectful and secure manner.
Quality of services provided	Provide a high-quality service for the Hospital, Coroner, Bereaved Relatives, Funeral Directors and all service users, that fulfils all of the standards set out in the Human Tissue Act 2004
Sustainable and efficient use of resources	To utilise existing resources to deliver a high quality service and raise carefully considered, risk assessed business cases where required.

Impact on BAF Objectives

BAF Objective	Impact
Quality, Safety and Patient Experience	Personalised care and quality will be upheld wherever possible We work with other partners in the region to develop the service.
Leadership and Governance	
Performance	Our performance is within expected levels.
People and Culture	There is some difficulty in having appropriate workstations for all staff due to the departmental layout and footprint. One member of staff is on long term absence. We will always try to accommodate requests received if feasible.
Strategy and Business Intelligence	Some areas are showing wear and tear such as the AHU and Post Mortem room The Eden operating system is running well, and the department is using Epic with no current issues identified. Some longer-term issues have been identified that may be dealt with under the BBF project. The Bereavement team is down to one member of staff working part-time, as much of the function was taken by the Medical Examiner team. When this is working well

there are no issues, but struggles under higher workloads.
Options are always investigated to repair/reuse equipment rather than purchase new.

Finance

We are billing the Coroner for Post Mortems and storage at the new rate, but currently this income is not going back into the Mortuary budget.

Risk

AHU in PM room is in poor condition, though still legally compliant
Not currently on risk register, is on the internal Estates register.

Risks lodged on Datix:

External Standards affected by this report and associated risks

Human Tissue Act 2004 – No Current shortfalls identified and fully compliant.

Fuller Inquiry: Phase 2 report – See GAP analysis in Appendix 1.

Mortuary Activity Report June 2026

Introduction and background

An overview of Mortuary activity and challenges currently faced by the Mortuary Department at Torbay Hospital. This report details how the Mortuary is performing against its legal obligations under the Human Tissue Act 2004 and what steps have been taken to provide a safe and effective service for the storage of deceased patients and providing a Post Mortem service for the Devon Coroner.

Assurance and Recommendations

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Compliance with all legal obligations under the Human Tissue Act 2004	All shortfalls from last year were addressed, no major issues are outstanding with compliance. Significant – No outstanding shortfalls, fully compliant	N/A
Air Handling Unit (AHU)	The AHU for the Post Mortem (PM) room has been graded as 'Poor' following inspections by external contractors. Though still legally compliant, the age of the unit causes it to be a risk factor for breakage. If the AHU were to break, we would be unable to carry out Post Mortem examinations, which would come with media attention, loss of income, risks to our HTA Licence, and increased pressure on other hospitals in the region to cope with the increased workload. The AHU is on the Estates risk register, and we have been told it will likely be in the next round of units to be replaced. Limited –AHU is on the Estates register, but remains a risk until work is complete.	N/A
Fuller Inquiry: Phase 2 report.	The report from phase 2 of the Fuller Inquiry (An Inquiry following the crimes of David Fuller in Kent, who accessed the Mortuary department and sexually assaulted deceased patients) has been published with several recommendations to provide assurance that deceased patients are being cared for appropriately and securely. Whilst we fulfil the legal requirements set out by the Human Tissue Authority under the Human Tissue Act 2004, The Fuller Inquiry seeks to	N/A

	further enhance controls to provide a higher standard of security and care. Whilst the recommendations are not Law, they have been considered as best practice by a multi-disciplinary panel. We currently fulfil most of the recommendations already, through our own process and the work that was carried out following phase 1 of the Fuller Inquiry. Please see Appendix 1 for a Gap analysis of where we are against the Inquiry recommendations. Satisfactory – Some areas require more work (See Gap Analysis in Appendix 1)	
Activity summary	In the past 12 months, the Mortuary department has looked after 1873 deceased patients, of which 442 had a Post Mortem examination. The total number of deceased patients is slightly lower for the year than it has been in the previous 3 years, and the number of Post Mortems is around 45 lower. The way that we care for deceased patients has changed in the last 3 years, and though more complex and involved for each individual case, we are now providing a better quality of care. We passed our HTA inspection with minimal areas of improvement identified and all shortfalls now completely addressed. 2 members of the Mortuary team have completed their registration with the Science Council and have been recognised as a Registered Science Technician (RSciTech) and a Registered Scientist (RSci). Further work is ongoing with remaining staff to achieve registration. There are some difficulties with ME referrals and MCCD completion with the clinician, but releases are generally carried out in a timely manner. Simon gave a talk at the Student Nurse study day about Care after Death and the procedures that take place when a patient passes away. This was very well received, with a lot of interest in students attending the department for further talks about what the Mortuary does. Significant – The Mortuary continues to provide a high-quality service.	

Mortuary facilities	It is appreciated that there has been investment in the Mortuary department in the last few years, and the increased capacity, along with the refurbished viewing facility, has improved the way that the department is able to function, as well as provide a better service to those that we care for and their relatives. There are still challenges within the department though, with the Post Mortem room being dated and not up to the standard of more modern facilities, with only 2 Post Mortem tables and no downdraft bench for Pathologist dissection. The current bench is a stainless steel counter top with a sink. We had some issues with drainage on this in May as well, though this has now been resolved. Ideally a Mortuary carrying out the number of Post Mortem examinations that we do, would have 3 or 4 PM tables to allow smooth operation of the department. Additionally, we have increased headcount in the department, which has helped to provide a better service, but also allowed Senior staff and the departmental manager to spend more time focusing on strategic issues and more complex operational issues. With the expansion of capacity within the Mortuary, we had to make a decision on how to utilise our existing footprint, and in doing so lost important admin space and workstations. With the Bereavement team now under Mortuary management, ideally, they would be located within the Mortuary, but with lack of appropriate work stations for Mortuary staff this has not been possible. We have some mitigating procedures in place with our Post Mortem Observation gallery being repurposed into a Manager's Office, and a PC being placed into one of the changing rooms to allow another work station for staff, but these are not ideal circumstances. There is also an issue whereby the same entrance to the Mortuary is used for Porters delivering deceased patients from the wards, as Bereaved relatives coming to see their loved ones in our viewing room. Due to the increased capacity, and the space we had available, one of the rooms where deceased patients are stored is off the same corridor that relatives use to access the viewing room. This can cause some issues	

	if Funeral Directors arrive to collect a patient from this area and a family is in the viewing room. We mitigate this with communication and managing workflow, but if an opportunity arose to reconfigure the layout, moving the viewing room to have a separate entrance for bereaved relatives would be preferable. In the short term, a "Viewing in progress" light has been created by one of the team and is used when a viewing takes place. With the introduction of Epic we are also able to see if there are any pending Mortuary transfers prior to a viewing taking place. In summary, we are able to function as a department, but with several mitigating factors. The investment that has taken place in the department is really appreciated, and with the current financial status of the Trust, I appreciate that any finances spent must be assessed for risk on a case-by-case basis. We will be putting forward a business case with phased options for development of the department, and hope that these are considered. Limited – Age of parts of the department are starting to restrict workflow/ability to function correctly	

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

The report has been discussed with the Medical Director, who is also the Designated Individual under the Human Tissue Act Licence that is held by the Trust to store deceased patients and carry out post-mortem examinations.

The report has also been signed off by the Associate Director of Operations for Cancer & Clinical Support Services.

Issues raised within this report have been raised at local meetings, Pathology Quality meetings, and Governance meetings for Cancer & Clinical Support Services.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Compliance with Human Tissue Act	Significant	Improvement from Satisfactory

Post Mortem room Air handling unit	Limited	Stays the same, pending investment.
Fuller Inquiry: Phase 2 report actions	Satisfactory	Stays the same, pending investment.
Activity Summary	Significant	Stays the same
Mortuary Facilities	Limited	Stays the same, pending investment

Consideration is required to support replacing the Post Mortem room Air Handling Unit, and to consider the options provided to improve the Mortuary facilities in an upcoming Business case.

Overall, the Assurance provided in delivering a safe, respectful Mortuary service is Satisfactory

Appendix 1 – Fuller Inquiry: Phase 2 report gap analysis.

	Fuller Phase 2 Action Plan					
	Recommendation	Progress	Action	Owner	Deadline	RAG
Recommendation 1	All Trusts with Mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of 1. The systems in place to identify any unauthorised access to the facility 2. The strength and effectiveness of barriers to prevent unauthorised access to the facilities 3. The systems in place to identify any access to deceased people for unauthorised purposes 4. How CCTV is used, including its monitoring and any audits undertaken	Partially met. A full local review of security of the Mortuary was undertaken in response to Fuller 1 Inquiry. This was undertaken with the Mortuary Manager, Director of Operations and Security team. Access to the Mortuary is via individual swipe cards and CCTV and swipe card audits are carried out each week. All access requests must be signed off by the Mortuary Manager, Director of Operations and DI.	Report sent in September 2025. Arrange cross-regional security review with Mortuary Managers from other Trusts.	Mortuary Manager ADO DI	31/08/2026	
Recommendation 2	All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the postmortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges	Completed in response to Fuller 1 Inquiry – CCTV in place in all areas referenced	Complete – no action	N/A	N/A	

Recommendation 3	All NHS trusts should routinely audit the access data of all facilities used to store deceased people	Completed in response to Fuller 1 Inquiry. Mortuary security audit carried out every Monday	Complete – no action	N/A	N/A	
Recommendation 4	The practice of using shared electronic swipe cards for specific staff groups should cease immediately	Completed in response to Fuller 1 Inquiry. All shared access cards revoked and individual access cards in use	Complete – no action	N/A	N/A	
Recommendation 5	All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons	No rule in place currently that prevents electronic devices within the Mortuary. Trust mobile phone policy in use, along with Policy for use of mobile communication devices within hospital buildings. A Process assessment was carried out to see if enforcing tighter controls of mobile phones would be feasible. In most cases it wouldn't be feasible to remove phones from all FD's entering the department. Signs prohibiting use of mobile phones installed in the Mortuary department	Complete – No further action	N/A	N/A	

Recommendation 6	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	Security breaches reviewed by Mortuary Manager, with input from Security team where required.	Complete – No further action	N/A	N/A	
Recommendation 7	The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority	N/A. No Body stores in use by the Trust. Only fully licenced Mortuary at Torbay Hospital	N/A	N/A	N/A	

Recommendation 8	All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	No swipe to exit system currently in use. Work has been costed and would be quite expensive to install all the required readers, plus upgrade the electric panel to be able to cope with them. Current price was sitting at over £8,000, and there wasn't a clear route for which budget would pay for this. This was discussed at the recent HTA meeting and the current control measures that are in place with audits was deemed to be adequate. It was felt the funding that would be required would be better spent in other areas of the department.	Undertake a risk assessment to document the residual risk involved in not completing the work.	Mortuary Manager	31/08/2026	
Recommendation 9	All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.	Complete. This is carried out by the Mortuary Manager each Monday via an automated Swipe permissions list and access log being sent, that is reviewed. Results of these audits are held on Q-Pulse. Senior APT is now trained in these audits and also completes them.	N/A	N/A	N/A	

Recommendation 10	NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	Complete. CMO stated that she had enough time to complete her functions as DI	N/A	N/A	N/A	
Recommendation 11	NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	Complete. Senior Managers and the Chief Executive were involved in HTA inspection feedback, and understand the importance of the HTA and DI role.	N/A	N/A	N/A	
Recommendation 12	NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	Complete. DI attends the correct governance forums	N/A	N/A	N/A	
Recommendation 13	A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager	Complete. Mortuary Manager has background in Mortuary services and holds Certificate and Diploma in Anatomical Pathology Technology. This is essential criterion within the job description	N/A	N/A	N/A	
Recommendation 14	NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	Partially met. There are processes in place in the department to assist the Mortuary Manager to complete all relevant tasks and staffing levels increased in 23/24 – duties and processes still in development as well as competencies	Resolve long term absence	Mortuary Manager	01/12/2026	

		Due to Long term absence in the department there has been short staffing for the last 6 months. Workload is manageable for day-to-day operation, but some strategic operations are delayed.				
Recommendation 15	All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include: 1. Staffing Matters 2. Security Incidents 3. All Serious Incidents 4. HTA Reports (where applicable) 5. All Security Audits, including audits of access and any access breaches	Partially met. A formal board report has been agreed and due to go to Trust Board in September -headings and info will be included in the report. Director of Operations updates on Mortuary matters via Divisional and Care Group governance Board report to be presented at September Board	N/A	N/A	N/A	
Recommendation 16	Trust boards should assure themselves that the recommendations in this Report have been implemented.	Partially met. Board report was developed and signed off in response to Fuller 1 Inquiry - A further formal board report has been agreed and is due to go to the Trust Board in September -headings and info will be included in the report.	N/A	N/A	N/A	

		Board report presented at the September Board				
Recommendation 17	Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people	Partially met. Temporary storage facilities have been assessed by the Mortuary manager, including site visits to Funeral Directors that the Trust holds SLA's with. This information will be contained in the board report. Board report presented at September Board	N/A	N/A	N/A	
Recommendation 18	Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements	Complete – represented by DI as Board member	n/a	n/a	n/a	
Recommendation 19	NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	Incomplete - Assessment needed to see if the current safeguarding training and policies cover deceased patients. Where this is not the case, plan to be developed and implemented.	Raised to Chief Nursing Officer and plan to be developed, will also be identified in September Board Report	ADO CNO	01/02/2026	

		UNSURE WHERE WE ARE ON THIS ONE – SH 04/06/2026				
Recommendation 20	The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores	In progress, the chief nurse had previously been involved in assurance of the dignity & Security of deceased patients when an emergency temporary storage facility was actioned. UNSURE WHERE WE ARE ON THIS ONE – SH 04/06/2026	Raised to Chief Nursing Officer and plan to be developed, will also be identified in September Board Report	ADO CNO	01/02/2026	
Recommendation 69	Where organisations work together to care for people after death, the arrangements should be formalised through contracts or service level agreements. This should include joint Standard Operating Procedures. The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively, and that they seek assurance that the arrangements protect the security and dignity of people after death.	Partially met. SLA's are in place that state the steps that have to be taken for third parties to manage the safety and security of deceased patients in their care on behalf of the Trust, though there are currently no shared SOP's in place. Time constraints have meant that this action has slipped, but we will look to get SOP's in place before winter pressures start.	Develop shared SOPs in line with SLA's	Mortuary Manager ADO	01/11/2026	

